Intimate Partner Violence Polyvictimization and Female Survivors' Help-Seeking: Variations by Race/Ethnicity

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Abstract

Purpose

This study reveals various patterns of IPV polyvictimization experiences among female survivors and examines interconnected relationships between IPV polyvictimization

experiences and help seeking from various help sources, moderated by survivors' race/ethnicity.

Methods

The study sample included 4,764 female survivor selected from the National Intimate Partner and Sexual Violence Survey in 2010. We first conducted a latent class analysis (LCA) to classify IPV polyvictimization based on seven IPV types. Logistic regression analyses were conducted to examine the associations between IPV polyvictimization and help-seeking (police, doctor, and psychologist). Interaction terms between race/ethnicity and polyvictimization were tested for moderating effects of race/ethnicity.

Results

LCA revealed three polyvictimization patterns: (1) Multiple Violence (MV), (2) Physical and Psychological Violence (PPV), (3) Psychological Violence (PV). Compared to survivors of PV, survivors of MV and PPV were more likely to seek all types of help. Black survivors were more likely to contact police than White survivors. Compared to White survivors, Black and Hispanic survivors were less likely to see psychologists. Black survivors of MV were less likely to talk to police than White survivors of MV.

Conclusions

A severe form of polyvictimization was associated with a greater need for professional help than other types of polyvictimization. Racial/ethnic minority survivors' complicated relationship with police and less use of mental health services need to be further examined. Access to legal and mental health services by racial and ethnic minority survivors could be improved by enhanced cultural sensitivity and increased awareness of different cultures within these areas.

Intimate partner violence (IPV) against women is a serious public health problem, as it not only negatively affects the survivor's physical health but may also result in life-long trauma and mental health symptoms, such as anxiety, bipolar disorder, sleep issues, experiences of depression, symptoms of post-traumatic stress disorder (PTSD), and greater propensity to engage in self-medicating or risky behaviors such as substance use and deliberate self-harming behaviors (Choi et al., 2016; Dichter et al., 2014; Weiss et al., 2017). Seeking help from various sources (e.g., police, medical services, mental health support) is critically important to reduce such negative consequences in the aftermath of IPV. Survivors' help-seeking seems to be associated with the nature of IPV they experienced; the more severe their experiences, the more likely they are to seek help (Flicker et al., 2011; Reyns & Englebrecht, 2014). Furthermore, many survivors experience more than one type of IPV, or polyvictimization (e.g., physical violence along with psychological abuse, sexual violence and/or stalking), potentially affecting survivors' help-seeking (Choi et al., 2016; Clark et al., 2019; McNaughton Reyes et al., 2018; Weiss et al., 2017). The literature, however, suggests that many survivors, especially racial/ethnic minorities, do not seek help, or they experience various barriers to certain sources when attempting to seek help (Hulley et al., 2022; Ravi et al., 2022; Robinson et al., 2021). For instance, survivors may not seek medical help due to cost, language barriers, and inaccessibility (Satcher, 2001); and they may not report their victimization to law enforcement due to ever growing fears and distrust of law enforcement by immigrant populations (Hacker et al., 2011). Help-seeking seems to vary based on the racial and ethnic background of the survivor, such as African American survivors being less

likely than White survivors to seek help and Hispanic and African American survivors being more likely to seek help from police than White survivors (Buzawa et al., 2011; Lipsky et al., 2009). Most of these studies, however, are based on local, community, or clinical samples with the limited representation of racial/ethnic minorities, limiting their generalizability, and rarely examined in the context of polyvictimization. This study fills this gap by using nationally representative data to examine this interconnected relationship among IPV polyvictimization experiences, seeking help from various help sources, and survivors' race/ethnicity.

