

Using mixed methods to understand the healing trajectory for rural Irish women years after leaving abuse

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Abstract

Research on effectiveness and satisfaction with domestic violence (DV) services is aimed at women who have accessed these services, leaving us little information about those who believe they cannot or choose not to do so. In addition, this research focuses exclusively on the structural barriers to access of information, or navigating systems to escape the abusive situation. Few studies have examined the sociocultural barriers to help seeking, either for escape from violence or for healing after safety has been established. This study uses mixed qualitative and quantitative methods to understand the healing journeys of 21 women receiving DV services in a rural region of Ireland. Qualitative findings reveal persistent physical and emotional symptoms years after establishing safety, feeling “frozen,” stigma and social conflict, and social isolation. Quantitative analysis to determine the relationship of symptoms, social support, and social conflict to help-seeking barriers finds no relationship with structural barriers. However, sociocultural barriers such as shame, hopelessness, social conflict, and feeling “frozen” were related. A trauma-informed nursing practice model is proposed, and implications for intervention and health policy are suggested.

Keywords

barriers to help seeking, domestic violence, help seeking theory, mixed-method research, trauma-informed nursing practice models, trauma recovery

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It is estimated that 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives (UN Women, 2015). Intervention research on violence against women has primarily focused on reducing violence, such as supporting appropriate criminal justice systems' responses (Dobash and Dobash, 2000; Fleury, 2002), understanding power and control in families (Johnson and Ferraro, 2000), and evaluation of hotlines, advocacy, and shelters (Bennett et al., 2004). While this research has resulted in policies related to the criminal justice system, it has focused on effectiveness and satisfaction for women *who have accessed* these services. Unfortunately, help seeking for violence is shockingly low, with estimates ranging from 4% to 27% (European Union Agency for Fundamental Rights, 2014). Despite the known incidence of violence against women and girls, there has been surprisingly little nursing research on the help-seeking journey of women. This research is critical in order to identify opportunities to recognize and engage women in needed services. The Substance Abuse and Mental Health Services Agency (SAMHSA) Trauma and Justice Strategic Initiative (2014) from the US has promoted policy aimed at enhancing the identification of traumatized women throughout the healthcare system. Unfortunately, trauma-informed organizational and systems change is not nearly as developed in Australia, the UK, Ireland, or Canada (Muskett, 2014). While the "British National Health Service" has not yet implemented policy in the area (Rose et al., 2012), there have been practice manuals and tool kits developed for use within the criminal justice system (Covington, 2016). Other strategies to address the low-service utilization of traumatized people is to presume that since any client we serve may have had a history of traumatic stress, assessing and referring routinely is a kind of trauma-informed "universal precautions" (Hodas, 2005). Since nurses are the largest healthcare workforce, they are in a unique position to take the lead on practice and policy initiatives. This present project offers research support for such work by identifying the sociocultural barriers for help seeking. We used mixed qualitative and quantitative methods to understand the healing journeys of 21 women who were out of the violence situation, but were still receiving domestic violence (DV) services in a rural region of Ireland. Implications from this study propose trauma-informed nursing practice delivery models that address holistic assessment and recovery.

Background

Most scholars recognize that help seeking is a journey involving a series of meaning-making judgments and social actions rather than as a single event (Saint Arnault, 2009; see also Liang et al., 2005). However, the help-seeking process for trauma recovery has received surprisingly little scholarly attention. According to Cultural Determinants of Help Seeking (CDHS) theory, Saint Arnault describes help seeking as taking actions to regain health, security, and well-being (Saint Arnault, 2009). The CDHS theory suggests that the first step in the help-seeking journey is the recognition of symptoms and the experience of need. Then, people interpret potential barriers; evaluate the meaning in terms of their sense of coherence; and explore their social context (see Figure 1). Next, the process of "seeking" begins, which is a socially oriented searching activity that includes "reaching out," "looking for," or "exploring" possible sources of help (Saint Arnault, 2009). However, this theory focuses on the sociocultural processes of help seeking. Recent research in trauma recovery is beginning to document neurobiological responses after trauma, including freezing and emotional numbing that decrease social engagement, inhibiting the help-seeking process

