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Sarah Waller's Help-Seeking Model: Understanding African American Women Intimate Partner Violence Survivors' Help-seeking Process

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Abstract

African American women overwhelmingly experience the poorest outcomes resulting from intimate partner violence (IPV) victimization. Despite theoretical advancements, there remain a paucity of theories that explicate this marginalized population's comprehensive help-seeking process that includes the domestic violence service provision system and the Black church. We conducted 30 in-depth, semi-structured interviews with women who self-identified as African American. We utilized sensitizing concepts

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from the Transtheoretical Model of Change and Intersectionality theories, along with Agency framework and employed constructivist grounded theory methodology. Sarah's Help-Seeking Model emerged from the data and includes nine phases: (1) Awareness, (2) Acknowledgment, (3) Assessment, (4) Enough, (5) Enlist, (6) Escalate, (7) Reject, (8) Resolve, and (9) Restoration. This is the first theory that identifies how this vulnerable and underserved population's mental health and social support-seeking process is partially mediated by mistrust of law enforcement, disappointment in linkage to care and services, fear of death, and willingness to survive.

Keywords
intimate partner violence, domestic violence, homicide, help-seeking, African American

Introduction

African American women bare the disproportionate burden of intimate partner violence (IPV) victimization among all racial and ethnic women in the United States (U.S.) (Petrosky et al., 2017; Violence Policy Center, 2022). IPV includes any physical, psychological, sexual, financial abuse, stalking, and controlling behaviors (Breiding et al., 2015). African American women experience the highest rates of intimate partner homicide among women of all racial and ethnic groups (Petrosky et al., 2017). National homicide trend data show that African American women are murdered at a rate that is 4.4 per 100,000 women, compared to 4.3 for American Indian/Alaskan Native, 1.8 for Latina, and 1.3 for white women (Petrosky et al., 2017). African American women are generally murdered at 35 years old, which is 6 years younger than the national average (Violence Policy Center, 2022). Some 66% of women, regardless of race or ethnicity, who were murdered sought help months before they were killed, which is indicative of failed help-seeking attempts (Black, 2011). Survivors also experience poorer proximal and distal health outcomes. One out of every three IPV survivors has lost consciousness at least once in her lifetime, average seven different occasions when they are injured and make nearly two times more emergency department visits than non-abused women (Black, 2011). More than one in three (38%) suffer from chronic neck or back pain, 31% develop cardiovascular disease, and 28% are on disability and unable to work (Black, 2011; Coker et al., 2000). The mental health effects are just as deleterious. Upwards of 70% of all IPV survivors experience depression, 51–75% experience posttraumatic stress disorder (PTSD),

and another 13% suffer from substance use disorders (Black, 2011). African American women experience more enduring symptoms due to prolonged exposure to more severe victimization and subsequent help-seeking barriers (Sabri et al., 2013; Waller et al., 2021). Despite the sequela of lethal and nocuous outcomes, there is a paucity of theories that identify their nuanced help-seeking efforts. We employed constructivist grounded theory (CGT) methodology to develop an emergent theory that identifies African American women IPV survivors' psychosocial help-seeking process, from problem identification to resolution. We specifically wanted to explain how they navigate barriers resulting from their race–class–gender intersectionality to secure urgent aid.

IPV Help-Seeking

Help-seeking for IPV victimization is a circuitous process that is shaped by both the survivor's cultural norms and her sociopolitical context. Help-seeking is conceptualized as a nonlinear process of seeking for interventions, resources, and/or support. It often begins with problem identification, includes women disclosing the abuse to informal supports along with obtaining access to formal providers and may end with termination of the abusive relationship (Lelaurain et al., 2017). Survivors generally begin disclosing the victimization to their kinship networks, specifically their family members and close friends. Those who receive supportive responses may then report the abuse to formal providers within the domestic violence service provision system, which is inclusive of the criminal legal, shelter, healthcare, and mental healthcare systems.

African American Women's Help-Seeking

African American women additionally contend with barriers resulting from the endemic and insidious nature of racism (Hankerson et al., 2022; Waller et al., 2021). Waller et al. (2021) conducted a systematic review of the literature and found that African American survivors are more likely to delay their help-seeking efforts until the abuse is at peak lethality because they anticipate experiencing racism from formal providers. In fact, women noted they would rather remain in their abusive relationship than withstand racial discrimination (Waller & Bent-Goodley, 2022; Waller et al., 2021). As such, considerations related to access to, and availability of services and supports also shape their help-seeking process. This is particularly evidenced among women who are financially dependent upon their partner or in other situations that make it more difficult for them to leave. Women who are

financially dependent on their partner may instead choose to remain in the abusive relationship while garnering support from their family and friend networks (Mannell et al., 2016).