IPV Polyvictimization

Intimate partner violence (IPV) is abuse or aggression that occurs in a romantic relationship, including current and former spouses and dating partners, which includes physical and sexual violence, stalking, and psychological aggression (Breiding et al., 2015). Previous studies have emphasized diverse IPV victimization patterns, with many survivors experiencing a combination of IPV subtypes over time (e.g., polyvictimization), often involving multiple partners (Beck et al., 2013; Choi et al., 2016; Clark et l.,2019; Krebs et al., 2011; McNaughton Reyes et al., 2018; Weiss et al., 2017; WHO, 2010). IPV Polyvictimization is defined for this study as having experienced multiple types of victimization, such as physical and sexual violence, stalking, and psychological aggression by intimate partners (Family Justice Center Alliance, 2019; Finkelhor et al., 2011). One study grouped polyvictimization subtypes into three different experiences based on the presence and level of four types of IPV: physical abuse, psychological abuse, stalking, and sexual abuse (Dutton et al., 2005). The first pattern was characterized by physical abuse, psychological abuse, and stalking, but low levels of sexual abuse; pattern two showed the same results of low sexual abuse levels, but with high levels of physical abuse, psychological abuse, and stalking; the third pattern included high levels of all four types of abuse (Dutton et al., 2005). Other studies have found somewhat similar IPV polyvictimization patterns: victimized by both physical and non-physical IPV; sexual violence only; a combination of mild physical and psychological violence; or a combination of non-physical abuse, such as psychological, emotional, or verbal (Ansara & Hindin, 2010; Beck et al., 2013; Choi et al., 2016; Clark et al., 2019; McNaughton Reyes et al., 2018; Weiss et al., 2017). IPV patterns have also been explored in a study among survivors who are college students, in which four different IPV polyvictimization patterns were

identified: physical violence; psychological and sexual violence; physical and sexual violence; and psychological, physical, and sexual violence (Eshelman & Levendosky, 2012). Overall, IPV polyvictimization has been acknowledged as a prevalent occurrence among survivors of IPV across a wide range of literature and data.

Health Outcomes of IPV Polyvictimization

A multitude of adverse health outcomes are associated with IPV and may vary based on the type of IPV polyvictimization. To illustrate, IPV in general is linked to headaches, insomnia, substance abuse, depression, and eating disorders (Dutton et al., 2005; Buller et al., 2014; Hill et al., 2016; Stockman et al., 2014). Physical IPV is associated with a variety of health outcomes, with mixed research results. Some literature has found a significant association between depression symptoms and physical IPV (Coker et al., 2002), while others have not found a significant relationship (Dichter et al., 2014; Mechanic et al., 2008). Physical IPV is also associated with an increased likelihood of alcohol misuse as well as the prevalence of sexually transmitted infections (Coker et al., 2002; Dichter et al., 2014; Lacey et al., 2013). Psychological IPV is linked to a number of negative health outcomes, including substance misuse, PTSD, anxiety, and depression symptoms (Coker et al., 2002; Lacey et al., 2013; Mechanic et al., 2008; Rogers & Follingstad, 2014). Coercive control, a specific subset of psychological IPV, is particularly associated with depression (Kelly & Johnson, 2008). Negative health outcomes as a result of sexual violence include a strong association with PTSD (Bennice et al., 2003), as well as depression, bipolar disorder, anxiety, difficulty sleeping, and substance abuse (Dichter et al., 2014; Dutton et al., 2005; Lacey et al., 2013; Mechanic et al., 2008). Additionally, women who experience IPV stalking are at risk for PTSD and depression symptoms (Logan & Cole, 2007; Mechanic et al., 2008). Ultimately, survivors of polyvictimization are more likely than those who experience one type of IPV to suffer from more severe health consequences (Ansara & Hindin, 2011; Cale et al., 2016; Choi et al., 2016; Clark et al., 2019; Haynie et al., 2013; Weiss et al., 2017).

Survivor Help-Seeking

Survivor help-seeking behavior is as unique as the circumstances of their IPV experiences. Survivors may seek help from those who are not professionals, such as individuals close to the survivor (e.g., family or friends), or from structural systems and services within society,

such as the police and health professionals (Machado et al., 2016; Ansara & Hindin, 2010). However, not all survivors choose to seek help. It is estimated that less than 40% of female victims of domestic violence seek help following their experiences (Truman & Morgan, 2014). Survivors' help-seeking is affected by many factors, such as individual (e.g., gender, race), interpersonal (e.g., types and severity of IPV), and sociocultural factors (e.g., community norms), which influence decision making at every stage of seeking help, such as deciding to seek help and selecting a source of support (Liang et al., 2005). However, given the severe health consequences of IPV and overall positive impacts of help-seeking in reducing negative health consequences (e.g., Renner et al., 2021; Wright & Johnson, 2012), survivors should be able to access appropriate help sources. While both informal and formal help seeking can be beneficial for survivors, for this paper we will focus on the utilization of formal help, such as medical and legal help, leaving informal help-seeking for future research.

