Published in final edited form as:

Trauma Violence Abuse. 2009 October ; 10(4): 358–374. doi:10.1177/1524838009339756.

Intimate Partner Violence and Barriers to Mental Health Care for Ethnically Diverse Populations of Women

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Abstract

Ethnically diverse populations of women, particularly survivors of intimate partner violence (IPV), experience many barriers to mental health care. The search terms “women” and “domestic violence or IPV” and “mental health care” were used as a means to review the literature regarding barriers to mental health care and minority women. Abstracts chosen for further review included research studies with findings on women of one or more ethnic minority groups, potential barriers to accessing mental health care and a non-exclusive focus on IPV. Fifty-six articles were selected for this review. Identified barriers included a variety of patient, provider, and health system/ community factors. Attention to the barriers to mental health care for ethnically diverse survivors of IPV can help inform the development of more effective strategies for health care practice and policy.

Keywords

women; domestic violence; intimate partner violence; barriers; mental health care

Background

Impact of Intimate Partner Violence on Ethnically Diverse Women's Mental Health

Intimate partner violence (IPV) has a profound effect on women's mental health (CHIS, 2001; Johnson et al., 2007), and frequently extends to other outcomes including quality of life, social and occupational functioning, and physical health (Hedtke et al., 2008). IPV, also known as domestic abuse or domestic violence, is defined as single or recurrent episodes of any threat or act of mental, physical, and sexual types of abuse from a previous or current intimate partner (CDC, 2006). The abuse which IPV survivors endure has been found to be associated with a range of psychiatric disorders such as post-traumatic stress disorder (PTSD), depression, and substance abuse, which are often a consequence of partner abuse (Martin et al., 2008; Golding, 1999; Campbell & Lewandowsky, 1997), but can also be antecedent to involvement in violent or negative relationships (Briere & Jordan, 2004; McHugo et al. 2005). Mental health conditions may vary based on the severity, frequency, and type of partner violence that women experience. Greater severity of physical IPV is associated with an increase in PTSD symptoms for female survivors (Woods, 2000). The type of violence a survivor experiences may have a differential impact on mental health as well. A study surveying 9,800 women in North Carolina found that 54% of women reporting both physical and sexual violence reported one or more days in the past month in which their mental health was not good as compared to 28% who did not report any violence (Martin et al., 2008). Finally, survivors with a higher frequency of abusive incidents are two to four times more likely to experience PTSD, depression, and substance abuse than are singly victimized women (Hedtke et al., 2008).

Women from minority populations are at higher risk for experiencing mental health problems and IPV by virtue of the greater likelihood that they are living in poverty which is associated with mental health problems. Thus, to the extent that minority women experiencing IPV are

low income, they may have greater risk for mental health problems co-occurring with IPV. In a recent study conducted on depression and PTSD among pregnant Latina women (Rodríguez et al., 2008), 51% of pregnant Latina survivors of IPV, most of whom were not US citizens, experienced depression, which is much higher than the 14% rate of depression of among white women with IPV exposure. In another population based study on IPV and mental health symptoms, 31% of female African American IPV survivors were depressed versus 14% of white IPV survivors (Houry et al., 2006). Similarly, in a study on IPV affected, American Indian/Alaska Native women, 40% reported a history of IPV associated with depression and other conditions (Evans-Campbell et al., 2006).

Use of Mental Health Care Services in ethnically diverse IPV Survivors

Despite the frequent and high rates of co-occurrence of IPV and mental health problems, there is significant evidence that the mental health needs of women affected by IPV are going unmet, and that these problems are heightened among women from minority groups. Female survivors of IPV are more likely than women not exposed to IPV to report needing mental health services (Lipsky & Caetano 2007), and fewer than one-third of women in the general population report seeking help related to partner abuse (National Center for Injury Prevention, 2003). The under-utilization of mental health services among women affected by IPV is even more pronounced among minority women, who are less likely than white women to seek help from various formal and informal sources, with Hispanic women being the least likely to seek help (Lipsky & Caetano 2007; Kaukinen, 2004; Lipsky et al. 2007; West et al., 1998).

Research findings from a number of studies point to substantial differences in the access to and utilization of health and mental health services by different racial and ethnic groups - African Americans, Latinas, and Asian Americans (Chow et al., 2003). In a study of approximately 350 IPV survivors, approximately 60% of Latina IPV survivors used health services in the preceding year as compared to 90.5% of their white counterparts (Lipsky et al., 2006). A 2004 investigation, found that 48.1% of Caucasian subjects who were referred to mental health counselors to treat IPV associated symptoms saw a specialist while only 26% of African Americans did the same (El-Khoury et al., 2004). Most of those who chose not to receive professional help turned to informal sources such as prayer. In a separate study, nearly 58% of Caucasian women reported prior use of mental health services while only 36% and 11% of African American and Latina women, respectively, used services provided by mental health clinics (Alvidrez, 1999). Additionally, in a sample 150 African American women, use of community services such as shelters and support groups for IPV affected subjects was as low as 1%-9% (Mitchell et al., 2006).

Untreated mental health symptoms may contribute to increased visits to the emergency department (ED). Females of minority ethnic groups are more likely than non-Latina whites to use emergency services as well (Chow et al., 2003). In a recent study, 36% of low-income, urban African American female patients who visited the ED reported being survivors of IPV (Houry et al., 2006). Of these patients, 24% reported moderate to severe depressive symptoms. In another study, the likelihood of Asian American use of emergency services was twice the odds of Caucasian use (Chow et al., 2003). The findings show that Asian Americans are more likely than Caucasians to have used emergency mental health services.

