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Overview

Many people experience interpersonal traumatization at least once in their lifetime (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), and a significant proportion develop serious mental health problems in the aftermath (Abel, 2001; Kilpatrick & Resnick, 1993; Kilpatrick et al., 2003; Norris & Kaniasy, 1994; Riggs, Rothbaum, & Foa, 1995). The individuals' psychological sequelae of traumatization place a heavy burden on themselves as well as the society (Solomon & Davidson, 1997). To counter this a number of effective treatment options for stress-related disorders have been developed (Bradley, Greene, Russ, Dutra, & Westen, 2005; Foa & Meadows, 1997; van Etten & Taylor, 1998). However, only a fraction of those traumatized and in need of mental health care seek and receive psychosocial care or treatment (Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Golding, Stein, Siegel, Burnam, & Sorenson, 1988; Mahoney, 1999; Müller, Schröttle, Glammeier, & Oppenheimer, 2004; Norris, Kaniasty, & Scheer, 1990). Indeed, accessing mental health care after interpersonal traumatization seems to be hampered by varied barriers which may ultimately diminish the efficiency of the available treatment. Consequently understanding these barriers and their influence on the individual help-seeking process is central to providing mental health care after traumatization. The aim of this thesis was to shed light on both: the individual help-seeking process and the influencing variables, i.e. barriers as well as promoters. Therefore a model integrating empirical data and theory was developed and tested. This model delineates parameters relevant to seeking psychosocial care or for refraining from it.

The thesis comprises four chapters, each of which corresponds to an independent paper; therefore some overlap was inevitable. The first chapter introduces the model, summarizing the available data on help-seeking after traumatization, discussing relevant theories of help-seeking and presenting the integrative model. It also offers a vision of the model's implications. The second chapter includes quantitative data of a study testing the integrative model of mental health help-seeking after interpersonal traumatization. So far only few empirical studies have investigated help-seeking after interpersonal traumatization. The objective of this study was to look into the proposed barriers and promoters in the help-seeking process and to test the model's four trajectories in the process of help-seeking. Regression analysis was used to analyze the data of our online survey's participants who had experienced interpersonal traumatization. The third chapter presents a content analysis of perceived barriers and promoters in help-seeking reported by survivors of interpersonal

traumatization and professionals providing help for this population. In the light of these data the model is discussed and revised. The fourth chapter comprehensively deals with the model's implications for improving access to mental health care for survivors of interpersonal traumatization. For this purpose interventions were developed based on the integrative model of seeking psychosocial care after interpersonal violence and the voices of those survivors and professionals who also participated in the previous study. The analysis in chapter four suggested that improving access needs a concerted approach targeting the interacting barriers and promoters of help-seeking. The thesis concludes with a general discussion of the main findings.

1 Seeking Psychosocial Care after Interpersonal Violence: An Integrative Model

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1.1 Abstract

Many people experience a traumatic event at least once in their lifetime. But only a fraction of those traumatized and in need of mental health care receive psychosocial care or treatment. This may be due to barriers people experience within the help-seeking process. The individual help-seeking process is consequently highly relevant for any mental health care for trauma survivors. Understanding why people refrain from asking for help or delay the help-seeking process is central to understanding help-seeking after traumatization. Based on empirical data and theoretical models, an integrative model of individual mental health help-seeking is developed. This integrative model delineates parameters relevant for seeking psychosocial care or refraining from it.

Keywords: trauma; interpersonal violence; help-seeking; utilization behavior; health services; model

Traumatization is linked to an increased risk for developing a mental disorder; especially posttraumatic stress disorder, major depression, alcohol and substance abuse, eating disorders, or somatization (Breslau et al., 1998; Kessler et al., 1995; McFarlane, 1992; Shalev et al., 1998). Research into the mental health treatment of trauma survivors has so far concentrated on developing and proving the efficiency of diverse treatment approaches for these disorders, and a number of highly effective treatment options for stress disorders exist today (Bradley et al., 2005; Foa & Meadows, 1997; van Etten & Taylor, 1998).