The literature suggests that formal help-seeking is effective in reducing repeat victimization (Macy et al., 2013; Xie & Lynch, 2017) and improving survivors' quality of life and mental health well-being (Rivas et al., 2016). Nonetheless, not many survivors seek formal help. Less than half of the 142 female survivors included in one study sought medical care (Morse et al., 2012). Another study revealed that a much lower number of survivors (22%) reach out to doctors or therapists (Ansara & Hindin, 2010). Many survivors are also not likely to seek help or report to the police, as indicated by numerous studies (Edwards et al., 2012; Lindquist et al., 2013; Wolitzky-Taylor et al., 2011). For instance, it was reported in one literature that only 20 to 25% of survivors chose to involve the police (Buzawa et al., 2011).

IPV Victimization and Formal Help-Seeking

There exists a considerable body of literature on the correlation between help-seeking and the type of IPV the survivor experiences. Those who experience physical IPV seem to have the highest prevalence of help-seeking, especially in the form of formal legal support (Duterte et al., 2008; Fanslow & Robinson, 2009; Henning & Klesges, 2002; Kim & Lee, 2010). However, one study emphasized that stalking IPV survivors sought more help than physical abuse survivors (Flicker et al., 2011). Sexual IPV survivors were not as likely to seek help compared to those who experienced physical IPV but were more likely to pursue medical attention than those who experienced psychological abuse (Duterte et al., 2008).

Psychological IPV survivors were the least likely to seek formal help (Lucea et al., 2013). Few studies examined the relationship between IPV polyvictimization and formal help-seeking. In one study that looked at survivors who experienced both physical IPV and stalking as compared to those who experienced physical IPV only, those who experienced both had a higher likelihood of seeking formal help (Flicker et al., 2011). The severity of IPV also impacts the likelihood of help-seeking behaviors among survivors; formal help-seeking behaviors seem to increase as the level of severity of the IPV increases (e.g., physical/sexual violence involving weapons and/or inflicting injuries), Ansara & Hindin, 2010; Bonomi et al., 2006; Duterte et al., 2008; Flicker et al., 2011; Leone et al., 2007). One study found those who experience severe IPV, such as experiencing physical injury, are three times more likely to seek help, as compared with those who do not experience as severe IPV victimization (Reyns & Englebrecht, 2014).

Help-seeking behaviors also vary based on the racial and ethnic background of the survivor. One study suggests that survivors of IPV who are African American are less likely than white survivors to seek help from mental health services (Lipsky et al., 2007). Specifically, a study that examined help-seeking among South Asian, African American, and Hispanic women reveals that around half of the women included in this study sought formal help (Yoshioka et al., 2003). According to Satyen et al. (2018), White, Hispanic, and African American survivors are all likely to seek formal help, but White women are more likely to seek mental health support or treatment, while Hispanic and African American women are more likely to seek help from police or a hospital. One study reported that almost 46% of African American survivors reported their experience to the police, 37% of Hispanic women reported, but only 16% of White women chose to involve police (Lipsky et al., 2009). One study found that African American survivors are 1.5 times more likely than White survivors to involve the police (Buzawa et al., 2011).

Current Study

In sum, the literature suggests that the type of IPV victimization is associated with the survivor's formal help-seeking, with variations that account for racial and ethnic differences among survivors. However, previous studies have several limitations, such as failing to include certain forms of IPV, such as stalking, not accounting for polyvictimization, not addressing variations in help-seeking across different IPV experiences, and a limited

representation of racial/ethnic minorities, severely limiting their generalizability. As a result, it is less known how IPV polyvictimization is associated with formal help-seeking and how race and ethnicity moderates this relationship. This study fills this gap by using nationally representative data, specifically answering two research questions: (1) How is IPV polyvictimization associated with the survivor's formal help-seeking? (2) Is the relationship between IPV polyvictimization and formal help-seeking moderated by the survivor's race/ethnicity? We hypothesized that the severe types of polyvictimization would be associated with an increased likelihood of formal help-seeking, and that the association between polyvictimization and formal help-seeking would depend on the survivor's race/ethnicity.

Method

Study Sample

This study used the National Intimate Partner and Sexual Violence Survey (NISVS) collected from 18,049 nationally representative respondents aged 18 or older in 2010 in the U.S. (Black et al., 2011). Informed by a previously conducted national survey, the CDC started to develop the NISVS by having a federally sponsored workshop to build data systems that monitor and respond to sexual violence, stalking, and intimate partner violence (Black et al., 2011). A pilot methods study was conducted in 2007 and its result was reviewed by the expert panel including practitioners, advocates, and subject matter experts in various types of IPV and/or designing measures of violence, who made recommendations on the design of the NISVS survey instrument (Black et al., 2011). The sample was selected by a dual-frame, stratified random digit dial (RDD) sampling design based on both landline and cell phone sampling frames by considering the growing cell phone only populations (Black et al., 2011). The NISVS used the following approaches to provide national and state level estimates. The samples were stratified by states, with oversampling from the smaller states. Weights were computed by considering the sampling methods, such as different sampling rates across states and varying selection probabilities in the landline and in the cell phone frames (Black et al., 2011). For this study, we first selected those who were victimized by intimate partners. Of 8,587 respondents who were identified as experiencing IPV, we selected 4,764 female respondents.