These results point to disparities in the use of mental health services by IPV-affected women of diverse ethnicities despite prominent mental health problems such as depression, PTSD, and anxiety. Patterns of help-seeking behavior among IPV-affected women suggest that IPV survivors may use informal care networks, no services, or may seek them but not use them, but the underlying reasons for observed patterns are less well-understood. In a survey of approximately 4,500 ethnically diverse women who have suffered from IPV, 71% of the subjects said they go to family or friends for help, 45% turn to the police or law enforcement,

and only 22% use the emergency department (Pakieser et al., 1998). In addition, despite the underutilization of mental health care services, many IPV affected women patients still express interest in psychosocial care and treatment as reported in a study by 84% of its subjects (Wong et al., 2006; (Chow et al., 2003)).

Lower rates of utilization of mental health services by ethnic minorities affected by IPV may be the result of factors typically associated with barriers to mental health services for all women regardless of IPV status, such as stigma, cultural differences in recognition and “perceived need” for care, or “enabling” factors, such as cost, accessibility, language barriers, or experience of poor quality (DHHS 2001). After controlling for “perceived need” and poverty, cultural differences in seeking and actually receiving mental health services persist, with Hispanic women consistently demonstrating the lowest rate of help-seeking behavior and utilization of specialty mental health services (Kimerling and Baumrind 2005). Cultural related factors that could create barriers for accessing needed mental health services may include limited language proficiency or access to Medicaid, both of which are associated with low acculturation (Alegria & Canino, et al. 2002). However, in the context of IPV, additional factors come into play and limit women's seeking or using mental health services, such as psychological control, low self-esteem, and hopelessness (Wilson & Silberberg, et al. 2007). Findings from these various studies of perceived need, seeking help, and accessing care, suggest that there may be contextual and individual behavioral factors unique to not only IPV but also mental health services, as distinct from physical health services, that could explain observed patterns of under-utilization of mental health services among IPV survivors.

Barriers to Access & Utilization of Mental Health Services

While published literature has documented the need for better access to and utilization of mental health services among female survivors of IPV, especially for minority women, the barriers to accessing and using services among minority women experiencing IPV are not well understood. The barriers to seeking, accessing, and using mental health services in minority populations affected by IPV may reflect a combination of factors associated with individual beliefs, practices, and resources among minority populations, as well as factors associated with the ways that mental health services are organized, financed, and delivered within communities. The behavioral health model of help-seeking behavior for vulnerable populations identified several types of factors reflective of individual and organizational characteristics that may explain observed patterns of seeking and using health services (Gelberg, Anderson, and Leake, 2002). The model includes predisposing factors (e.g., race/ethnicity, acculturation, or socioeconomic status), enabling factors (resources, e.g.), need (perceived health and health literacy, e.g.), and health behavior (e.g., personal health practices). Each of these factors may play a role in the recognition of and response to *physical health*, but *mental health* problems, IPV status, and minority status, either alone or in combination, may pose unique challenges for women to overcome in seeking and accessing needed care. To address these questions, we conducted a literature review to systematically examine available evidence on the sociocultural, behavioral, and organizational barriers to accessing and using mental health services among minority women with histories of IPV. This paper presents the results of this inquiry and considers the implications of findings for outreach, assessment, and treatment.

Methodology

Four databases were searched in September 2008 as a means to investigate IPV and mental health care among diverse populations of women: CSA PsycInfo, NCBI PubMed, CSA Social Services Abstract and ISI Web of Knowledge: Web of Science. The databases included information on biomedical topics including psychology and related disciplines, such as social

work and health care policy. The selection of databases reflected the multidisciplinary aspect of IPV as a social and health problem.

In all databases, search terms used included “women,” “domestic violence OR intimate partner violence,” and “mental health care” to identify potentially relevant articles for this review. For the purpose of this paper, “ethnically diverse women” refers to all females of racial, minority groups, excluding non-Latina whites, within the United States.

Inclusion criteria for publications included research studies with findings on women of one or more ethnic minority groups, findings on potential barriers to accessing mental health care and a non-exclusive focus on IPV. Letters, review articles, opinions, editorials, and articles in languages other than English were all excluded. The selection process was further augmented by reviewing books and bibliographies from the articles that were found. The authors read and reviewed all of the abstracts to further identify potential articles for this review.

Results

The search of the term “women” in the PubMed database resulted in 465,917 articles, which further narrowed down to 2,568 results with “women AND (domestic violence OR intimate partner violence).” Further specificity was found with the search “women AND [(domestic violence OR intimate partner violence) AND mental health care]” leading to seven results. Using the same successive list of key search terms, the CSA PsycInfo database resulted in 133,592; 3,651; and eight articles respectively. Consequently, the CSA Social Services Abstract outcomes were 14,437; 1,044; and one respectively, while Web of Science yielded over 100,000; 3,687; and 181 results respectively. Web of Science yielded the most results as it is composed of five separate citation databases, Science Citation Index Expanded, Social Sciences Citation Index, Arts & Humanities Citation Index, Index Medicus and Current Chemical Reactions, while the other sources utilize their own respective databases. All search results, ranging from 1996 to 2008, are summarized in Figure 1.

In all, 55 of the 197 unduplicated articles that resulted from the database search terms were reviewed. Other articles were eliminated from analysis as they did not provide pertinent information that could be effectively utilized in the review.

A summary of the 55 reviewed articles are depicted in Table 1.