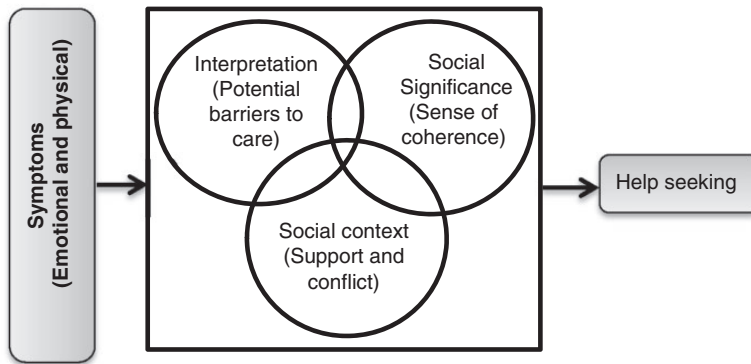


Figure 1. Cultural determinants of help seeking.

(Courtois, 2004; Courtois and Ford, 2009; Van der Kolk et al., 1996a). Therefore, we believe that a complete trauma-informed help seeking theory is needed. For the purposes of this study, based on both the CDHS and neurobiological theories, we define help seeking as a socially engaged, culturally informed exploration of the world aimed at decreasing suffering.

Research has suggested that informal sources and general health providers are favored help options for trauma, and report that specialty services have the lowest use (Barrett and St Pierre, 2011). In their study of help-seeking actions among Canadian women who had experienced abuse within the last year, sampled from a general practice office, about one third of women (34.0%) reported using no formal supports or services. Women more frequently used informal sources of support (67.5%). The most frequently used formal support in that study was contacting a counselor (Barrett and St Pierre, 2011).

Fugate et al. (2005) reported how women's personal beliefs were significant barriers to seeking help for DV. Interviews with 491 women from primary care services revealed that most did not contact any mental health agency or a counselor (82%), use medical care (74%), or call the police (62%). Also, 29% did not talk to anyone about the abuse. A New Zealand study of a sample of 956 women found that while 75% had told someone about the violence, more than 40% of women said *no one had helped them* (Fanslow and Robinson, 2010). Almost one-quarter of the sample (23.3%) indicated that they had not told anyone about their partners' violence. Finally, in a multi-national survey of 42,000 women across 28 European Union Member States, the Fundamental Rights Agency found that help-seeking rates ranged from 4% to 27% depending on the country (European Union Agency for Fundamental Rights, 2014). Taken together, these studies consistently report that a minority of women who have been in a DV situation have sought help for it, that informal sources are most commonly used, and that specialty services are the least likely to be used (Ansara and Hindin, 2010).

Very few studies have examined the inner dialog that prevents help seeking for DV trauma. Fugate et al. (2005) asked women who had not sought any help from formal services about their reasons. The reasons they gave included: the perception that the violence was "normal/not serious"; the fear that they would be forced to leave the relationship; emotional investment in the relationship; staying for the sake of the children; shame; and believing that they should "deal with it alone." Other studies have examined the ways that stigmatization can deter help seeking. One review conducted by Westbrook (2008)

identified three types of stigmatization. Consistent with other research (Murray et al., 2015), internalized stigma takes the form of self-recrimination, such as feeling weak, helpless, deviant, ashamed, or to blame (Westbrook, 2008). Social stigma was described as the fear that people would be unsupportive, expect them to leave, or would find them weak or “stupid” for staying. Cultural stigma involved cultural rules about violence or abuse, or judgmental attitudes, including norms that DV is a private matter and must be kept secret, public beliefs that abuse is normal, and/or beliefs that abuse always involves physical injury.

Aim

The purpose of this study is to use mixed methods to explore the help seeking and healing trajectory of 21 women who were receiving DV services in a rural area in the west of the Republic of Ireland. This project used a sequential, explanatory mixed-method design with a nested quantitative subsample. We used semi-structured interviews to understand their experiences and well-being, and surveys to explore symptomology, social support, social conflict, and perceived barriers to seeking help.