Measurements

IPV Victimization

The NISVS asked the respondents about their lifetime victimization experiences. Respondents self-reported their own IPV victimization across several types of IPV, using 60 items in total. This study classified them into seven categories based on the type and severity of violence: (1) psychological aggression (5 items) (e.g., told you that you were a loser, a failure, or not good enough; told you no one else would want you); (2) coercive control (14 items) (e.g., tried to keep you from family or friends; threatened to take your children away); (3) severe physical violence (9 items) (e.g., kicking; slamming; beating); (4) less severe physical violence (3 items) (e.g., threatening to physically harm you; pushing or shoving); (5) stalking (7 items) (e.g., making unwanted phone calls to you; watched you from a distance); (6) rape (12 items) (e.g., having sex by using physical force); and (7) non-rape sexual assaults (10 items) (e.g., exposing their body parts to you; fondling or grabbing your sexual body parts). We recoded all categories dichotomously. For example, if survivors reported experiencing at least one of the five psychological aggressions, their responses were coded 1 (yes) for psychological aggression. These dichotomized categories were used for the IPV polyvictimization classification as described in the analysis section. While some research suggests that summing IPV experiences generates more robust classifications (e.g., Hardesty et al., 2015), our preliminary analysis of data showed that using the summation tended to produce skewed classification results because of a wide range of differences in the frequencies across items. As a result, we concluded that dichotomous IPV measures were suitable for the study's analysis.

IPV Severity

The NISVS asked the survivors if they were ever concerned for their safety during their IPV experiences. We used it to create a dichotomous variable indicating the severity of IPV victimization. Those who answered yes were coded as having experienced severe IPV victimization. Other variables suggesting the severity of IPV in the NISVS (e.g.experiences of nightmares or injury) were excluded from this study because they were only asked of those experiencing certain IPV types (e.g., sexual assaults).

Help-seeking

The NISVS asked survivors if they ever talked to the following professionals: police, doctor or nurse, and psychologist or counselor, respectively. We created three dichotomous variables

indicating seeking formal help from each of these professionals.

Survivors' Race and Ethnicity

The NISVS asked respondents what their race is and if they are of Hispanic or Latina/Latino origin. The race question provided seven categories: White, Black, Asian, Native Hawaiian and Pacific Islander (NHPI), American Indian and Alaska Native (AIAN), Other Race, and Multiracial. Those seven categories were reduced to three due to small sizes of non-White and non-Black categories: White, Black, and Others. Adding the Hispanic origin question, we recoded them into four categories: non-Hispanic White, Black, Hispanic, and Other Races.

Demographic Characteristics

This study controlled for five demographic characteristics of the survivor. The NISVS asked the highest level of *education* respondents have completed with eight categories, ranging from no schooling to postgraduate. We created a dichotomous variable with two categories: less than high school graduation and high school graduation or more. The respondent's annual household *income* was measured with eight categories, ranging from less than $10,000 to $75,000 or more. They were reduced to two categories considering the federal poverty threshold in 2010 when the data was collected: less than $20,000 and $20,000 or higher. The NISVS measured sexual and gender identity with four categories: heterosexual or straight, gay or lesbian, bisexual, and transgender. We reduced them to two: heterosexual/straight and sexual and gender minority (SGM). *Nativity* was measured by asking if respondents were born in the United States, including U.S. territories and U.S. military bases or not, resulting in two categories: foreign-born and U.S.-born. *Age* was captured as a continuous variable.