To guide the review of the articles, we created a framework for categorizing the barriers to mental health care. The framework emerged from previous qualitative research that involved ethnically diverse IPV survivors who discussed their experiences with health care. This framework (Figure 2) categorizes barriers into those resulting from (1) the patient, (2) the provider and (3) the health care system/community (Rodríguez, 1996).

While the results are organized according to these three categories of barriers to mental health care utilization, specific barriers in the categories are not necessarily exclusive to that category.

Patient Barriers

The review of literature on IPV and mental health care access for ethnic minority women resulted in a range of barriers related to the patient. They can be sub-categorized as barriers to mental health care access and utilization due to sociopolitical, cultural, and financial factors.

Sociopolitical—The lack of utilization of mental health care services by female, IPV survivors can be associated with the individual patient and their interpretation and response to the IPV. Many survivors can be overwhelmed with emotions such as shame, guilt or fear that

can prevent them from seeking out the proper form of help (Plichta, 2007). In one study, an IPV affected, female patient said, “It’s really embarrassing to go to someone and say, ‘My husband’s abusing me.’ To your doctor, to your family, anybody” (Rodríguez et al., 1996).

Due to many patients’ reluctance to acknowledge mental health problems as well as a lack of familiarity with the mental health care system, many IPV survivors do not fully utilize mental health care services provided to them. Similarly, families’ disapproval of receiving mental health care due to their unfamiliarity with the treatment themselves has led to the same result (Davis et al., 2008). Nevertheless, possibly as an example of the heterogeneity of ethnically diverse women, one study reported that many women assumed violence was a normal part of intimate relationships as a part of men’s display of love, thus leading to their lack of services utilization (Petersen et al., 2004).

Another barrier to mental health care utilization is partner intrusion in care visits and/or treatment as well as “abusive partner control tactics.” In a 2007 survey of 2,027 women attending health care clinics in Boston, one in 20 women reported that partner intrusion impeded their seeking and using health care services, ultimately raising the risk of mental health conditions (McCloskey et al., 2007). In another study, participants reported that they were “trying to protect [their abusive partners]” and did not tell peers because they might threaten and/or never forgive them (Petersen et al., 2004). In order to avoid this, many female survivors do not accept having a history of IPV at all.

Many immigrant female IPV survivors are faced with language barriers that prevent them from gaining insight into the variety of services provided to them (O’Mahony et al., 2007). These immigrant survivors of IPV may experience difficulty in finding and using mental health care services due to limited English proficiency or the lack of ability to effectively communicate with a health care provider. IPV surviving, Latina immigrant women who have limited English proficiency have indicated a fear of government agencies, lack of financial resources, social isolation, as well as limitations due to immigration laws, all preventing them from obtaining the help that they require (Sentell et al., 2007). In one study of nearly 9,243 Latina and Asian American clients from San Diego County, patients with limited English proficiency were less likely to access mental health care via emergency services as opposed to outpatient services than English-proficient patients (28% of Latinas with limited English proficiency compared to 39% of English-proficient Latinas and 33% of Asian Americans with limited English proficiency compared to 46% of English-proficient Asian Americans) (Gilmer et al., 2007). One national study of Latina and Asian Americans found that among insured Latinas, those with low English proficiency received the worse quality of primary care (Pippins et al., 2007). While most studies show LEP as a barrier to utilization, one study of Cambodian refugees reported that patients inquired about services by medical care and mental health care providers because of limited English-speaking proficiency, again possibly supporting the heterogeneous nature of ethnic groups (Marshall et al., 2006).

Cultural Values—A second subcategory of barriers to mental health care for ethnically diverse female IPV survivors has to do with culture related stigma concerns that lead to the underutilization of mental health care services. In one study, a healthcare provider said, “The word clinic itself scares [the patients,] especially if it’s mental, because then they say ‘I do not wish to be called crazy’” (Barrio et al., 2008). This label that IPV affected women are inclined to apply to mental health conditions was examined in one study in which 15,383 low-income women with mental health problems such as depression were asked about stigma-related concerns. From this group of subjects, it was found that there was a tendency for immigrant African women, immigrant Caribbean women, U.S.-born black women and U.S.-born Latinas to not want treatment for their depression due to stigma-related concerns as well as being members of ethnic minority groups (Nadeem et al., 2007). Moreover, many ethnic minority

women face prejudice and discrimination based on their ethnic group and may suffer a “double stigma” as they confront mental health problems as well (Gary, 2005). Due to these fears of being labeled as IPV affected women, many survivors avoid and therefore underutilize mental health care services provided to them.

In many cases, IPV affected female patients reported feelings that they were not supposed to discuss the issue of IPV as they thought it was supposed to be a “secret” (Peterson et al., 2004). Additionally, many patients also reported that their religious communities reinforced the notion of keeping IPV issues a secret and not leaving violent relationships despite the associated health problems (Peterson et al., 2004).

In another 2004 investigation, it was found that African Americans were less likely than their Caucasian counterparts to turn to mental health care services due to a cultural emphasis on “self-reliance.” Results suggest that some African American women believe that receiving mental health services would be akin to publicizing weakness. Instead the use of prayer or spirituality as a means to cope with mental health issues was more private and thus, more culturally accepted. There is also a sense of dual identity that many African American women experience. In working through IPV related issues these women must carry with them the concerns about their identity as part of a particular ethnic community and their identity as a woman, often times these values of these two groups do not coincide and ultimately many ethnically diverse women choose to heed the needs of the community rather than herself as an individual. (El-Khoury et al., 2004).