Methods

The data from this study were baseline data from a larger study examining the healing trajectory of women after an integrative healing program (Saint Arnault and O'Halloran, 2015). The Institutional Review Board at the University of Michigan approved all of the research at the Irish site. A total of 21 women receiving DV services in a rural area of Ireland were recruited with information letters and posted flyers. All participants had been out of their abusive relationship and in stable homes at the time of their interview, and were deemed by the Refuge staff to be ready and able to participate in our research. Inclusion criteria included women aged over 21 who were receiving services, had a case manager, and spoke and read English. Exclusion criteria included severe distress (a score over 20 on the Kessler 6 screening tool, described below) or those who were actively psychotic.

Interested women were screened with the Kessler 6, which is a 6-item screening tool designed to detect individuals who are likely to be suffering from non-specific psychological distress (Kessler et al., 2002). A score of 13 indicates probable clinically significant psychological distress. If the woman met the criteria, they received surveys either by mail or with an emailed online link. The author interviewed all women with the co-author present, and all but one of the interviews was tape-recorded with consent of the women. Interviews were about one hour in length. Interviews and surveys were completed between 2011 and 2013.

Measures

The concepts for this study were drawn from the CDHS theory. Demographic data included age, education, employment, and use of psychological and medical services. *Symptoms* were operationalized as depression, anxiety, and physical symptoms. *Depression* was measured with the Center for Epidemiologic Studies Depression Scale (CES-D) (Noh et al., 1992; Radloff, 1977). The CES-D is a 20-item self-report scale, and the cut-off for indicating risk for clinically significant depression is 16. Cronbach alpha reliability was .95. *Anxiety* was assessed using the Zung Self-Rating Anxiety Scale (Zung, 1971), which is a 20-item

instrument designed to measure state anxiety, and cut-off for moderate to severe anxiety is 45–59 ($\alpha = .88$). *Physical symptoms* were measured with the 22-item Composite Symptom Checklist, which included 22 physical items including sleep, gastrointestinal problems, pain, and cardiac and neurological symptoms (Saint Arnault and Fetters, 2011; Saint Arnault and Kim, 2008; Saint Arnault et al., 2006). *Interpretation* was operationalized as perceived barriers to care. The *Barriers to Seeking Care for Trauma Scale* was developed based on the Barriers to Seeking Care Scale used in the Mental Health Supplement of the Ontario Epidemiology study in 1996 (Boyle et al., 1996) (see Table 1). The original scale included 22 reasons for not seeking professional health for physical or emotional symptoms in the last year. However, based on the literature reviewed above, we added seven items related to trauma help-seeking, including shame, confusion, fear of the consequences, normalisation, feeling frozen, and feeling undeserving ($\alpha = .85$). *Meaning* was operationalized as sense of coherence, and was measured with the Sense of Coherence Scale (SOC) comprising 13 statements that examine clarity, comprehension, and meaning (Antonovsky, 1993; Eriksson and Lindstrom, 2006) ($\alpha = .72$). *Social context* was operationalized as support and conflict in the social environment. *Social Support* was measured with the Social Support Questionnaire for Transactions (SSQT) (Suurmeijer et al., 1995) which measures satisfaction with social support in five domains ($\alpha = .94$). *Social conflict* was measured with the Social Conflict Scale (SCS), a subscale of the Quality of Relationship Inventory (Pierce et al., 1991, 1997) ($\alpha = .87$).

Qualitative dimensions of the concepts in the CDHS model were assessed with a *semi-structured interview* developed by the first authors. Open-ended questions about symptoms, the meaning of symptoms, well-being, interaction with the social world, challenges related to seeking help, and meaning of life were asked.

Analysis

Thematic analysis of interviews involved coding grounded statements with two coders, then abstracting upward to discover themes that women shared. These themes were operationalized in the quantitative database, and a subsample of women completed the Barriers to Seeking Care for Trauma Scale. We clustered the barriers to seeking care items based on their commonalities, resulting in 15 categories of barriers to help seeking.