Analysis

The analysis was conducted in two steps. First, we ran latent class analysis by Mplus v.7 (Muthén & Muthén, 2012) to classify IPV polyvictimization based on seven dichotomized variables of IPV victimization (e.g., psychological aggression, severe physical violence, rape). We chose latent class analysis because unlike traditional clustering approaches, such as K-means and hierarchical clustering, which focus primarily on classification, latent class

analysis takes the model-based approach which allows us to use rigorous statistical tests when determining the optimal class model (Magidson et al., 2020). Further, it provides posterior probabilities, which show how good the classification is (Magidson et al., 2020). The analysis was conducted as follows. Starting with a one-class model (Model 1), we generated multiple models by increasing the number of classes that were supposed to share similarities in their polyvictimization experiences until we could not obtain statistically and practically proper solutions using the Lo-Mendell-Rubin (LMR) adjusted likelihood ratio test of model fit (Lo et al., 2001). LMR test provided the *p* value, which shows whether one model is statistically better than another by comparing two neighboring class models (Nylund et al., 2007). The models were generated until the *p* value of LMR test was greater than 0.05, which indicates there was no improvement in fit by adding more classes. Then we reviewed information criteria model fit statistics, such as Akaike Information Criteria (AIC), Bayesian Information Criterion (BIC), adjusted BIC, and entropy measure for each model. Lower values on AIC, BIC, and adjusted BIC indicate a better fit. If the entropy value of the certain model was higher than 0.8, indicating 80% of the individuals were relevantly classified in latent classes, we considered it sufficiently high (Clark & Muthén, 2009). Also, the size of the smallest class was considered in the model selection. We excluded the class solutions of which the smallest class included less than 10% of the sample. After narrowing down class models based on the criteria above, we took a closer look at the substantive meaning of each solution by reviewing how each of seven IPV types was represented in the model. Each solution provides the probability of each type of victimization taking place per class. Probabilities of 0.70–1.00 were deemed to indicate a high probability of a certain type of victimization; 0.40–0.69, a moderate probability; and 0.40 or less, a low probability (Collins & Lanza, 2010). The model fit indices and the substantive meaning of each solution provide a good basis for a data-driven decision (for excellent discussions of this topic, see Asparouhov & Muthen, 2014; Nylund et al., 2007; Nylund-Gibson & Choi, 2018). The final number of latent classes of polyvictimization was determined based on parsimony, substantive sense, distinction (e.g., each class is unique), and practically meaningful class division (e.g., not too many, not too few classes; Bauer & Curran, 2003; Lubke & Neale, 2006).

Once the IPV polyvictimization class membership was determined, we conducted logistic regression analyses to examine the associations between IPV polyvictimization and help-

seeking, using the survey package of R (v4.1.3; R Core Team, 2022), survey (Lumley, 2004) after exporting the classes from Mplus and converting the latent variables into observed variables. This package is designed for the analysis of complex survey samples (Lumley, 2004) by allowing us to utilize the features of the NISVS, such as the sample strata and weights (Black et al., 2011). We fit a logistic regression model by specifying the option of the model as quasibinomial (R code family = quasibinomial), which accommodates non-integer counts created by differential sampling weights (Fox & Weisberg, 2018). Three logistic regression analyses were conducted with each of three help sources as the dependent variable, with IPV polyvictimization, IPV severity, and race/ethnicity as independent variables and other demographic information as control variables. Lastly, we added the interaction term, *IPV Polyvictimization* × *Race*, to the model to examine if the associations between help-seeking and IPV polyvictimization varied by survivors' race/ethnicity.

Results

The latent class analysis was conducted to obtain the optimal number of latent classes of IPV polyvictimization as reported by 4,764 respondents (see Table 1 for sample characteristics). Table 2 describes the fit statistics. The LMR appeared to find Model 3 as the best solution. Based on the AIC, BIC and adjusted BIC, Model 4 was identified as the best solution as it produced the lowest values of all three criteria. Entropy showed acceptable values for both Model 3 and 4. When assessing the size of the smallest class, the size of the small class in Model 3 was acceptable (23.9% of the total sample), while it was too small in Model 4 (3.4%). Based on the LMR and the size of the smallest class, Model 3 was determined to be an optimal class solution.

Table 1 Goodness of Fit Statistics (*N* = 476)

Table 2 Latent Class Analysis Results

Table 3 shows the three-class solution, Model 3, with the estimated probabilities of experiencing various types of IPV. The first class was characterized by a moderate probability (0.55–0.58) of psychological aggression and coercive control, with low probabilities of all other IPV types, ranging from 0.05 to 0.23. This group was labeled as *Psychological Violence (PV)*, which comprises 46.9% of survivors. The second class (29.3%) was characterized by the perfect probability of experiencing less severe physical violence (1.0), and high probabilities of severe physical violence (0.82), psychological aggression (0.94), and coercive control (0.92); this group was labeled as *Psychological and Physical Violence (PPV)*. The third class, labeled as *Multiple Violence (MV*; 23.9%), showed high probabilities of multiple IPV types, with psychological aggression, coercive control, less severe and severe physical violence at 0.91 or higher; non-rape sexual assault at 0.86, and stalking at 0.78.