The Role of the Black Church

The Black Church is a long-standing trusted resource within the African American community, particularly considering the tenuous relationship the community has with formal providers (Hankerson et al., 2018; Taylor & Chatters, 1986). As such, survivors readily rely upon religious resources during their IPV help-seeking (Anyikwa, 2015; Shaw et al., 2022; Waller et al., 2021). This context is critical to understanding African American women's help-seeking, particularly since they are overrepresented in low-wage jobs that were significantly impacted by COVID-19-related business disruptions (Holder et al., 2021). Despite the complexities that underpin their IPV help-seeking, there remain a dearth of theories that adequately explicate African American women's specific strategies (Waller et al., 2022). Current theories explaining IPV help-seeking identify Asian American and Latina women's help-seeking (Liang et al., 2005; Raj & Silverman, 2007; Randell et al., 2012). Yet, there remains a critical need to explain African American, cisgender women's experiences.

Methods

CGT Methodology

We employed CGT methodology for analysis. Unlike grounded theory, which dictates that researchers approach data "tabula rasa," CGT allows us to incorporate our experiences and knowledge of existing theories into theoretical development (Charmaz, 2014). This is crucial since the research team is well experienced in conducting research and providing clinical and social services assistance to this population of IPV survivors. Employing CGT allowed us to examine help-seeking across multiple contexts, namely participants, situations, and hypotheses. This methodology also allowed us to centralize the voices of this multiply marginalized, under-researched population of survivors who are often overlooked in the literature (Collins, 2002).

Data Collection

Data were collected from 30 African American women IPV survivors via semi-structured interviews, demographic surveys, field notes, and memos

(Table 1: Participant demographics). CGT calls for data collection and analysis to co-occur (Charmaz, 2014). Individual, in-depth, semi-structured interviews were conducted until each theme reached saturation and no new themes emerged. Interviews averaged 60 minutes in duration. Data were transcribed line-by-line via a professional transcription service. Transcripts were verified by the first author. Clean transcripts were uploaded via Dedoose, a web-based data management system utilized to analyze the qualitative data (Salmona et al., 2019). The first author analyzed the quantitative, demographic data to understand the frequency distribution. To capture "rich data," field notes that included insights about the participants and non-verbal facial expressions were recorded immediately following each interview (Charmaz, 2014).

Data Analysis

CGT methodology demands that analysis employs the constant comparative method of theory development (Charmaz, 2014). The constant comparative method includes four hierarchal phases, namely (1) initial coding, (2) focused coding, (3) axial coding, and (4) theoretical coding (Charmaz, 2014). Initial coding allowed us to identify what was occurring in the data. We identified 660 codes during focused coding. During focused coding, we began sorting and separating child codes and synthesized emerging themes into parent codes that later became categories. As a means of further refining our analysis, we organized the data in tables based upon themes. This allowed us to understand the ways that survivors' cognitive evaluations of available services and supports influenced how they navigated their psychosocial barriers during their IPV help-seeking process. Theoretical coding allowed us to hone emergent themes based upon their relationship with other themes, which made the theoretical codes integrative. Memos of analytic insights were included in a methodological journal. This allowed us to add rigor to the analytic process.

The Transtheoretical Model of Change (TTM) and Intersectionality theories as well as Agency framework were conceptually bound, and theoretical constructs were used as sensitizing concepts for analysis. TTM is a phase-oriented model that captured survivors' cognitive and behavioral aspects of change (Chang et al., 2010). Intersectionality illuminated the way that survivors' overlapping oppressions resulting from race–class–gender politics have created multiple levels of social marginalization (Crenshaw, 1990). Agency is a strengths-based framework that allowed us to examine the ways that survivors are empowered to act upon available choices (Logie & Daniel, 2016).

Table 1. Participant Variables of the Sample of African American IPV Survivors, aged 21–63.