Considerably less attention has been paid to the fact that these efficient approaches reach only a fraction of those in need of treatment. This may be due to a number of factors inherent to the individual and his or her social environment. In order to improve mental health care for trauma survivors we have to understand those factors and their relationships. The present article suggests a guiding hypothesis for future research: while need is the central condition for later help-seeking, the traumatized individual has to perceive and represent it and develop a wish and intention to seek help. The introduced model describes a number of factors

relevant for this process. It thus offers a frame for research aiming to understand and eventually close the fatal gap between the need for help and help-seeking.

After a short review of research on help-seeking after trauma and of relevant theories, the article presents an integrative model of mental health help-seeking after interpersonal traumatization and discusses its implications for research and practice.

1.2 Help-Seeking for mental disorders and traumatization

The current article focuses on the documented shortfall in mental health care for traumatized individuals despite sufficient treatment methods. The number of studies investigating the mental health help-seeking behavior in a traumatized population is very limited, and available studies have focused on Vietnam veterans (Elhai, North, & Frueh, 2005; Koenen, Goodwin, Struening, Hellman, & Guardino, 2003). In the studies assessing a nonveteran population, 11% to 53% of traumatized individuals sought psychosocial help (see Table 1). Amaya-Jackson et al. (1999) found in their analysis of a cross-sectional epidemiological survey that 21% of individuals with posttraumatic stress did not access mental health care despite perceived need.

Table 1 Psychosocial help-seeking after traumatization.

Study	Type of trauma	Psychosocial help-seeking
Freedy et al., (1994)	crime	27%
Fugate et al., (2005)	domestic violence	18%
Golding et al., (1988)	sexual assault	18%
Kimerling & Calhoun, (1994)	sexual assault [a]	19%
Logan et al., (2006)	domestic violence [b]	53%
Mahoney, (1999)	sexual assault	21%
Müller et al., (2004)	assault	11%
Norris et al., (1990)	crime	23%

[a] sample from a rape crisis center [b] only women with protective order

The low rate of mental health help-seeking after traumatization and the observed gap between self-assessed need and help-seeking are the target of the integrative model developed in this article. What are barriers preventing formal help-seeking? What are the factors promoting help-seeking? A number of reasons account for the gap between the objective need and mental health help-seeking. In the following, we present the growing body of research identifying potential subjective barriers.

Six well-established subjective barriers to mental health help-seeking have been identified in numerous studies (Christiana et al., 2000; Fox, Blank, Rovnyak, & Barnett, 2001; Issakidis & Andrews, 2002; Koenen et al., 2003; Meltzer et al., 2000). These are: (a) the attitude that an adult has to cope without help, (b) lack of knowledge about mental health or help providers, (c) lack of insight into the problem, (d) shame about the disorder or need for help and fear of stigmatization, (e) the pathology itself, and (f) perceived structural barriers like costs or lack of time.

In addition to these general barriers to treatment, some studies with traumatized subjects report the relevance of specific barriers. Shame and guilt are of special importance in this population (Fugate et al., 2005; Mazza, Dennerstein, & Ryan, 1996; Mol et al., 2002). Also the reactions of the environment play an important role. Maercker and Müller (2004) observed that the reluctance to disclose the trauma is heightened by a negative reaction of the social environment, while at the same time the subjective urge to talk about the traumatic experience is also increased. The relationship to the offender adds to the traumaspecific barriers (Fugate et al., 2005; Müller et al., 2004; Ullman & Filipas, 2001).

Of all factors promoting help-seeking behavior, suffering and symptom load have been shown to be the most prominent (Andrews, Issakidis, & Carter, 2001; Elhai et al., 2005; Issakidis & Andrews, 2002; Meltzer et al., 2000; Thompson, Hunt, & Issakidis, 2004). For traumatized subjects, the number of traumas experienced as well as the severity of the trauma play a comparable role in help-seeking (Elhai et al., 2005).

1.3 Theories of help-seeking

Most of the aforementioned studies on help-seeking for mental illnesses are descriptive or exploratory. This is probably due to the fact that relevant theories of health behavior have mainly been developed in the context of physical illness and preventive health behavior. The following selection of models of health and illness behavior has been made with respect to their academic acceptance, because they cover different aspects of health and illness behavior, and because of their relevance to the aim of this article·and this is by no means an exhaustive review.