We dichotomized the barriers to seeking care according to agreement or disagreement, and used *t*-tests to explore whether there were differences in help-seeking barrier mean scores for symptoms, social support, social conflict, or SOC. The use of *t*-tests has been described as appropriate for very small samples (De Winter, 2013). Based on the literature review earlier indicating the importance of social and cultural barriers in the help-seeking process, we hypothesized that there would be differences in sociocultural barrier means for women with higher symptoms and social conflict, or with lower social support or SOC, but not for women who endorsed structural barriers to help seeking.

Results

Women ranged in age from 34 to 65 ($M = 45.5$; $SD = 7.6$). Most of the women had either secondary or technical educational preparation. The years in the abusive relationship ranged from 3 to 20 and most women had been in the relationship over 10 years. The years out of the relationship varied from 2 to 10 years, and averaged 5 years. Two of the women were with new long-term partners.

Table 1. Help-seeking barriers.

Barrier	Survey question		
Structural barriers	Financial	I am concerned that the help I need will be too expensive I do not have adequate financial resources My health coverage will not cover the type of treatment I need	
	Information	I am unsure about where to go to for help or how to access help	
	External barriers	I cannot not get time away from work or family responsibilities Others are preventing me from getting the help I need I have distance or transportation problems	
	Inconvenience	I thought getting help takes too much time or is inconvenient	
	Availability	I am concerned that I will not be able to get any help soon enough I feel that the help available will not provide the type of treatment or help that is best for my problem The kind of help I need is not available	
	Dissatisfaction	I am not satisfied with services that are available	
	Prejudice	I have sought help before but it did not help Professionals from my own cultural or ethnic group are not available I feel that there will be prejudice, racism, or discrimination against me I feel that my culture, ethnic background, or specific situation will not be understood	
	Fear consequences	I am afraid of the consequences for myself, my children, or my family I am scared about being put into a hospital against my will I am worried that if others discover my health problems or my situation, I could lose housing, my security, or my children	
	Internal barriers	Self-help	I want to, or think I should, solve problems on my own
		Normalization	I think my situation is normal or is not severe
Wait and see		I think the problem will probably go away by itself	
Hopelessness		I think help probably would not do any good	
Frozen		I feel confused or unable to plan out all the details or steps I feel paralyzed or frozen and unable to act I can't seem to clarify my feelings or know what I need	
Social barriers		I am afraid I will explain my needs and no one will help me anyway I feel that I cannot trust people to help me I am afraid I can't clearly express my needs I feel that there is no one who can understand or help me	
Shame		I thought my situation was too personal or wanted to keep it private I am concerned about what others might think I believe that people will judge me I am ashamed or embarrassed I worry that I don't deserve to ask for help	

The intake Kessler score ranged from 7 to 20 ($M = 13.4$; $SD = 4.9$). The CES-D scores ranged from 18 to 49 ($M = 42.4$; $SD = 12.4$). The Zung Self-Rating Anxiety Scale scores ranged from 18 to 57 ($M = 36.6$; $SD = 12.0$). Physical symptoms scores ranged from 19 to 56 ($M = 35.2$; $SD = 10.9$). About one-third of the women endorsed current treatment for a

major depression disorder; three said they had a diagnosis of an anxiety disorder; most were on psychiatric medication (primarily sleeping medications and antidepressants); and three had a history of panic attacks.

Qualitative findings

Persistent symptom burden. Most of the women were on medications and all of them had attended counselling. Despite these attempts to get help, the women reported that the effects of trauma had been resistant to the therapies that were provided for them. One woman put it this way:

...going to counselling...[for] post-traumatic stress since 1997...they told me to 'get up, get dressed, and do your hair nice'...that's my coat of armor every morning.

Another woman said:

I really fight it every day. I fight the fear and the loneliness... I get up, usually 'cause they tell me to in counselling. But, it's more like retail therapy... I have to get up 'cause of the depression and everything.

One woman was seeing a counselor, a psychiatrist, was on medication, and had a support worker. Despite this support, she said:

A lot of times... someone might just say something and I will have a lot of flashbacks... I hold my breath a lot and that's a big thing. And, at night time I hold my ears and try to keep the nightmares away.