Age ($M = 40$ years, SD = 10.48)		
20–29	4	13%
30–39	10	34%
40–49	9	30%
50–59	4	13%
60–64	3	10%
Marital status		
Single	17	57%
Married	4	13%
Separated	5	17%
Divorced	3	10%
Cohabitating	1	3%
Duration of relationship ($M = 9.38$ years, SD = 8.63)		
0–4 years	10	34%
5–9 years	8	27%
10–14 years	6	20%
15–19 years	1	3%
20–24 years	3	10%
25+ years	2	6%
Education		
Middle school	1	3%
GED	6	20%
High school diploma	6	20%
Associate's degree	11	37%
Bachelor's degree	2	6%
Graduate degree	4	14%
Occupational status		
At home	8	27%
Per Diem	7	24%
Part time	11	37%
Full time	2	6%
Retired	1	3%
Disability	1	3%
Number of children		
0	4	13%
1	10	34%
2	9	30%
3	3	10%
4	1	3%
5+	3	10%

SD = standard deviation.

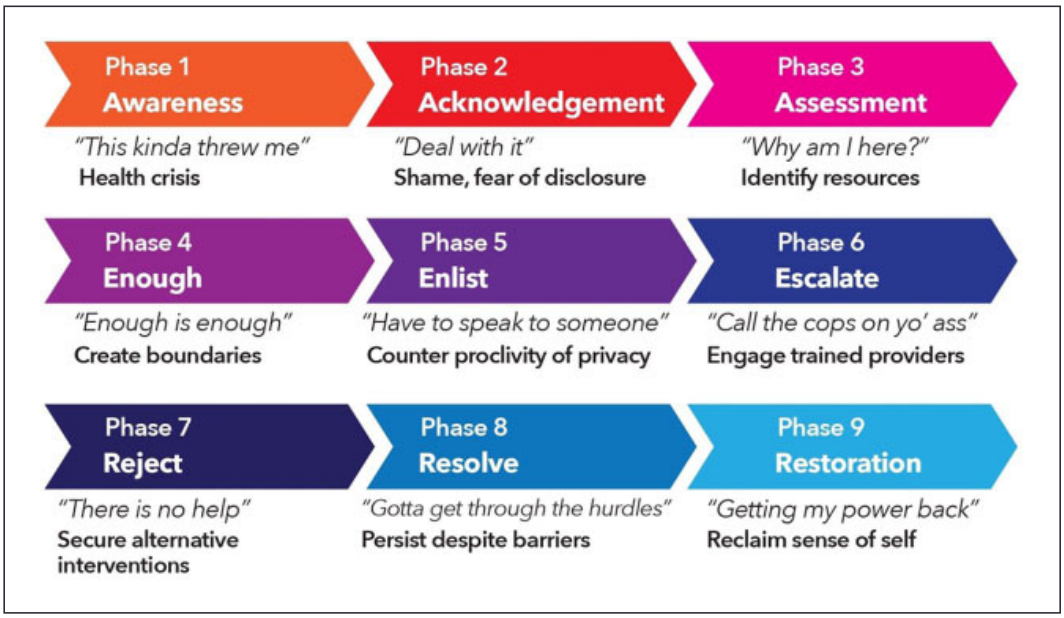

Figure 1. Sarah Waller's Help-Seeking Model.

Results

Nine major themes, which correspond to phases of the help-seeking process, emerged from the data. The phases explicate four cognitive phases followed by five behavioral phases of African American women IPV survivors' IPV help-seeking (see Figure 1: Sarah Waller's Help-Seeking Model). Waller's Model postulates that survivors navigate internal factors, including shock and shame, and external barriers, specifically stigma, racial discrimination, and a scarcity of culturally congruent interventions, during their journey toward securing crisis services and support. Survivors may advance and/or relapse as well as skip phases of help-seeking, depending upon multiple factors including but not limited to their positionality within their sociopolitical context. The model was named in memory of the first author's maternal grandmother who was the consummate caregiver in her small rural community of Elizabeth City, North Carolina. To protect confidentiality, pseudonyms are used in lieu of survivors' names.

Phase 1: Awareness—"This Kinda Threw me"

IPV help-seeking begins with women's awareness that they are experiencing IPV. During this phase, many of the women described feeling blindsided that their partner was abusing them. These women could not believe that their partner had the capacity to harm them, especially since their partner initially doted over them. Some of the women shared the ways that the beginning of

their relationship reflected the love and romance that is often depicted via mainstream media. Other women began experiencing a series of internalizing disorders, including dissociation, anxiety, and depression. Faith stated that a mundane discussion with her long-time boyfriend quickly spiraled into an out-of-control argument that ended with him becoming physically abusive. He choked her until she blacked out while she was holding their 2-year-old son. She said:

> It just felt so unreal. To really sit there waiting for my son to get checked out. Me? Because of the domestic situation? It just felt like I was in a movie. Like you're the one watching it on to the end. But now I feel like I'm the one in the movie. That's what it felt like. Like I was in the movie and I just wanted to wake up, but it wasn't happening.