Many of the theories include very similar constructs under different labels (Bandura, 1998; Nigg, Allegrante, & Ory, 2002; Noar & Zimmerman, 2004). These common elements are: attitudinal beliefs (appraisal of pros and cons); self-efficacy beliefs (beliefs about control over the behavior); normative beliefs; risk-related beliefs and emotional responses as well as intention and planning. Targeting the aspect of decision making in health behavior, the theory

of planned behavior (Ajzen, 1991; Madden, Ellen, & Ajzen, 1992), the theory of action phases (Heckhausen, 1987; Madden et al., 1992), and the transtheoretical model (Prochaska, DiClemente, & Norcross, 1992) describe help-seeking in terms of action phases or stages.

While the theory of planned behavior (Ajzen, 1991; Madden et al., 1992) highlights the relevance of the intention to act, assuming that the stronger the intention, the more likely the actual performance of the behavior, the theory of action phases (Gollwitzer, 1991; Heckhausen, 1987) puts greater emphasis on the phase of goal striving. It posits that the efficiency of goal striving depends on the volitional strength resulting from the intention formation, conflicting intentions, the quality of planning and of implementation intentions and the situational conditions. The transtheoretical model (Prochaska et al., 1992) refines this decision-making process for health behavior. It comprises five stages: (a) precontemplation, (b) contemplation, (c) preparation, (d) action, and (e) maintenance. During the precontemplation stage, the individual has no intention to change·and usually is not even aware of his or her problems. Problem awareness is given in the contemplation stage, and the individual is evaluating the pros and cons of change but has not yet decided on it. In the preparation stage, the individual is intending to take action and is making preparations. Change is implemented in the action stage, and if it lasts for more than 6 month, the maintenance stage is reached. Relapse can result in a recycling through the stages. Furthermore, the theory identifies 10 so-called change processes like consciousness raising, self-reevaluation, or stimulus control central to the change process. The relevancy of these different change processes and interventions varies across the different stages (DiClemente & Prochaska, 1982; Prochaska et al., 1992).

All three models constitute a basic framework for understanding and explaining the mental health help-seeking process in a traumatized population. For that purpose, population and action-specific variables have to be added. The inconsistent empirical evidence for the transtheoretical model is a result·at least partly·of insufficient validity of the stages or their assessment and imprecise conceptualization of the relationship between stages and processes of change (Adams & White, 2005; Whitelaw, Baldwin, Bunton, & Flynn, 2000). The development of a model specific for mental health help-seeking after interpersonal violence should increase validity and conceptual clearness.

Unlike the described models, Andersen's behavioral model of health care use (Andersen, 1995) does not target decision making but focuses on the influencing variables in help-seeking. The model comprises three groups of variables that are linked in a linear and causal sequence: (a) predisposing variables, determining the probability that a need occurs, (b)

enabling variables, including structural variables of the health system as well as individual resources, and (c) need variables. Need is divided into evaluated need and perceived need; the perceived need is supposed to be more important for actual help-seeking behavior. Numerous studies support the importance of all three groups of variables (Kouzis & Eaton, 1998).

Andersen's behavioral model of health care use is the model most often referred to in research on help-seeking, but it has been criticized that a clear delineation of the interaction of the variable layers is lacking (Young, 2004). It offers a selection of relevant variables without attempting to explain the process by which they guide individual behavior and can thus complement theories targeting decision making. The distinction of evaluated and perceived need is a strength of the model, but it would benefit from a specification of these concepts.

Perceived need is the focus of the illness representation model (Young, 2004). This model identifies an emotional component and five cognitive components of illness representation: identity; consequences; illness time line; control /cure, and cause. Leventhal proposed that these representational dimensions act as a filter and organizing schema for available information and that they direct regulation processes. The model assumes that individuals create mental representations of their illness using three sources of information: information accumulated by the person in previous social interactions and from cultural knowledge, information from the significant social environment, and the current experience of the illness itself. This model complements the other theories with its emphasis on the representation of the problem the affected persons create for themselves.