In addition to stigma related cultural barriers, the level of acculturation may play a role in seeking mental health services. In a study of Latina, IPV survivors, patients appeared less likely than non-Latina whites or blacks to use social and health services partly due to low acculturation (Lipsky et al., 2006). Low acculturated immigrant women may not feel they can easily relate to their mental health care providers due to differences in cultural values. This suggests a need for greater access to culturally and linguistically compatible providers who may facilitate greater trust by patients (Thomas, 2000; Chow et al., 2003).

Financial—One of the more apparent barriers to easily accessible mental health care services is a limit or lack of financial resources (Prins et al., 2008; Davis et al., 2008). A 1998 study showed that African Americans, much like other ethnic groups, are more likely than Whites to live in deep poverty, which includes about 14% of Black families and only 3.5% of White families (Snowden, 2001). As a result, many IPV affected women, particularly of ethnic minority origin and those living in poor neighborhoods may not carry insurance coverage that is necessary for appropriate health care (Chow et al., 2003).

According to the Commonwealth Fund Women's Health Survey in 1998, nearly 18% of women surveyed did not meet their health care needs simply due to high costs alone, with nearly 54% of these women not having health insurance. Many IPV affected women in desperate need of mental health care are not able to seek out such treatments due to high costs set by the health care system as well as the limitations in access and other resources associated with it as well. These findings suggest that utilization of mental health services is associated with available finances that many ethnically diverse women do not have access to.

This lack of financial availability forces many ethnic women who need treatment for IPV to create a priority list and consider their children's needs first. Not only do mothers tend to avoid seeking assistance altogether with concerns of dismantling their child's perspective of a “good father” or prominent male figure (Zink et al., 2003), but they also prioritize their children's health care over their own due to limits in finance (Lujan, 2006). One of few studies focused on the perspectives and experiences of IPV exposed immigrant Latina women, reported that

these women frequently used emergency services to obtain health care for their children, which eventually led to lack of time and money in prioritizing their own health conditions (Lujan, 2006).

Clinician Barriers

The literature review further resulted in findings of clinician related barriers. These barriers are categorized into lack of screening, discrimination and “other factors” that clinicians display as they encounter patients affected with IPV.

Practice—A major barrier in IPV affected, ethnically diverse women accessing mental health care services ultimately lies in how the clinician goes about effectively detecting IPV and its related conditions as well as delivering mental health services to those patients. Very few clinicians routinely screen for IPV and most clinicians do not screen for IPV at all (Plichta, 2007; Klap, 2008). Therefore, many IPV affected women appear in the health care system, yet remain unnoticed by their clinicians, thereby making the patients feel alienated by the clinicians, deeming them ineffective (Plichta, 2007). Similarly, few clinicians screen for mental health conditions such as depression resulting in another barrier to mental health care for IPV survivors (Samson et al., 1999).

Other studies examined the relationship between clinician's specialty or prior IPV training with screening for IPV (Jaffee et al., 2003). Physicians were less likely to screen their patients for IPV if their specialty was emergency medicine while obstetrics/gynecology physicians, female physicians, and those with IPV training within the last 12 months were found to have higher screening rates in their practices (Jaffee et al., 2005).

IPV training may instill skills and confidence in being able to detect IPV and take proper steps in caring for survivors. One study found that physicians with IPV training were more confident in recognizing survivors as well as making referrals and asking IPV screening questions (Jaffee et al., 2005).

Discrimination—Another barrier found from the search was perceived discrimination by clinicians toward IPV affected female patients. Despite hopes of an unbiased system of health care, studies report perceived discrimination among ethnically diverse female patients. A study by Ryand and Burke in 2000 showed that doctors rated black patients as less intelligent and less educated as well as more likely to abuse drugs and alcohol, to fail to listen to medical advice, and to lack social support, despite the patients' backgrounds being taken into account. In a study of Haitian immigrant, female, IPV survivors, it was reported that their negative experiences in accessing services were associated with perceived discrimination and cultural insensitivity. (Latta et al., 2008). More work is needed to identify possible discrimination among other ethnic minority populations.

Other—A variety of other, clinician-related barriers to mental health care access have been indicated by research as well. In a survey of 453 clinicians serving people with mental illnesses, it was found that clinician's heavy workloads prevented them from providing adequate services to families (Kim, 2008). Similarly, some ethnically diverse IPV survivors feel that clinicians are not interested in IPV related services nor do they motivate trust (Rodriguez et al., 1996).

Moreover, having the abusive partner with the female IPV survivor or their children in the room with them have served as obstacles in accessing care as well. This not only limits the patient's willingness to disclose any IPV but also limits the clinician's willingness to inquire about IPV from the beginning.

Further research to unveil many other clinician-related barriers to health care access will prove beneficial in identifying and eventually correcting such obstacles.

Health System and Community Barriers

The last category of potential barriers to utilization of mental health care services by ethnically diverse, IPV affected women are related to the health care system and community. Some articles suggest that there are health care system and community barriers that are particularly related to immigrants. From a large-scale perspective, certain aspects of the health care system and the community's fear and distrust of formal health care organizations can deter women from seeking help, such as disclosure of immigration status for undocumented women or child protection involvement for particular family conditions

The climate of animosity for immigrants in the U.S. has contributed to policies and practices that reduce access and deter many immigrants from seeking help for mental and other health care problems. A study in 2000 reports a Latina immigrant saying, "You believe that the moment you are going to ask for help, they're going to return you to your country, and that's something that perhaps we, as Latinas, see ourselves obligated to tolerate the violence due to the fear of being deported" (Bauer et al., 2000). Similarly in 2003, another immigrant in need of health care services said, "I couldn't get no help. Every time I turn around and try to get some help, everybody turned me down on account of [the fact that] I've still got an open court case." Immigration status, along with associated immigration laws and government restrictions, has played a role in influencing the access and utilization of mental health care services. Similarly, in a study on IPV affected, immigrant Haitian women, undocumented women in the U.S. reported fears regarding deportation of themselves, their abusive partners or their children (Latta et al., 2008).