Several respondents believed that they experienced long-term victimization because they were neither able to recognize their partner's violence against them nor were they able to categorize it as IPV. To this end, Alecia shared that she was unaware that her husband employed controlling behaviors throughout their 25-year marriage. She was only able to recognize it after terminating the relationship and working with a therapist. After years of experiencing coercive control, she refused one of his directives. Her response triggered what had otherwise been benign acts of control to quickly escalate to physical violence. Women who noted they had similar experiences admitted that their inability to more readily identify that their partner was abusing them significantly delayed their help-seeking efforts.

Phase 2: Acknowledgment—"Deal With it"

Most of the survivors shared that their cultural norms of privacy and faithfulness in their relationship largely influenced their decision to secretly cope with the abuse on their own rather than seek assistance from their kinship network or formal providers. In addition to struggling with anticipatory stigma and internalized shame, these women believed that they had the tools necessary to navigate the underpinnings of their partner's proclivities toward inflicting physical, sexual, and psychological abuse without engaging law enforcement to assist them. Several women shared that they felt compelled to protect their family members. Their justifications ranged from fear of retribution to concern about their family members' reactions. One survivor refused to divulge her ongoing victimization because of how deeply she feared the perpetrator. Ebony said, "I was scared of him. I was afraid of the repercussions because of some of the threats he made. I was afraid to talk about it, so

I didn't." She remained secretive about the abuse until one of her close friends forced her to admit it.

Phase 3: Assessment—"Why am I Here?"

Survivors in this phase began to assess their sense of self and quality of life. Many of them questioned "why am I here?" These women began an existential self-examination of their existence. Their continuum of introspection ranged from questioning the purpose of their life to why they remained in an abusive relationship. Several other women began contemplating suicide as a way to escape the abuse while others shared the ways their mental well-being began to deteriorate. To that end, Bonita shared her concerns about her mental health. After 5 years of experiencing severe physical and psychological abuse from her partner, the stay-at-home mother of three young children said:

> I realized that the last month or two, that maybe anxiety or depression is really real. So lately, I need some type of documentation of what's going on here because in my mind, I'm not okay. I'm not going to do anything that's going to hurt my kids, but I'm not okay. There are days [that] I'm just not okay. I'm not okay, I've lost a lot of weight, this is not my size [pointing at herself], in the last month. So, I know I'm not okay.

A few survivors disclosed that they relied upon prayer and their faith in God to defend against their partner's abusive tactics, while others used substances as a means of escaping the reality of their abuse.

Phase 4: Enough—"Enough is Enough"

Most of the survivors reached a point when they began to declare that "enough is enough." These women determined that they were no longer going to accept the abuse they were experiencing and were at a breaking point. Many were at a crossroad in their help-seeking process. They were either going to remain contemplative or take action against the abuse. These women were tired of trying to negotiate limits of their relationship without seeing any lasting changes in their abusive partner's attitude or actions. Some women decided to engage law enforcement. One respondent shared that she refused to engage law enforcement, despite experiencing severe physical abuse. However, one incident changed her stance. Her partner thwacked her in the face with a wooden broom handle. This left her bleeding profusely and a chunk of her flesh hanging out of her face. At that point, she feared for her life. She began questioning what would happen to her children if she died.

Keisha said, "It gets to the point where you're forced to do things." She reflected that she had to make changes within the relationship or risk getting murdered. She said:

> Once I got two scars in my face. The next scars, I'll be in a casket. So, it was just like, no, I gotta stop this somehow, someway. I think that was the last time he probably put his hands, physically, just really put his hands on me.

Some of the women decided to fight back as a means of actively resisting the abuse. These women admitted that they stabbed, beat, and/or cursed out their perpetrator. They decided to physically resist the victimization after realizing previous tactics that they employed were ineffective. Sandra's experience epitomizes how many of the women used their physical strength to brawl and go toe-to-toe with their abusive partner. She explained that she reached a point when she began to talk to herself. She said:

> You're not going to sit there and let them slay you. You're not just going to wallow in self-pity and dwell. You're not going to do that. You're going to go do what the f--- you got to do to get these, get the demons and the people, whatever, vampire. You're going to be a Vampire Slayer. Get them off of you.