Physical pain and digestive problems were the most common. One woman said:

I have shoulder pain, and a bad back... I would have had a huge amount of anxiety... it's a huge overwhelming feeling that just takes over, you are kind of paralyzed... I have been on my meds for 5 or 6 years... I get palpitations in my body but other than my back no other problems.

Another woman reported:

I have headaches a lot of the time, but it's just in one spot. [Before, it was] all down my face and back... I find coming down the stairs in the morning hard. My hands go numb a lot, even just talking on the phone... I [have to] sleep on my stomach with hands under the pillow, and I still wake up at night time just to get things going sometimes [to get the numbness to go away].

This woman had chronic pain:

Primarily [pain in my]... back... my walking is disabled some. I swap and change pain meds all the time. If I am having a really, really bad week I take half of a sleeping pill. I'm taking so many painkillers I need to take something for my stomach.

Feeling "stuck" and "frozen." Women used words like "stuck," "frozen," "on edge," and "trapped" to describe their healing journey. One woman, who had been out of the relationship for eight years, stated:

I have nightmares when I am stressed or when he comes near me. I go into that freeze mode where nothing works.

Another said:

You think it's over and done but it's just something that knocks you back.

One woman put it this way:

I suppose for the last few months I have felt stuck like I am not moving forward. I'm not moving backwards. I'm just in this place where I am stuck.

Another woman said:

At times I sit with the kids and you feel trapped.

Some women were always feeling on the alert, saying:

It's like he's not there but he is always there.

Another woman reported:

I just live in fear. I lock my doors and don't open my windows. I did this past weekend. I had a great weekend and my friend came to stay with me . . . when there is someone around I feel more secure.

Stigma and social conflict. The questions about interaction with the social world revealed the impact of social and cultural norms, and the power of stigma in women's lives. Most women described how they had been cut off from family members on both sides because they left the violence. They felt especially hurt and confused by this rejection by their own parents and siblings. Many women received pressure to stay in the abusive relationships from family. One woman said:

My relationship was so bad with my mom, and after the first time [I left . . . my husband] . . . he went to my dad and my dad made me take him back, and that is just so embarrassing.

Another woman couldn't believe the response from her family, saying:

So I find that difficult 'cause I don't feel like they can accept 'the me' that I am now.

One woman explained:

I suppose my sisters couldn't cope when I fell apart.

This woman made the startling comment:

The funny things about family is when I was in the relationship they were the most supportive, but once I left it was just, like, I had done the unthinkable, I had left. [My] mother she said "you made your bed and you lie in it."

Social isolation. A fourth finding was that women had shame or social fears that had led them to cut off interactions with their family and community after leaving the

relationship. In some cases, interpersonal relationships, even with children, were strained. This woman said:

I find keeping busy [helps], but when I get too busy I just get overwhelmed . . . I just shut off towards the kids, and sit in my room. They leave me alone when I shut down.

The social isolation of women was profound. This woman said:

Several people have come into my life since and I just cut them off.

Another sobbed as she reported:

. . . [I realized] how isolated I have become and how much of a recluse and how cut off I have become from everyone because that's the easy option.

Searching for meaning. We asked women how they would describe the “the meaning of their lives.” In nearly every case, the question generated anxiety, sadness, and confusion. One woman said:

I suppose the meaning of life for me would just be able to love and be loved, and love yourself . . . I suppose having energy. I don't have a lot of energy. I am tired all of the time. I suppose just light heartedness.

Another said:

My life would have meaning if I knew what my life path was. Not have to rely on other people, trust myself more than I have been. If I could just like myself a bit more.

One woman, who refused to be tape-recorded as she responded to the question, cried and trembled as she recounted her suicide attempt a year before, which she said was because she had “nothing left to live for.”