There is only one model specific to trauma victims: The model of help-seeking among female survivors of intimate partner violence by Liang, Goodman, Tummala-Narra, and Weintraub (2005) presents a theoretical framework of the help-seeking processes among survivors of intimate partner violence. The model comprises three stages: problem recognition and definition, the decision to seek help, and the selection of a help provider. These stages are thought to be influenced by individual, interpersonal and sociocultural factors. Individual factors are the readiness of the affected woman to change the situation, her recognition of the problem as undesirable and continuous, and her way of relating to others. Interpersonal factors are the dynamics of the relationship, the problem definition provided by the offender, the reaction of the social environment on disclosure, potential costs of help-seeking like stigmatization, and availability of different sources of help. Sociocultural factors are cultural values and structures that reinforce power inequality between men and women, emphasize family privacy, and reject divorce. The aim of this model is about seeking help to stop intimate partner violence rather than explaining mental health helpseeking after interpersonal

violence. Still, a considerable overlap in the influencing variables is to be expected between both cases.

1.4 An integrative model

In the following section, the basic structure of the integrative model of mental health help-seeking after interpersonal traumatization is presented, followed by the description of those individual, interpersonal, structural, and sociocultural variables influencing the process from traumatization to help-seeking.

1.4.1 Structure

The proposed model integrates existing theory and empirical evidence in order to combine their strengths and to maximize its fit for a traumatized population. The theories discussed conceptualize problem identification and representation, intention formation, and goal striving as important steps on the way to health behavior change or help-seeking. The proposed model includes these concepts and adds a trauma-specific step. The basic model consequently consists of five central concepts: interpersonal traumatization, perceived problem, wish for treatment, treatment intention, and help-seeking, which are supplemented by the influencing variables presented further in Figure 1. In the following, we introduce the five factors of the basic model.

Interpersonal traumatization refers to an interpersonal traumatic event overstraining the coping potential of the individual and resulting in a transient or lasting posttraumatic stress reaction. It includes all forms of interpersonal violence and singular as well as complex traumatization and stress reactions like fear, irritability, insomnia, avoidance, and functional impairment.

Perceived problem includes the subjective definition and relevancy of the traumatization, the expectations about its time course, the subjective impairment resulting from it, and the experienced worry and suffering. It is the motivating element in the model. *Wish for treatment* represents the early, more emotional and less specific idea to seek professional help (like psychotherapy, counseling, pastoral care) in order to cope with mental health problems.

Treatment intention is the elaborated, rationally based intention. It is the endpoint of a deliberative assessment of the desirability and feasibility of the wish for treatment. Only the treatment intention is associated with commitment for action.

Help-seeking refers to the mental health help-seeking behavior. It is the need demonstrated in actual help-seeking or a request for help. It comprises every contact with services independent of quality or persistence. We do not target the maintenance of the contact (e.g., therapy),

which we consider to depend on a similar but not identical process. Dropout was linked to catastrophic cognitive styles and posttraumatic avoidance in one study (Bryant et al., 2007), but research into treatment maintenance in posttraumatic stress disorder (PTSD) has not identified reliable predictors for dropout so far (Minnen, Arntz, & Keijsers, 2002).

In accord with stage models (Weinstein, Rothman, & Sutton, 1998), the proposed integrative model posits a specific sequential order of qualitatively different levels, which are influenced by specific variables. Unlike traditional stage models, it presumes that the levels are not categorical but continuous in nature and successively build on each other. A change in a precedent level affects the parameter value of the higher level. Consequently, the variables influencing the trajectories to precedent levels are not irrelevant on higher levels due to the dependency of higher stages on preceding ones.

1.4.2 Variables influencing the basic model

In addition to the factors central to the described theories of help-seeking, the model integrates variables identified in research to explain the influences on the trajectories between the five main levels (see Figure 1). These variables cover general and trauma-specific, individual, interpersonal, and sociocultural factors. They were chosen based on their empirical support and their relevancy for the target population. For the sake of clarity and parsimony, only the most proximate variables were included as influencing variables, and the developed model will abstain from specifying the exact pathways and interrelations between the influencing variables.