Language barriers represent another barrier to access to mental health care services for immigrants with limited English proficiency (LEP). Because a high proportion of immigrants are LEP, the lack of translators or systems for translating is a barrier to mental health care. In addition to this, is the lack of clinicians who can speak the languages of the non-English speaking patients they see (Barrio et al., 2007).

Beyond language, the health care system rarely trains clinicians with the goal of providing care with an appropriate attitude and sensitivity towards patients of all ethnicities. In one investigative study, it was found that physicians did not "enjoy" providing care to IPV affected women and portrayed it as "low-paying, frustrating and boring." (Plichta, 2007). They further explained that the work of assisting IPV-affected women can be very difficult without any support of health care systems as well. This sensitivity toward diverse patient groups, whatever ethnicity, religion, sexual orientation, or age, may be associated with the lack of support that health care systems provide toward those people. This affects the mental health care provided by clinicians. Without change in the direction toward enhanced workforce sensitivity to the wide range of diversity in all aspects many patients, will not be able to receive appropriate mental health care.

Conclusion

Through this literature review, we were able to identify a number of barriers to mental health care access for IPV affected, ethnically diverse women that are related to patients, clinicians, and broader health care delivery systems. The results point to a complex interplay of behavioral and systems characteristics, some of which are universal barriers to accessing health services, as reflected in Anderson's behavioral health model (Anderson et al. 2000), and others of which are distinct and unique to the experience of mental health needs among minority women in the context of IPV exposure. These observations and research findings have important implications

for community outreach and education, policy and systems changes, and the need for additional research to improve practice and outcomes

The huge gap between the number of ethnically diverse women who have survived IPV and those who have sought out and/or actually received treatment indicates that there is an urgent need to address the limitations that minority women have in recognizing and responding appropriately to a possible mental health problem by seeking help, whether it is formal or informal. To increase the numbers of women who actually seek out mental health care for IPV, an important first step is acknowledgement of the abuse by the survivor and her family. Ensuring the privacy and the protection of those survivors who choose to speak out could possibly help eliminate some reservations that many IPV affected ethnically diverse women often face. Outreach and community education efforts regarding the mental health impacts of IPV and sources of assistance for mental health care would also be useful in helping to change beliefs about ways to address IPV and mental health problems.

The financial aspect of mental health treatment serves as a barrier, particularly for those seeking a change in immigration status, and prevents many ethnically diverse women from accessing mental health care. Improvements need to be made to ensure these diverse groups that their mental health status will not hinder their opportunities to access proper care. As a result of high rates of un-insured or under-insured, combined with mental health providers' increasing unwillingness to take third-party reimbursements, access to mental health services is increasingly problematic for all individuals. In addition, the public mental health system limits its services to those individuals who have severe psychiatric diagnoses and who have financial need, thus leaving out many individuals who do not qualify for their services. Approaches to providing low-cost mental health services need to be developed and marketed to diverse communities as a means to provide those IPV affected women living in poverty more awareness and ability to receive services with more financial ease. In addition, mental health services can be expanded in a cost-effective way by integrating them into existing primary care networks for low income populations, such as community health centers. Including screening procedures for IPV and mental health problems in primary care settings with integrated programs will increase the ability of health care systems to recognize and respond appropriately to both IPV and associated mental health disorders. The beliefs, attitudes, and practices of clinicians and health care administrators pose barriers to accomplishing these goals of integrated care. From a clinical standpoint, overcoming staff resistance and gaining administrative support in integrating mental health care into general practice is a challenge that, if overcome, would contribute significantly to increasing access and reducing unmet need for mental health services (Plichta, 2007). At the moment, mental health care representatives are not widely integrated into general practice or emergency departments, nor are they integrated into or in and out-patient procedures. There is also a need for health care policy makers to recognize mental health services as a legitimate and important part of health care in general. Only with the integration of mental health professionals into general practice can there be the creation of more support and resources to combat this issue (Heideman et al., 2007).

In the investigation of ethnically diverse patient utilization of health services in the United States, it is often overlooked that the "societal institutions, including those that educate and train mental health professionals, have been shaped by white American culture [, and] that cultural legacy has left its imprint on how mental health professionals respond to patients in all facets of care ..." (U.S. Department of Health and Human Services, 2001). Therefore, the methods and approaches to handling patients of all cultures are steeped in white societal norms and practices. This creates complicated interactions in which "patients from one culture may manifest and communicate symptoms in a way poorly understood in the culture of the clinician" (U.S. Department of Health and Human Services, 2001). For these reasons, the interactions between the clinician and patient can be filled with miscommunication and

misunderstanding if the two are culturally incompetent (U.S. Department of Health and Human Services, 2001).

Due to the complicated nature of the cultural interactions between the survivor and the system, as well as the relative responses to IPV, barriers involving language and communication, cultural values, and stigmas often make seeking out any type of service challenging for those in need of help (Barrio et al., 2008; Ayalon et al., 2007). Awareness of patients' cultural perceptions about IPV and their willingness to access mental health care is equally important when treating IPV survivors. Instructing clinicians, and all of those who treat IPV survivors, how to effectively treat patients while keeping in mind the large role that stigma plays in the detection and treatment process is imperative to diagnosing IPV. Increased collaboration between community agencies would give IPV survivors a support system that is carefully trained and capable to treat patients with sensitive concerns like stigma.