These women fought back because they believed they had no other recourse in their quest to privately get their partner to amend his ways. Rather than engaging law enforcement, male family members and friends, they decided to fight back.

Phase 5: Enlist—"Have to Speak to Someone"

Several survivors reached a point in their help-seeking process when they believed it was time for them to enlist support from people within their friendship and/or kinship network. They could no longer suffer in silence and cope with the abuse because it was deleterious to their sense of self. Survivors in this phase of help-seeking universally expressed "I have to speak [to] someone." They largely relied upon those closest to them to provide them with the immediate emotional support they needed to persist with help-seeking. Deborah was married to her abusive partner for more than 24 years before she finally decided to terminate the toxic relationship. She said:

> Nobody is supposed to lift hands on nobody. We're human beings. Even animals we can't hit. We have to speak to somebody. You can stay until you pass away [die] or something happens. You have to speak to somebody. And somebody like a member of your family.

She acknowledged the difficulty she experienced with disclosing the abuse to her family while underscoring the value of her life. She said she decided to tell her family despite noting "telling my family was hard." She disclosed because she was aware of the implications of her daughter's exposure to IPV and how it could impact her definition and perspective of marriage. She was concerned about her daughter's mental well-being and how her childhood exposure to IPV could influence her perceptions of a healthy marriage.

Phase 6: Escalate—"Call the Cops on yo' ass"

During this phase of help-seeking, many of the women believed they exhausted all their options to curb the violence. Yet, the victimization continued. In some cases, the nature, severity, and frequency of the abuse worsened throughout the duration of the relationship. These women knew they had to take immediate action because they believed their lives were in imminent danger. Survivors felt compelled to counter their cultural norms of privacy and engage law enforcement. Many of the women were reticent about engaging the police because they were afraid that responding officers would kill their partner. Other women expressed concern about possibly endangering everyone within their household if the police mishandled the incident. To this end, Tanya said:

> We [African American women IPV survivors] don't go to the police unless it's detrimental. Like it's reached that boiling point. If it hasn't reached that boiling point, we don't go to the police because we feel like we can't trust them.

Survivors noted that they knew they had to engage the police because nothing else was working. Some of the women shared the ways their partner manipulated them after having a violent episode. A few of the women were tired and knew they had to take drastic measures to stop the vicious cycle of victimization. To that end, Terri said:

> Well sometimes they threaten you and your family, people close to you. That's how they get you in. But me? No, I'm different. My ass is going to the f---ing cops. I'm going to go to the court system. I'm going to call the cops on yo' ass. I'm not playing with nobody because I'm not scared of a gun. I'm not scared of an empty threat. I'm not scared of sh--!

This participant shared the ways that he and other abusive men have threatened her family members. Some of the perpetrators were savvy, weaponizing the court system and, in some cases, their children against them.

Tanya said she had to "call his bluff" and let him know she was not scared of him or what he would do to her. In fact, this participant expressed that her engaging the police was her form of resistance.

Phase 7: Reject—"There is no Help"

Most of the survivors who actively engaged the domestic violence service provision system shared that they experienced a series of barriers that precluded them from securing more immediate intervention. As a result, they rejected the system. The women became frustrated because they believed that providers made it more difficult for them to receive the same services and supports that their white peers were readily afforded. Their frustration was palpable. A few of the survivors started yelling and banging on the interview table while sharing the foreboding feelings they had that their partner was going to kill them. Some of these women's lives were in imminent danger. Yet, many of the women noted that providers offered calloused, delayed, and ineffective responses to their cries for help. To that end, Karen said:

> We end up staying in the situation till we probably lose our lives because there's no help. Like for me, I don't know what I'm going to do. I don't know what to do anymore. I don't know what to do. I really don't know what to do. So, I guess I'm probably going to just have to stay there until he kills me there. I know if he wanted to kill me that day I wouldn't live, because the police had taken so long to come.

Karen escaped her husband's severe physical abuse by running down the hallway and barricading herself behind their bedroom door. He then began destroying their wooden furniture and decorative glass fixtures peppered throughout their home. She recalled making a series of frantic calls to emergency dispatch in the violent episode. She noted that the dispatcher likely heard glass shattering in the background. She was told that "they were coming" but questioned whether officers were en route to her home. Karen said, "the precinct is right there. It doesn't take nothing for the police to go in the car and just come around the block." It took officers more than an hour to arrive. She feared that her husband was going to kill her that day with their 8-year-old daughter witnessing it.