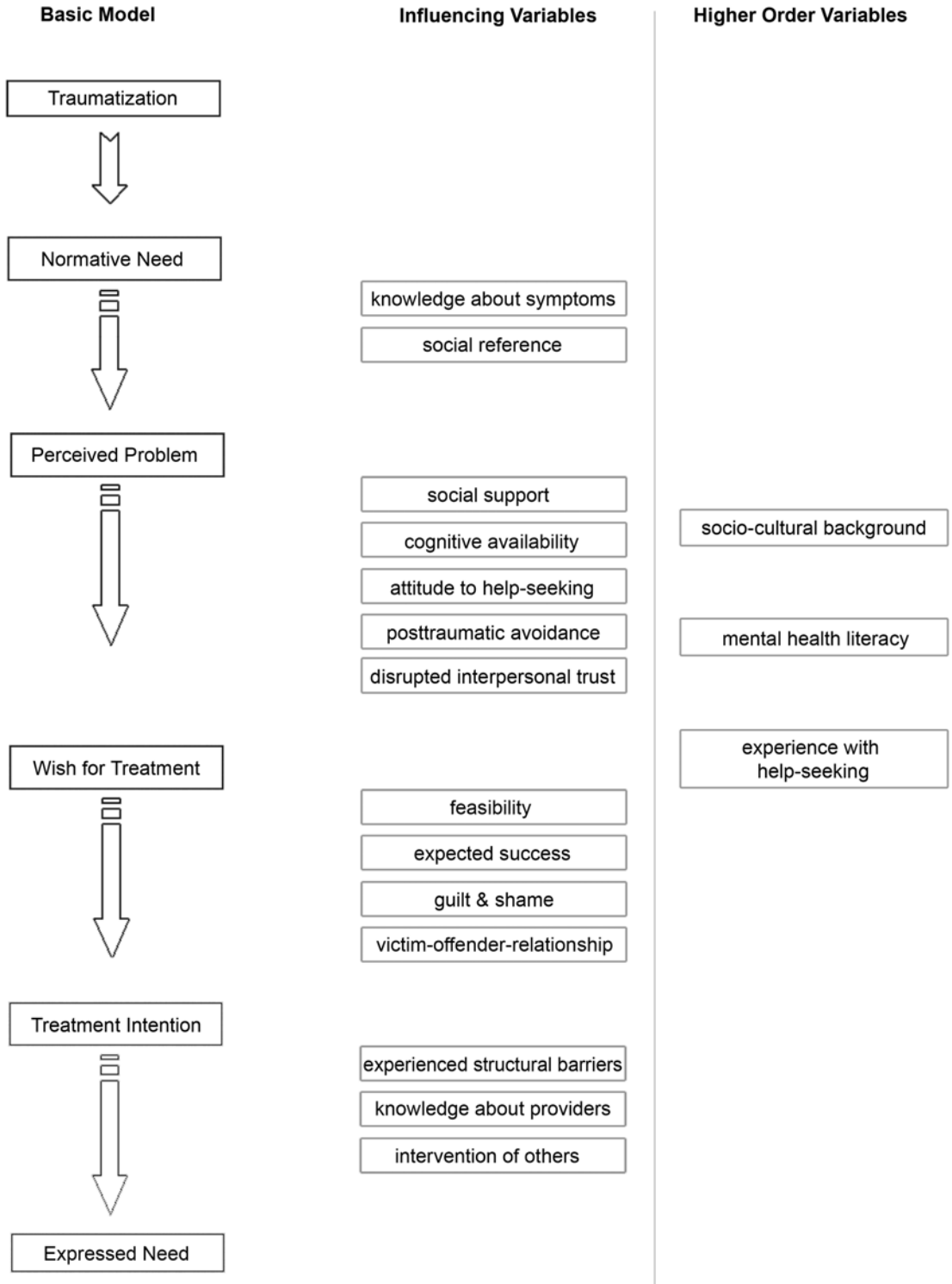
In the following sections, details on the trajectories between the model levels are provided and the influencing variables are specified. The higher-order variables (right column in Figure 1) are broad concepts of well-known impact on several pathways of the model: sociocultural background (Cauce et al., 2002; Kaukinen, 2004; Liang et al., 2005; Lin, Inui, Kleinman, & Womack, 1982; West, Kantor, & Jasinski, 1998), mental health literacy (Jorm et al., 1997), and previous experience with help-seeking (Liang et al., 2005; Wolf, Ly, Hobart, & Kernic, 2003).