Cultural competency, the ability to function as a professional with effective and congruent cultural beliefs, behaviors, and attitudes for each client (Rodríguez et al., 2008), is crucial when dealing with IPV. It's important to realize that "... cultural competence enhances the probability of accurate assessment and effective intervention in the case of abused women" (Campbell et al., 1996). Practitioners should take more time to understand and educate themselves on the culture of their patients allowing them to exhibit more sensitivity towards diversity and the ability to provide a higher level of care and ultimately, increasing their cultural competency and decreasing the amount of discrimination that IPV affected women experience at the same time.

In addition, actively directing women towards the correct mental health care channels could identify many women affected by IPV who would otherwise be dismissed (Plichta, 2007; Coker, 2003). Increased collaboration amongst various community agencies including schools, community mental health agencies, hospitals, and law enforcement is necessary. All community agencies should have the correct training to screen for IPV and provide the proper care to survivors. Community services and agencies are often some of the most common and frequent settings which IPV affected women encounter, making it imperative that there is a wide and varied effort to establish links between health care settings and community services for IPV affected women (Petersen et al., 2001).

Limitations in the literature that concretely defines culture as a prominent player in the issues that prevent IPV affected, ethnically diverse women from seeking and using mental health services make it difficult to determine exactly what needs to be done to lessen these challenges. More research is needed to improve our understanding of the social and political factors that influence individual-level beliefs and behaviors that seem to impede women from seeking help. More research is also needed to identify non-formal sources of support and evaluate their effectiveness. It is also important to understand how to change the larger social and political factors that are manifest at the level of individual behavior and cultural beliefs but actually need to be addressed at the level of public policy, health care systems, and community institutions.

All of the research in this review on barriers to care for IPV and mental health points to the challenges that ethnically diverse IPV survivors report and experience regularly. Action must be taken on all levels including research, policy and practice in order to do so. Only through more research and inquiry into the field of ethnically diverse women's mental health and IPV, will we begin to analyze and find solutions to this complex health care issue. Overcoming these barriers could potentially open up services to women of ethnic minority groups who have been unable or unwilling to utilize mental health services for IPV related illness.

Implications for Practice, Policy, and Research

- There is a strong need to increase the numbers of women who actually seek out mental health care for IPV. Acknowledgement of the abuse by the survivor and her family is of the utmost importance. Ensuring the privacy and the protection of those survivors who choose to speak out could possibly help eliminate some reservations that many IPV affected ethnically diverse women often face.
- Improvements need to be made to ensure these diverse groups that their mental health status will not hinder their opportunities to access proper care. In addition, the development of low-cost mental health services should be provided and advertised to the proper communities as a means to provide those IPV affected women living in poverty more awareness and ability to receive services with more financial ease.
- There is also a need for health care policy makers to recognize mental health services as a legitimate and important part of health care in general.
- Instructing clinicians, and all of those who treat IPV survivors, how to effectively treat patients while keeping in mind the large role that stigma plays in the detection and treatment process is imperative to diagnosing IPV. Increased collaboration between community agencies would give IPV survivors a support system that is carefully trained and capable to treat patients with sensitive concerns like stigma.
- Practitioners should take more time to understand and educate themselves on the culture of their patients allowing them to exhibit more sensitivity towards diversity and provide a higher level of care, ultimately increasing their cultural competency and decreasing the amount of discrimination that IPV affected women experience at the same time.
- Increased collaboration amongst various community agencies including schools, community mental health agencies, hospitals, and law enforcement to actively direct women towards the correct mental health care channels is necessary.
- More research is needed to improve our understanding of the social and political factors that influence individual-level beliefs and behaviors that seem to impede women from seeking help. More research is needed to identify non-formal sources of support and evaluate their effectiveness as well as to understand how to change the larger social and political factors that are manifest at the level of individual behavior and cultural beliefs but actually need to be addressed at the level of public policy, health care systems, and community institutions.

Key Points of the Research Review

- There is limited research on the barriers in receiving mental health care for ethnically diverse women.
- Barriers to utilization of mental health care can be defined using a framework related to the patient, the clinician and the health care system/community.
- Areas involving an individual's sociopolitical stance, cultural values, and financial status play major roles in the utilization of mental health care for IPV affected, ethnically diverse women.
- Clinicians can create barriers to receiving mental health care based on their practice setting and their tendencies to discriminate against those of ethnic minority origin.

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Suggested Readings

- El-Khoury MY, Dutton MA, Goodman LA, Engel L, Belamaric RJ, Murphy M. Ethnic Differences in Battered Women's Formal Help-Seeking Strategies: A Focus on Health, Mental Health, and Spirituality. *Cultural Diversity and Ethnic Minority Psychology* 2004;383–393. [PubMed: 15554800]
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Letters, opinions, editorials, review articles

	Pubmed	PsycInfo	Social Services Abstract	Web of Science
RESEARCH STUDIES				
Women	465,917	133,592	14,437	>100,000
- AND -				
Domestic Violence OR Intimate Partner Violence	2,568	3,651	1,044	3,687
- AND -				
Mental Health Care	7	8	1	181

FIGURE 1. Pubmed, PsycInfo, Social Services Abstract, and Web of Science database search terms and results. Conducted Sept. 2008.