Most of the survivors became so exasperated following their interactions with providers that they began to reject the domestic violence service provision system. These women stated, "there is no help." They found providers within the domestic violence service provision system largely inattentive to their needs. Some of the survivors felt like providers gave them the

runaround, rather than immediately connecting them with critical services and supports. Other women shared that they were disbelieved and devalued by providers. This disparaging treatment resulted in most the women believing they were not fully assisted when they relied upon providers within formal systems of support. Shayla said:

> Well, if there is help out there, I haven't found it as of yet. I just felt like when I reveal things, it just falls on deaf ears. So, I don't know. People make their promises that they'll help as much as they can and even if they do end up giving me resources, I feel like those resources were just giving me [the] runaround.

Melissa echoed her sentiments. This respondent's former husband became abusive shortly after the terror attacks on September 11. He was one of the first responders who became physically ill and was later diagnosed with PTSD and depression following his tour of duty on that fateful day. Responding officers' respect for his service translated into him receiving preferential treatment. When she reported the victimization, she shared that her complaints were minimized. She noted that officers' allegiance to her husband left her feeling like she could not trust anyone in law enforcement to fully support her during her crisis help-seeking. Melissa said:

> I don't trust them anymore. I would never call them again for my help. But you'd have to have witnesses because they definitely weren't advocating for me. They didn't come to help me.

Several women also described feeling abandoned and overall neglected by the domestic violence service provision system. These women noted that providers should be especially helpful to African American women because of all the adverse life experiences they have endured resulting from structural and systemic racism, as well as racial discrimination. Women stated that providers' refusal to provide more caring support was also harmful to their children's socioemotional and physical well-being.

Phase 8: Resolve—"Gotta get Through the Hurdles"

Some of the survivors remained resolute that they "gotta get through the hurdles" to get crisis assistance from the domestic violence service provision system. These women were persistent despite experiencing a series of hindrances. They were determined that they were not going to let providers' poor treatment discourage them from getting what they needed. Several participants shared stories of navigating barriers while interacting with multiple

systems of support, while others described multiple issues within one of the pathways. They experienced difficulties while engaging the criminal legal, shelter, and healthcare systems, as well as the Black church and their kinship network. Regardless, these women were determined to keep asking and seeking for help until they received it. Ariyanna's experience illustrates the experiences of many of the women within this phase of help-seeking. She said:

> I just felt, it was a long road to stand up and to when he finally got caught. Because I was determined to keep trying, to keep trying to stand up. Keep trying to do something and not do nothing. I was determined to just keep trying on my maybe my third or fourth try of calling the police and him actually getting caught.

Simone similarly shared that her desire to live is what inspired her to continue seeking help. She also noted that her young daughter also inspired her, questioning who would raise her children if she was dead.

> I ain't giving up. I'm not giving up at all, and I'm not going to let him kill me. I'm not going to do that either. I'm going to do what needs to be done for my kids. It's not easy, but anything worth having is not easy. So, even with all the no's I've gotten, I came back. I'm back here a months later, somebody will help me, and somebody will help me.

All the survivors within this phase of help-seeking displayed a steely resolve to persist until they were accommodated. They shared the ways each of the pathways failed them. As such, the survivors decided to rely upon themselves to secure the assistance they desperately needed. Once they secured what they needed, they were focused on "getting my power back."

Phase 9: Restoration—"Getting my Power Back"

Survivors within the final stage of help-seeking were able to maintain a sense of independence from the perpetrator after securing the necessary assistance. They journeyed through the maze of self-discovery and were reclaiming their sense of self. These women shared the ways they believe they "lost parts" of themselves while enduring the victimization. They began reclaiming their power and making decisions for themselves. To that end, Esther said:

> It made me feel like I was maybe getting my power back. Because I felt like maybe I had lost it through the abuse. That made me feel better. I'm taking my life back.

Alecia echoed these sentiments when reflecting on her relationship with her former husband. She stated that she did not realize the extent of the abuse until after she terminated the relationship and began seeing a therapist. She also began spending time with her friends, adult daughters and enjoying life. After 25 years of marriage, Alecia described some of the ways that she began reclaiming control of even her family's routines. She said:

> I don't have to cook spaghetti on Thursdays because he only wants spaghetti on Thursdays. I don't eat spaghetti no more. You'd be surprised, like, the little things. It's the little things. We aren't going to buy a ground turkey. Girl, we got beef. He didn't eat pork, so we did turkey for him. We don't have to do that anymore.