1.4.2.1 Influences on Traumatization·Perceived Problem Trajectories.

It is well known in clinical practice that traumatization affects its victims differentially and that only a fraction of those exposed to a potentially traumatizing event will suffer from a full PTSD (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). The traumatic event and the stress reaction are individually perceived and processed by the affected individual, resulting in a cognitive representation of the problem and an emotional

reaction. Two influencing variables are included in the model: knowledge about traumatization and social reference.

Figure 1 Integrative model of traumatization and seeking psychosocial care.



Knowledge About Traumatization. A recent review of public beliefs about mental disorders (Angermeyer & Dietrich, 2006) concluded that a substantial part of the lay public cannot

correctly recognize mental disorders. Such a lack of knowledge should diminish problem perception because of the inability of the affected individual to conceptualize and organize his or her experiences and to appraise their meaning. Though the role of posttrauma education is still unclear, education about trauma and potential symptoms has been proposed as a posttrauma intervention (Bisson, McFarlane, & Rose, 2000).

Social reference comprises the feedback the affected person receives from his or her social environment. Due to the uncertainty and disruption the traumatic event evoked, the affected individual is prone to rely more heavily on social cues and internalized stereotypes in attempting to make sense of his or her experience (Krause, De Rosa, & Roth, 2002). Social feedback·be it invited or unrequested·is therefore expected to influence problem perception, either promoting or hampering a realistic representation.

1.4.2.2 Influences on Perceived Problem·Wish for Treatment Trajectories.

Solving the perceived problem is the final goal of the affected individual, and seeking professional help is just one way to serve it. Even a realistic problem representation therefore does not automatically translate into a wish for treatment.

Social support. The more social support a person has, the less likely he or she is to use mental health services and vice versa (Kimerling & Calhoun, 1994; Kouzis & Eaton, 1998; Sherbourne, 1988; Wills & DePaulo, 1991). On the other hand, support may also increase help-seeking (Liang et al., 2005; Wills & DePaulo, 1991). This apparent contradiction is probably due to the different aspects of social support. The current model allows for this diversity by incorporating support in terms of an accepting and helpful environment on this trajectory and support for help-seeking on the intention–expression trajectory. Coping with the aid of social support depends on the availability, quality, and active usage of this resource, all of which might be impaired for a traumatized population (Hadeed & El-Bassel, 2006; Kaniasty & Norris, 1993; Yap & Devilly, 2004). A negative reaction of the social environment impedes access to social support (Cordova, Walser, Neff, & Ruzek, 2005) and negates the positive effect of disclosure (Bolton, Glenn, Orsillo, Roemer, & Litz, 2003). At the same time, a negative reaction increases the desire to disclose (Maercker & Müller, 2004) and is correlated to disclosure to formal support sources (Starzynski, Ullman, Filipas, & Townsend, 2005).

Cognitive availability of formal help. In a study on help-seeking for domestic violence, „didn't think of it" was a frequently given reason for not contacting formal help (Starzynski et al., 2005), indicating a lack of cognitive availability of this option. This cognitive availability

of psychosocial help can be influenced by advice from acquaintances (Wills & DePaulo, 1991), by a proactive offer of help, and by the presence of psychosocial services in the media or the social environment of the affected person (Wills & DePaulo, 1991).

Attitude to help-seeking. The model assumes that the general attitude of the affected person toward utilizing psychosocial care is relevant for a wish for treatment to emerge. This attitude is derived from normative beliefs transmitted by family, friends, the social network, and the sociocultural environment of the individual. Even though the prevalent attitude toward psychosocial care and the mentally ill is positive, mental illness and the need for treatment is viewed as disgraceful and a sign of weakness (Angermeyer & Dietrich, 2006; Byrne, 2000; Goldney, Fisher, & Wilson, 2000; Wills & DePaulo, 1991). Sartorius (2002) considers stigma to be the most important obstacle to the provision of mental health care, and the fear of stigmatization extends even to the expected reaction of the health professional himself (Priest, Vize, Roberts, Roberts, & Tylee, 1996).