FIGURE 2. Conceptual framework depicting potential barriers to mental health services utilization by IPV-surviving, ethnically diverse women.

Table 1

Descriptions of reviewed articles.

Authors (In order of References)	Year of Publication	Article Title	Focus Topics Utilized in Review	Study Method	Sample Size	Specific Ethnic Groups of Interest
Alegria M, et al.	2002	"Inequalities in use of specialty mental health services among Latinos, African Americans ..."	Mental health care, ethnic diversity, barriers	Quantitative	7,708	African Americans, Latinas, non-Latina whites
Alvidrez J	1999	"Ethnic Variations in Mental Health Attitudes and Service Use Among Low-Income ..."	Ethnically diverse women, barriers, mental health care	Qualitative/Quantitative	187	African Americans, Latinas, non-Latina whites
Ayalon L, et al.	2007	"The Experience of Black Consumers in the Mental Health System-Identifying ..."	Women, mental health care, barriers	Qualitative	34	African Americans
Barrio C, et al.	2008	"Unmet Needs for Mental Health Services for Latino Older Adults ..."	Women, mental health care, barriers	Qualitative	74	Latinas
Bauer HM, et al.	2000	"Barriers to health care for abused Latina and Asian immigrant women."	Ethnically diverse women, barriers, health care	Qualitative	28	Latinas, Asian Americans
Briere J, et al.	2004	"Violence against Women: Outcome Complexity and Implications ..."	IPV, women, barriers, health care	Review	N/A	No specificity/Diverse
Campbell JC	1997	"Mental and Physical Health Effects of Intimate Partner Violence on Women ..."	Mental health, IPV, women	Review	N/A	No specificity/Diverse
Chow J, et al.	2003	"Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas"	Ethnically diverse women, mental health care, barriers	Quantitative	78,085	No specificity/Diverse
Coker A, et al.	2003	"Social support reduces the impact of partner violence on health ..."	IPV, mental health	Quantitative	191	No specificity/Diverse
Davis R, et al.	2008	"Treatment Barriers for Low-Income, Urban African Americans ..."	Mental health care, barriers	Quantitative	220	African Americans
El-Khoury MY, et al.	2004	"Ethnic Differences in Battered Women's Formal Help-Seeking Strategies ..."	Ethnically diverse women, IPV, mental health care, barriers	Quantitative	376	African Americans, non-Latina whites
Evans-Campbell T, et al.	2006	"Interpersonal Violence in the Lives of Urban American Indian and Alaskan Native ..."	IPV, mental health care, women, barriers	Quantitative	112	American Indian
Gary F	2005	"Stigma: Barrier to Mental Health Care Among Ethnic Minorities"	Mental health care, barriers	Review	N/A	No specificity/Diverse
Gelberg L, et al.	2000	"The Behavioral Model for Vulnerable Populations: Application to Medical ..."	Health care, barriers	Qualitative/Quantitative	363	No specificity/Diverse
Gilmer T, et al.	2007	"Initiation and use of Public Mental Health Services by Persons with Severe ..."	Ethnically diverse women, mental health care	Quantitative	9,243	No specificity/Diverse

Authors (In order of References)	Year of Publication	Article Title	Focus Topics Utilized in Review	Study Method	Sample Size	Specific Ethnic Groups of Interest
Golding JM, et al.	1999	"Intimate partner violence as a risk factor for mental disorders: A meta-analysis."	IPV, mental health, women	Quantitative	N/A	No specificity/Diverse
Hedtke KA, et al.	2008	"A Longitudinal Investigation of Interpersonal Violence in Relation to Mental Health ..."	IPV, mental health, women	Quantitative	4,008	No specificity/Diverse
Heideman J, et al.	2007	"Effects of a Nationwide Programme: Interventions to Reduce Perceived ..."	Barriers, health care	Quantitative	2,757	No specificity/Diverse
Houry D, et al.	2006	"Intimate Partner Violence and Mental Health Symptoms in African American ..."	IPV, mental health care, ethnically diverse women	Quantitative	569	No specificity/Diverse
Jaffee K, et al.	2005	"Physician- Identified Barriers to Intimate Partner Violence Screening"	Barriers, IPV, health care	Qualitative/Quantitative	143	No specificity/Diverse
Johnson S, et al.	2008	"Patient Perceived Barriers to Treatment of Depression and Anxiety ..."	Mental health care, IPV	Quantitative	179	No specificity/Diverse
Kaukinene C	2004	"The Help-Seeking Strategies of Female Violence-Crime Victims"	Women, IPV, barriers	Qualitative/Quantitative	8,000	No specificity/Diverse
Kim H, et al.	2008	"Attitudes and Perceived Barriers to Working with Families of Persons with Severe Mental ..."	Barriers, mental health	Qualitative/Quantitative	453	No specificity/Diverse
Kimerling R, et al.	2005	"Access to Specialty Mental Health Services Among Women in California"	Mental health care, ethnically diverse women	Quantitative	3,750	No specificity/Diverse
Latta RE, et al.	2005	"Considering the Interplay of Cultural Context and Service Provision in Intimate Partner ..."	IPV, women, barriers	Qualitative	15	Asian Americans
Lipsky S, et al.	2007	"Impact of intimate partner violence on unmet need for mental health care ..."	Ethnically diverse women, IPV, mental health care	Quantitative	7,924	African Americans, Latinas, non-Latina whites
Lipsky S, et al.	2005	"The role of alcohol use and depression in intimate partner violence among ..."	Mental health, IPV, ethnically diverse women	Quantitative	579	African Americans, Latinas
Lipsky S, et al.	2006	"The Role of Intimate Partner Violence, Race, and Ethnicity in Help-Seeking Behaviors."	Ethnically diverse women, mental health, IPV, barriers	Quantitative	329	Latinas
Lujan E, et al.	2006	"Abused Immigrant Latina Mothers' Perspectives on the Health ..."	Women, mental health care, barriers	Qualitative	32	Latinas
Marshall GN, et al.	2006	"Rates and Correlates of Seeking Mental Health Services Among Cambodian Refugees."	Women, mental health care	Quantitative	339	Asian Americans
Martin SL, et al.	2008	"Physical and sexual violence among North Carolina women-Associations ..."	IPV, mental health, women	Qualitative/Quantitative	9,830	No specificity/Diverse
McCloskey LA, et al.	2007	"Abused women disclose partner interference with health care ..."	IPV, health care, barriers	Quantitative	2,027	No specificity/Diverse