Table 3 Survivor Characteristics by Race/Ethnicity

Table 1 summarizes the characteristics of 4,764 survivors included in the analysis. As the analysis used the sample strata and weights in the NISVS, weighted percentages and unweighted sample sizes were reported. The majority of survivors were White (68.2%), followed by Black (14.1%), Hispanic (12.1%), and Other Races (5.6%). PV was prevalent the most, followed by PPV and MV, for all racial/ethnic groups except Other Races, whose difference was not significant. Slightly less than 10% had less than high school educational attainment. About a quarter (23.6%) reported their annual income lower than $20,000. Less than 10% were sexual minorities; 12.3% born outside the U.S. Slightly less than two-thirds (61.1%) reported experiencing severe victimization. More than one third (36.5%) sought help from a psychologist or counselor; 34.5% talked to the police.

Four race/ethnicity subgroups showed differences in demographics and help-seeking. While 6% of White survivors and 6.9% of Other Race survivors had less than a high school education, more than a quarter of Hispanic survivors (28.2%) reported having less than a high school education. The percentage of White survivors with an annual income of less than $20,000 (18.8%) was the lowest. More than half of Hispanic and Other Race survivors (51.7% and 56.5%, respectively) were born outside the U.S. White survivors (41.9%) and Other Race

survivors (34.9%) sought help from a psychologist or counselor more than Black (21.1%) and Hispanic survivors (25.2%). On average, White survivors were the oldest (45.49), with Hispanic (37.13) and Other Race survivors (38.28) being the youngest.

The results of logistic regression analyses were reported in Table 4, which shows the associations of help-seeking with IPV polyvictimization and socioeconomic factors. Supporting the first study hypothesis, survivors of PPV and MV were more likely than survivors of PV to contact police (OR = 1.93 for PPV and OR = 3.55 for MV), a doctor (OR = 3.02 for PPV and OR = 5.21 for MV), or a psychologist (OR = 1.46 for PPV and OR = 2.63 for MV) at $p < 0.01$ level. Note that the odds of survivors of MV seeking all types of formal help, relative to PV survivors, were nearly twice those of PPV survivors. The level of severity of IPV victimization was associated with seeking all types of help, with the odds ratios ranging from 2.43 to 5.09, with the highest odds of reporting to the police (OR = 5.09), followed by the doctor (OR = 2.91) and the psychologist (OR = 2.43) at $p < 0.001$ level.

Table 4 Logistic Regression Analysis Results of the Associations Between Help-Seeking and IPV Polyvictimization by Race

Survivors' characteristics were associated with help-seeking. Other Race survivors (OR = 0.39, $p = 0.035$) and foreign-born survivors (OR = 0.62, $p = 0.023$) were less likely to talk to police about their IPV victimization. Psychologists were less likely to be used by the survivors who were foreign born (OR = 0.56, $p = 0.003$), Black (OR = 0.44, $p = 0.001$), or Hispanic (OR = 0.50, $p = 0.017$), while SGM survivors were more likely to contact psychologists (OR = 1.60, $p = 0.014$). Older age was positively associated with seeking all types of help, with the odds of 1.01 for all types of help at $p < 0.001$ level.

Interaction terms between race and IPV polyvictimization showed that survivors' race and ethnicity were moderating the relationship between IPV polyvictimization and help-seeking, supporting the second study hypothesis. Compared to White survivors who experienced MV, Other Race survivors of MV were more likely to talk to police (OR = 2.88, $p = 0.049$).

Discussion

Latent class analysis revealed that female IPV survivors experienced three distinctive forms of polyvictimization: (1) Psychological Violence (PV), consisting mostly of psychological aggression and coercive control, (2) Psychological and Physical Violence (PPV), comprised of psychological aggression, coercive control, and physical violence, and (3) Multiple Violence (MV), with almost all types of IPV (e.g., psychological, physical, and sexual) involved with high probabilities. While the number of polyvictimization forms varies across previous studies, likely due to their methodological differences, the current study findings seem to correspond to three broad polyvictimization forms suggested by the literature: mostly psychological violence, mostly less severe psychological and physical violence, and severe psychological and physical violence with other IPV types co-occurring (Ansara & Hindin, 2010; Beck et al., 2013; Choi et al., 2016; Clark et al., 2019; Dutton et al., 2005; McNaughton Reyes et al., 2018; Weiss et al., 2017).