Quantitative findings

The qualitative findings above showed that women experienced significant sociocultural issues during their healing journey, including struggling with symptom burden; feeling stuck or frozen; stigma and social conflict; social isolation; and a struggle to find meaning in their lives. However, they did not always explicitly relate these issues to help seeking. Therefore, to understand this connection more fully, we used *t*-tests to explore whether there were differences in mean scores for symptoms, social support, social conflict, or SOC for women who endorsed barriers to help seeking on the Barriers to Help Seeking Inventory.

Only four women endorsed that the fear of prejudice was a barrier. About half of the women endorsed that they did not seek help because it was inconvenient; unavailable; prevented by external barriers (such as time off at work or transportation issues); or they feared the consequences of help seeking. In addition, about half of the women endorsed the statement that they did not seek help because they believed “the problem would leave on its own.” Over two-thirds of the women said that they faced structural barriers including lack of information, financial barriers, and dissatisfaction with the care available. Most of the women endorsed sociocultural barriers to help seeking, including hopelessness; normalization; feeling they must solve it on their own; shame; and social

barriers (thinking no one would help, that they couldn't explain what they needed, and mistrust). Finally, all but one woman endorsed feeling frozen.

There were no differences in mean levels of symptoms, social support, social conflict, or SOC for most of the structural barriers to help seeking. However, women who endorsed dissatisfaction with the services that were available had higher mean scores for anxiety symptoms ($M=50.2$; $SD=5.2$) than women who did not ($M=34.0$; $SD=15.6$) ($t(6)=12.5$; $p=.05$).

There were no differences in mean levels of symptoms, social support, social conflict, or SOC for women who endorsed either normalization or for those who believed they should solve it on their own. However, women who endorsed shame had higher mean scores for depressive symptoms ($M=47.9$; $SD=10.2$) than those who did not ($M=33.5$; $SD=3.5$) ($t(9)=-1.9$; $p=.02$). Also, women who endorsed hopelessness had higher mean scores for depressive symptoms ($M=48.5$; $SD=9.2$) than those who did not ($M=33.5$; $SD=3.5$) ($t(9)=-4.0$; $p=.01$).

Women who endorsed hopelessness also had higher mean scores for physical symptoms ($M=37.8$; $SD=11.1$) than those who did not ($M=24.5$; $SD=3.5$) ($t(11)=-1.6$; $p=.02$). Women who endorsed the belief that the symptoms would leave on their own also had higher mean scores for physical symptoms ($M=41.3$; $SD=11.1$) than those who did not ($M=27.0$; $SD=3.6$) ($t(11)=-2.7$; $p=.02$).

Women who endorsed social barriers had lower mean scores for social support ($M=42.7$; $SD=7.9$) than those who did not ($M=66.0$; $SD=25.5$) ($t(9)=2.6$; $p=.03$). Women who endorsed social barriers also had higher mean scores for anxiety symptoms ($M=49.4$; $SD=7.7$) than those who did not ($M=37.4$; $SD=9.1$) ($t(11)=-2.5$; $p=.03$).

Since all but one woman endorsed feeling frozen, it was not appropriate to carry out *t*-tests. However, feeling frozen was significantly and positively correlated with depressive symptoms ($r=.68$; $p=.01$) and anxiety symptoms ($r=.65$; $p=.02$). Feeling frozen was significantly and negatively correlated with social support ($r=-.81$; $p=.00$) and SOC ($r=-.67$; $p=.01$). We also used chi-square analysis to understand the interaction between feeling frozen and the other structural and sociocultural help-seeking barriers. There were no significant chi-square results between feeling frozen and any of the structural barriers. However, significant chi-square results were present for shame ($\chi^2=10.0$; $p=.00$), social barriers ($\chi^2=5.0$; $p=.03$), and hopelessness ($\chi^2=12.0$, $p=.00$).

Discussion

Trauma-informed nursing practice model

While these data are from a small sample of women, the mixed methods we used provided a rich and varied look at their healing journeys, as well as the help-seeking barriers they faced. Our previous work on sociocultural aspects of help seeking (Saint Arnault, 2009), combined with the literature and these analyses, allows us to theorize about the processes of help seeking after escaping DV, and present a trauma-informed nursing practice model to promote healing, social engagement, and help seeking (see Figure 2).