Authors (In order of References)	Year of Publication	Article Title	Focus Topics Utilized in Review	Study Method	Sample Size	Specific Ethnic Groups of Interest
McHugo GJ, et al.	2005	"Women, Co-Occurring Disorders, and Violence Study: Evaluation Design ..."	Women, IPV, barriers	Quantitative	2,101	No specificity/Diverse
Mitchell MD, et al.	2006	"Coping Variables that Mediate the Relation Between Intimate Partner ..."	IPV, mental health care, ethnically diverse women	Quantitative	143	African Americans
Nadeem E, et al.	2007	"Does Stigma Keep Poor Young Immigrant and U.S.- Born Black and Latina Women ..."	Mental health care, ethnically diverse women, barriers	Quantitative	15,383	African Americans, Latinas
Nation Center for Injury Prevention and Control	2003	"Costs of Intimate Partner Violence against Women in the United States"	IPV, ethnically diverse women	National Report	N/A	No specificity/Diverse
O' Mahony J, et al.	2007	"Health Care Providers' Perspective of the Gender Influences on Immigrant Women's ..."	Ethnically diverse women, mental health	Qualitative	7	No specificity/Diverse
Pakieser RA, et al.	1998	"Battered women: Where they go for help"	IPV, women	Quantitative	4,448	No specificity/Diverse
Petersen R, et al.	2001	"Partner violence: Implications for health and community settings"	Mental health, women, IPV	Quantitative	392	No specificity/Diverse
Petersen R, et al.	2004	"Moving Beyond Disclosure: Women's Perspectives on Barriers and Motivators ..."	Women, IPV, barriers	Qualitative/Quantitative	67	No specificity/Diverse
Pippins J, et al.	2007	"Association Between Language Proficiency and the Quality of Primary Care ..."	Health care, barriers	Quantitative	1,792	Latinas
Plichta S, et al.	2007	"Interactions Between Victims of Intimate Partner Violence Against Women and ..."	Ethnically diverse women, IPV, health care	Review	N/A	No specificity/Diverse
Prins M, et al.	2008	"Health Beliefs and Perceived Need for Mental Health Care of Anxiety and ..."	Mental health care	Qualitative/Quantitative	71	No specificity/Diverse
Rodriguez MA, et al.	2008	"Intimate Partner Violence, Depression, and PTSD Among Pregnant Latina Women"	Ethnically diverse women, IPV, mental health care	Quantitative	210	Latinas
Rodriguez MA, et al.	1996	"Breaking the silence. Battered women's perspectives on medical care."	Ethnically diverse women, barriers, health care	Qualitative	51	African Americans, Asian Americans, Latinas, Non-Latina whites
Samson AY, et al.	1999	"Posttraumatic stress disorder in primary care"	Mental health care, IPV, women	Quantitative	296	No specificity/Diverse
Sentell T, et al.	2007	"Access to Mental Health Treatment by English Language Proficiency and ..."	Mental health care, barriers, ethnically diverse women	Quantitative	41,984	No specificity/Diverse
Snowden L	2001	"Barriers to Effective Mental Health Services for African Americans"	Mental health care, barriers	Review	N/A	African Americans
Thomas EK	2000	"Domestic violence in the African American and Asian American communities ..."	Ethnically diverse women, mental health care, IPV, barriers	Review	N/A	African Americans, Asian Americans

Authors (In order of References)	Year of Publication	Article Title	Focus Topics Utilized in Review	Study Method	Sample Size	Specific Ethnic Groups of Interest
U.S. Department of Health and Human Services	2001	"Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health ..."	Mental health care, ethnicity	National Report	N/A	No specificity/Diverse
West CM, et al.	1998	"Sociodemographic Predictors and Cultural Barriers to Help-seeking Behavior ..."	Barriers, ethnically diverse women, health care	Quantitative	1,970	Latinas, Anglo Americans
Wilson KS, et al.	2007	"Health Needs and Barriers to Healthcare of Women Who Have Experienced Intimate Partner ..."	IPV, barriers, women	Qualitative	35	No specificity/Diverse
Wong EC, et al.	2007	"Survivors of violence-related facial injury: psychiatric needs and barriers to mental health ..."	IPV, barriers, mental health	Quantitative	62	No specificity/Diverse
Woods SJ	2000	"Prevalence and patterns of posttraumatic stress disorder in abused and postabused women."	Women, IPV, mental health	Quantitative	160	No specificity/Diverse
Zink T, et al.	2003	"How children affect the mother/victim's process in intimate partner violence ..."	Barriers, women, IPV, mental health care	Qualitative	32	No specificity/Diverse