The findings revealed that approximately one-third of IPV survivors sought formal help. This is consistent with previous findings that survivors tend to turn to informal sources of help, such as family and friends, more than formal help (Ravi et al., 2022; Seon et al., 2022; Voth Schrag et al., 2021). However, severe polyvictimization experiences, such as PPV, MV, and IPV severity, were associated with seeking all types of help sources. This echoes previous studies which have indicated that the greater perceived severity of the violence or the urgency of the need for help is likely to motivate their formal help-seeking behaviors (Fugate et al., 2005; Leone et al., 2007; Reyns & Englebrecht, 2014). Other than the severity of violence, a variety of other factors may explain the lack of formal help-seeking behaviors. For example, survivors may not identify or perceive their partner's behaviors as abusive or may be unaware of available resources (Ravi et al., 2023; Robinson et al., 2021). Certain geographic areas, such as rural communities, may lack available services for survivors (Ravi et al., 2023) or have a rather normalized view of IPV (Wright et al., 2022). Survivors may even blame themselves and feel guilty about the violence or experience fear of retaliation from their abusive partner (Evans & Feder, 2015; Ravi et al., 2023). Survivors may face challenges accessing formal services due to a lack of insurance, transportation, or child care (Fugate et al., 2005; Robinson et al., 2021). The nature of the survivor's relationship to the perpetrator can further complicate the challenge of disclosing violence or seeking help. For

instance, survivors may fear losing their relationship with their partner (Evans & Feder, 2015; Fugate et al., 2005) or may depend on their abusive partner for housing or financial resources (Ravi et al., 2023). Survivors with children may experience internal conflict regarding reporting abuse or leaving the partner: despite wanting to protect their children from the harmful effects of IPV, they may also fear losing their children due to child protective services involvement (Ravi et al., 2023; Rhodes et al., 2010).

Race/ethnicity provides another context associated with survivors' help-seeking. In certain situations, Other Races and foreign-born survivors were less likely to seek help from police than White survivors. Considering that Other Races survivors, more than half of which were foreign-born, in the current study tended to fall in the low-income bracket, especially significantly lower than White counterparts, and that low income communities tend to have distrust for police forces (Bell, 2016; Hitchens et al., 2018), this may have been due in part to police suspicion and distrust. Another possibility is that Other Races survivors, compared to their White counterparts, may experience less severe IPV, which is less likely to be reported to the police than more severe IPV (Lipsky et al., 2009). However, the current study results did not support it: Other Races survivors reported the IPV severity as much as their White counterparts did. Interestingly, when victimized by MV, which is likely to impact survivors more severely than other polyvictimization forms (e.g., PV, PPV), Other Races survivors were more likely to contact the police than their White counterparts, indicating that the form of polyvictimization moderates the relationship between race/ethnicity and help-seeking from the police. Other Races survivors victimized by multiple types of IPV (i.e., MV) may have various complicated needs, some of which may make them perceive the police as a desired source of help, especially for those in low income communities where police can be one of the few resources available to the survivors with limited financial means (Cattaneo, 2010). Note that Other Races are not homogenous in this study; instead they included Asian, Native Hawaiian and Pacific Islander, American Indian and Alaska Native, Other Race, and Multiracial survivors. As such, all the differences in the historical and cultural contexts among them could not be speculated with relation to the study findings, necessitating future research.

Racial and ethnic minority survivors of IPV, including those who identified as Black, Hispanic, or foreign-born, were less likely to seek mental health support compared to their

White and U.S.-born counterparts. These findings are similar to those reported in recent systemic reviews (Hulley et al., 2022; Satyen et al., 2018). Lower use of mental health services among some racial and ethnic minorities may be attributed to various factors, including cultural beliefs and stigma (Clement et al., 2014), financial concerns (Tambling et al., 2022), and a lack of culturally appropriate resources for mental health support (Kim et al., 2022). For example, Hispanic individuals seem to utilize mental health services less often due to financial burdens, such as a lack of health insurance and the high cost of the services, and cultural beliefs about mental health, which often leads to shame in discussing mental health issues with psychologists (Green et al., 2020; Menendez et al., 2019). Similarly, some African Americans experience greater perceived stigma and normative beliefs against seeking psychological help, (Taylor & Kuo, 2019). For example, internalizing the 'strong black woman' archetype can also contribute to Black survivors' reluctance to seek psychological services and reliance on culturally acceptable coping, such as prayer (Waller et al., 2022). Moreover, the underrepresentation of Black service providers and mistrust of White service providers can further impede Black survivors of IPV from accessing much needed mental health services (Taylor & Kuo, 2019).