We propose that symptom burden, shame, stigma, and feeling frozen interact to shape the help-seeking journey long after safety has been established. We theorize that the symptoms women experience were a catalyst to seek help, a drain on their energy, and impaired their ability to function. This means that symptom reduction is a nursing care priority. However, our findings show that symptoms and feeling frozen interact, such that symptoms may be

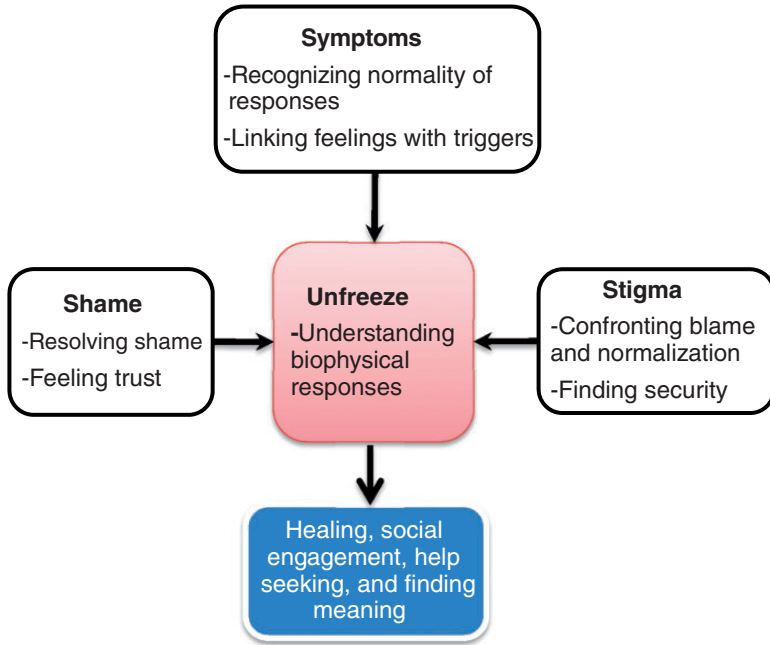


Figure 2. Trauma-informed nursing care model (nursing problem and nursing care goal).

resistant to treatment unless or until the feeling of being “frozen” is addressed. Feeling frozen is also experienced as symptoms, including fear, anxiety, depression, and hopelessness. Feeling frozen, in turn, interacts with stigma and conflicts within the social environment. We theorize that feeling frozen is caused by stigma and shame. Therefore, since these social issues reinforce feeling frozen and symptoms, treatment must address the critical aspects of shame and stigma. Therefore, we propose a three-pronged trauma-informed nursing care model that educates women and providers about the holistic needs of survivors: psychological (resolving symptoms); social (resolving shame and confronting stigma); and biophysical (unfreezing).

The centrality of feeling frozen was revealed in both the women’s narratives and the prevalence of it among the women, as well its correlation with symptoms, lower social support, and SOC. From a biophysical standpoint, the presence of retractable “freezing” as well as hypervigilance in trauma recovery is receiving increased research (Ogden et al., 2006; Porges, 2009; Van der Kolk et al., 1996a, 1996b). Cozolino and Santos (2014) describe the complex interrelationships among shame, social systems, and neurobiological states, providing compelling arguments for a treatment model that incorporates attention to neurobiological underpinnings into routine trauma care (Cozolino and Santos, 2014). Understanding interrelated concepts such as freezing, numbing, and emotional dysregulation may help women understand and address underlying biophysical mechanisms necessary to begin the road to recovery. These concepts are part of most trauma-informed service guidelines (see Kezelman and Stavropoulos, 2012). However, these guidelines are not routinely implemented, and some advanced training in biophysical mechanisms in trauma recovery for nurses and other health providers is

warranted (Kusmaul et al., 2015). Nurses may not fully integrate the emerging biophysical perspectives into their routine practice; however, they are in a unique position to take the lead on this because of their foundational biopsychosocial approach.