She described feeling a newfound sense of liberation and independence. Like most survivors within this phase of help-seeking, she discussed learning how to erect and reinforce healthy boundaries. Many of the women also expressed the importance of self-love and appreciating the fullness of who they have become. They were pleased with the woman they are becoming and relishing in their newfound. identify. Survivors were finally making themselves a priority in life, and they thoroughly enjoyed it.

Discussion

This study yielded the first theoretically informed framework that identifies nine phases of African American women's IPV help-seeking (Figure 1). Importantly, to our knowledge, this study is the first to show and outline internal factors such as denial, shame, ambivalence, and disbelief, along with common naturally occurring social support process partially mediated by lack of mistrust of law enforcement, disappointment in linkage to care and services, fear of death, and willingness to survive. These findings are consistent with the other help-seeking models and builds on the strengths of African American women, so they can deal more effectively with the stress associated with IPV (Overstreet et al., 2018; Rosenstock et al., 1988; Waller et al., 2021).

Sarah Waller's Help-Seeking Model addresses the serious gap in the literature, specifically identifying the ways that African American women in the United States interact with fractured systems of support. Though providers may be eager to assist, many lack the infrastructure, and understanding of culturally salient needs and norms that are required to assist them during this circuitous, painful, and dangerous process. There is an urgent need to identify and build upon their strengths and resilience and help them obtain sustained

proximal and distal outcomes during their recovery. Structural and systemic interventions are necessary to improve their social determinants of health, functioning, mental health, and quality of life—all of which are things that Grandma Sarah was an expert in providing to members of her small rural community.

Our review of literature was able to find two studies that employed grounded theory methodology to develop theories but there were specific to South Asian and Latina women survivors (Raj & Silverman, 2007; Randell et al., 2012). Therefore, there is a need for this theory especially among marginalized populations like African American women who have high rates of IPV although not the highest rates of victimization, but often have cultural and systematic barriers and challenges that preclude their immediate help-seeking. There is an urgent need to identify their experiences and current IPV evidence-based models fail to address the continuum of help-seeking from problem identification to resolution. There are barriers specific to African American women that Waller's Model helps identify, thus making it a theory that has immediate utility. There is also an urgent need to develop culturally salient interventions for African American women. This model helps to identify multiple potential entry points for intervention and implementation scientists. Furthermore, a better understanding of the gaps in domestic violence services and systematic barriers that African American face is also needed.

The results indicate that women who are in violent intimate relationships have multiple stages that they may go through before they might be able to change their circumstances and potentially leave an abusive relationship. The impact of outlining and understanding each of the stages may be better understood over time. Although participants generally indicated that they were eventually engaged in care, the numerous barriers and mistrust of police or law enforcement were common, reinforcing prior findings that this is a high-risk isolated population that may need alternative interventions and strategies. While service engagement was high, the length of time to access help and or leave their partner was generally long, sometimes in life-threatening situations, which goes against the recommended urgency for optimizing positive outcomes. The findings align with previous research indicating that African American women are in need of support (Satyen et al., 2019).

This new model may have significant benefits for individual and public health because it addresses and highlights significant stages, gaps, and barriers. Future campaigns, tools, and programs on IPV awareness and prevention should use and highlight the nine stages of Waller's Model so providers and individuals can better understand and meet survivors where they are in the different stages of the model. Prior studies have suggested that there are

different stages of abuse, like the power and control wheel (Rankine et al., 2017). Waller's Model differs because it infuses intersectionality and a strengths-based perspective to theoretical development. Still, it is important to acknowledge that women have their own internal and external processes that may be an adaptive coping mechanism, which can impact the readiness and level of treatment engagement. This study sample, given the high rates of IPV, all went through various stages of the model. Thus, additional research with this model is needed to further explore how African American cope and use social support to survive their abusive relationships. To maximize the benefit of Waller's Model, continued research is needed to develop a safe and effective programs and evidence-based interventions. Although all participants reported IPV, the results indicate and suggests that combination of phases are needed to facilitate reductions in further IPV. Future iterations of this theoretical model should identify areas for refinement and consider the use of technology to extend the impact of the model.