Sexual and gender identity was associated with the survivor's help-seeking; SGM survivors were more likely to seek help from psychologists than their heterosexual/straight counterparts. It seems to be consistent with what the limited number of research studies have found on this population; SGM survivors tend to prefer mental health counseling where they can receive support and help (Durso & Gates, 2012; Hardesty et al., 2011). This is particularly true when mental health clinicians or healthcare workers are found to be supportive and trustworthy, as evidenced by cultural competence and judgment free settings (Kennedy et al., 2024). Transgender and gender diverse survivors especially are found to seek mental health support at greater rates than their cisgender peers, likely due to this population having a history of limited family and social support that causes them to turn to more formal support seeking (Scheer & Baams, 2021). Furthermore, largely due to perceived lack of support from police and legal authorities, many SGM victims do not report due to fears of not being believed or supported (Russell & Sturgeon, 2019).

The current study results should be viewed within the context of the limitations. Data was self-reported; respondents were asked to recall multiple IPV incidents over time, potentially

limiting their accuracy. Due to small sizes, several categories were combined into Others: Asian/Native Hawaiian and Pacific Islander, American Indian and Alaska Native, Other Race, and Multiracial. Similarly, sexual and gender identity categories were dichotomized, aggregating gay or lesbian, bisexual, and transgender respondents into 'SGM.' As such, study findings on these aggregated categories may not accurately represent each subgroup's experiences. Finally, the severity of IPV polyvictimization was measured only by one variable (i.e., safety concern). Future studies should explore additional elements of IPV severity to allow for further exploration of severity measures associated with IPV help-seeking.

Conclusion

The current study classified IPV polyvictimization experiences among female survivors to examine how IPV polyvictimization was associated with survivors' help-seeking, and how race/ethnicity moderated this relationship. The results of IPV polyvictimization classification suggest three subgroups: mostly psychological violence, both psychological and physical violence, and almost all types of violence. While a severe form of polyvictimization, including severe physical violence and sexual assaults, is positively associated with help-seeking, race/ethnicity seems to influence the survivor's decision to seek help and selection of a type of help source to be utilized. Racial/ethnic minority survivors' complex relationship with police and likelihood of psychological counseling need to be further examined by future research. Law enforcement and mental health service providers will be able to better serve racial/ethnic minority survivors by evaluating whether their services are accessible by racial/ethnic minority survivors and how those survivors' needs are met by their services and strengthening their cultural sensitivity to the experiences and cultural contexts brought in by a variety of survivors. For example, racial/ethnic minority survivors have reported positive experiences with IPV service providers who demonstrate cultural humility and sensitivity, which in turn helps reinforce these survivors' future help-seeking (Howell et al., 2018; Rodriguez et al., 2018; Sabri et al., 2015). Effective collaboration among various service providers, including police departments, hospitals, and community service agencies, can be crucial for delivering tailored services that acknowledge the unique circumstances of survivors who utilize these services (Saxton et al., 2022). For instance, some racial/ethnic minority survivors' hesitance to utilize law enforcement and/or mental health services can be mitigated by community collaboration. Improved training on how IPV manifests in relationships could help to reduce

biases of law enforcement. Although policies against discrimination exist in most police precincts, these policies often do not result in a change of practice, causing many survivors to experience bias and discrimination from law enforcement that likely affects their comfort with reporting IPV (Russell & Sturgeon, 2019). Furthermore, improved cultural competence in healthcare and social services will continue paving the way for improved support services for survivors, which will improve the likelihood of disclosure to IPV to healthcare workers (Kennedy et al., 2024).

When survivors' needs are holistically addressed, this leads to the improvement of both services and of survivor satisfaction. Additionally, social workers and staff members assisting IPV survivors in medical or social services settings should proactively follow up with the survivors after discharge or termination to ensure ongoing safety (Dichter et al., 2021). Moreover, service providers would need to evaluate survivors' awareness of their rights and assist survivors in navigating the legal system for protection from abuse (Ravi et al., 2022). Given the correlation between educational attainment and help-seeking, integration of IPV education into school would be essential (Temple et al., 2013). All entities that work with or encounter IPV survivors – e.g., law enforcement, medical agencies, religious organizations, schools, and workplaces – should work alongside each other to offer a variety of support options for survivors (Voth Schrag et al., 2021).

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