We also found that feeling frozen was related to sociocultural barriers to help seeking, including shame, social barriers, and hopelessness. While most policies that endorse trauma-informed services recognize the importance of shame and self-blame, they do not necessarily link shame with the biophysical responses of freezing and hypervigilance. One effort in that direction is the articulation of the *Concept of Trauma*, recently published by SAMHSA, which outlines the complex interaction of what they call the three “Es”: Event, Experience, and Effect (SAMHSA Trauma and Justice Strategic Initiative, 2014). As noted earlier, while these guidelines are not developed as completely in Australia, the UK, or Ireland, there are suggestions that these principles can be helpful in those countries (Muskett, 2014). Practitioners can help women address stigma in their lives, helping them to gain skills in managing social conflicts, confronting stigma beliefs in themselves and others, and finding security in their social world. Practitioners can also help women understand the interactions of stigma and shame with persistent symptoms, biophysical mechanisms, and the social “triggers,” helping survivors begin to untangle and address these phenomena to promote healing. This multipronged and iterative approach can help women to restore security, restore self-trust, and find trusting relationships, ultimately healing and finding meaning in their lives.

Scholarship on the process of social and cultural normalization of DV has focused on policymaking and social discourse, especially in minority communities (Brassard et al., 2015; Madhani et al., 2015). This can have an unintended consequence of implying that the normalization process is aberrant from an enlightened social norm, and that anti-violence campaigns should be focused on the “other” cultures in our society that might have a high tolerance for violence (Montoya and Agustín, 2013). However, our data found that the normalization of violence was an important sociocultural barrier to help seeking for mainstream Irish women. While measurement of the prevalence of the normalization of violence is an emerging science, from an intervention perspective these beliefs should be reframed and challenged at every point of contact. Moreover, media campaigns aimed at community outreach should address this vigorously.

There are limitations to this study, including the small sample size, the rural characteristic of the women, and a primarily Caucasian sample. Therefore, caution should be used when generalizing to other cultures and sociodemographic characteristics. In addition, it is unknown whether the physical or emotional symptoms were related to the experience of DV or other factors. We did not attempt to disentangle this complexity and, indeed, allowed the women to create their own causal inferences related to symptoms. Additional research with a longitudinal perspective would be needed to tackle this complexity. However, we used mixed methods to gather multidimensional data and explore the deeper connections among complex phenomenon related to distress, sociocultural dynamics, healing, and help seeking. We hope that this approach can be a model for more studies of women in a variety of cultures and sociodemographics. These methods can also be used for cultural comparisons.

Conclusion

Help seeking for trauma healing is a socially engaged, culturally informed activity. Important sociocultural and biophysical barriers to help seeking include symptom burden, feeling frozen,

shame, and stigma. Unfortunately, the interactions among biophysical and sociocultural concepts have been largely unexplored in nursing research, practice, and policy. Understanding these can guide trauma-informed nursing practice models that integrate a biophysical understanding of the trauma response and sociocultural understandings into routine psychological care for survivors. In addition, advanced training in biophysical mechanisms in trauma recovery is warranted. Moreover, because such a large proportion of trauma survivors do not seek care specifically for their trauma recovery, policy in nursing must address trauma-informed assessment and intervention across all of our constituents, along the lines of a “universal precautions” approach. Nurses are in a unique position to take the lead on this because of their biopsychosocial approach to health and healing.

Key points for policy, practice and/or research

- Sociocultural and biophysical barriers to help seeking are an important part of the help-seeking trajectory. However, it is unknown how much these account for the very low help-seeking rates for DV. This research helps us understand these sociocultural barriers, which include cultural beliefs and perceived social barriers, as well as feeling frozen, perhaps spurring vigorous research in this area.
- Providers need to understand the relationships among biophysical mechanisms, sociocultural beliefs such as shame, the normalization of violence and stigma, and the social consequences of these, such as social isolation. The interplay among dynamic variables suggests that an iterative, trauma-informed nursing practice model that may improve our ability to promote healing for DV survivors.
- Trauma-informed nursing policy initiatives can regulate the need for advanced training in biophysical responses to trauma, as well as understanding that most people do not seek care for trauma-related healing, thereby mandating routine assessment into routine care.

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