Although poor linkage to care was a problematic theme throughout the interviews, further exploration of types of assistance, stigma, and barriers as a part of IPV screening and/or referrals, may also be appropriate for this population and is an underexplored gap in IPV research for African American women. Importantly, relatively few interventions involve African American women (Gilbert et al., 2015, 2021), even though it is well known that this population has a high risk for experiencing severe IPV while having poor linkage to care (Petrosky et al., 2017; Waller et al., 2021, 2022). Because our analysis of this sample indicated that linkages to services were so challenging among participants who wanted to seek help and or leave their partners, future research should further examine the impact of various barriers on linkage to outcomes for those who were able to reach that phase. This may also help identify more targeted linkage and immediate options. Research of this nature is especially important given the increasing rates of IPV since the COVID-19 pandemic (Toccalino et al., 2022), which could further complicate linkage efforts.

This study highlights the need for intensive services and support for women impacted by IPV and how social support systems can play a key role in integrating new theoretical culturally tailored behavioral health interventions into IPV services. Interventions that educate participants about IPV, empowers them to identify unhealthy relationship dynamics individually or through social support networks with a shared decision-making throughout each of the stages of the model. African American women who experience IPV who engage in shared decision-making with their social network tend to achieve better outcomes (Battaglia et al., 2003), but the lack of culturally tailored frameworks and interventions for IPV and social support have

contributed to current health disparities and inequities among African American survivors. We can begin to address these disparities by applying new theoretical frameworks and models, such as Waller's Model. African American women experiencing IPV face several significant barriers to linkage to care. They also tend to have untreated mental health conditions, histories related to poor social determinants of health including unmet basic food and safe housing needs, and difficulty managing other practical needs such as transportation and underemployment (Waller et al., 2021). Using this new theoretical model, practitioners should recognize the unique needs of this population while integrating behavioral health interventions with healthcare services in a way that empowers women experiencing IPV.

Waller's Model also points to the need to develop interventions that align with African American women's social support process that is inclusive of religious and spiritual networks, and harnesses resources that are naturally nested within the Black community. The Black church is a well-known trusted pathway for providing a range of services for parishioners and members of the African American community (Hankerson et al., 2018; Taylor & Chatters, 1986). Nearly 80% of African Americans are religiously affiliated and women are the largest population within the Black church (Cox & Diamant, 2018). African American women are known to readily rely upon religious resources and church-based support networks during times of need (Waller et al., 2021). Partnering with female clergy, pastor's wives and domestic violence ministry leaders who are already vested in empowering and equipping survivors may be a means of delivering culturally salient solutions. Other novel delivery methods could include locations where African American women are known to routinely frequent, including hair and nail salons.

Strengths and Limitations

These findings should be considered in light of several limitations. First, the small sample size in New York City limits generalizability of the results of other African American women experiencing IPV. Second, Waller's Model can be applied in clinical and non-clinical settings but may require some training of case managers and other frontline persons. Nonetheless, the ecological factors remain important, and other studies can explore the nuances which predict resilience and sense of well-being in African American women who might be engaged at different phases of the model. Despite these limitations, this study has addressed gaps in existing research on culturally tailored help-seeking models to address IPV, mental health and social support for African American women. This study is also the first to address potentially important phases previously not considered in other models or frameworks.

Future studies are needed with larger representative samples of African American women to further investigate Waller's Model—to what extent do women experience the different phases of leaving ones' partner? To what extent do the experiences of trauma from violence play a role in navigating the model? Future studies should also employ mixed research methods to identify risk environments, protective environmental factors including positive social and community networks and individual characteristics of this sample of women. In addition, further research is needed to gain a better understanding of how systemic racism and other intersectional factors interact with violence and linkage to care among African American women. More research is needed to better understand how and where to implement culturally tailored services for African American women so they can access them with fewer barriers.

Conclusion

African American women experience IPV homicide at a higher rate than women of other racial and ethnic groups. Their IPV help-seeking is complicated by racism and systems that were not designed to understand their complex needs. To our knowledge, Waller's Help-Seeking Model is the first framework that identifies the specific mental and social services needs for this underserved population of survivors. Initial cognitive phases of women's help-seeking explicate this population's self-reliance prior to exploring external mechanisms for support. Most of the survivors experienced barriers when they engaged with organized systemic responses. These helping systems were at the least ineffective and at worst harmful. Yet, survivors remained persistent in their attempts to get assistance. Sarah Waller's Help-Seeking Model is consistent with other models and shows that African American women rely primarily on an inner resolve to navigate the stress of survivorship. Understanding the help-seeking behaviors of African American women as a unique group will help service providers in identifying gaps in the current IPV service delivery models.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

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