Posttraumatic avoidance of trauma-related stimuli·including avoidance of thinking and talking about the trauma·is a core feature of PTSD. Different theories of posttraumatic stress claim that this posttraumatic avoidance aims to avoid stimuli triggering intrusion and hyperarousal (Ehlers & Clark, 2000; Foa, Steketee, & Rothbaum, 1989; Horowitz, 1993). This conceptualization has been supported by empirical evidence (McFarlane, 1992; Steil & Ehlers, 2000) and is also valid for help-seeking after traumatization. The wish to avoid trauma-related stimuli opposes the wish for treatment and impedes it (Schwarz & Kowalski, 1992).

Disrupted Interpersonal Trust. Trust is essential in the relationship between help seeker and help provider facilitating the willingness to seek care, the expression of feelings, the exchange of information and the submission to treatment (Anderson & Dedrick, 1990; Hall, Camacho, Dugan, & Balkrishnan, 2002). Disrupted interpersonal trust is also a common reaction to traumatization. This is especially true for interpersonal violence (LaMothe, 1999). This factor is expected to be negatively related to the desirability of any form of social support and consequently to the wish for treatment.

1.4.2.3 Influences on Wish for Treatment·Treatment Intention Trajectories.

The intention to seek treatment is developed in a deliberate process in which feasibility and desirability are assessed and advantages and disadvantages are weighted against each other.

Feasibility depends on the perception of abilities and resources necessary to seek help. The affected individual assesses feasibility, taking into account his or her knowledge about

institutions or professionals offering psychosocial care and the perceived structural barriers like lack of time, lack of money, local distance, and cultural or language barriers (Bui, 2003; Christiana et al., 2000; Fox et al., 2001; Fugate et al., 2005). In case of victims of intimate partner violence, the fact that such victims are (often) under the control of the violent partner may also reduce perceived feasibility of seeking formal help (Müller et al., 2004).

Expected success describes the anticipation that help-seeking will lead to a reduction of the perceived problem; the stronger the expectation that receiving psychosocial care will help reducing the perceived problem, the higher the desirability to do so. Fox and associates (2001) found that virtually all of their subjects considered the expectation that mental health services would help them to be central for their behavior. Unfortunately, developing PTSD is related to a tendency for negative appraisal·among others, being unable to see the trauma as a time-limited event (Dunmore, Clark, & Ehlers, 1999; Ehlers & Clark, 2000). Consequently, looking at all traumatized individuals, those who have been affected more severely are possibly also those having the least hope for success of help.

Guilt and shame. Feelings of guilt and shame are a common reaction to traumatization. Guilt arises from appraisal processes of responsibility for the traumatic event or its outcome, shame from appraisal concerning the violation of important internal standards (Ehlers & Clark, 2000). Disturbingly, international studies show that the attribution of guilt to the victim is still a common reaction (Nayak, Byrne, Martin, & Abraham, 2003). In the light of guilt and shame, the act of seeking formal help threatens the need for self-esteem and the need to belong. The adaptation strategy is secrecy·so that guilt and shame prevent the affected person from help-seeking (Byrne, 2000). Actually, both emotions are a negative predictor of help-seeking (Mazza et al., 1996; Mol et al., 2002; Starzynski et al., 2005).

The victim–offender relationship. A closer victim–offender relationship impedes helpseeking (Müller et al., 2004; Zoellner et al., 2000), especially in the formal help system (Kaukinen, 2002). For rape victims, the victim–offender relationship may be one of the most important determinants of help-seeking (Mahoney, 1999). If the offender is a friend, relative, or partner, the assessed desirability of psychosocial care is reduced because of conflicting motives (i.e., the wish to protect the offender and to continue the relationship·for the sake of children, financial support, or right of residence·or the fear of revenge) (Bui, 2003; Fugate et al., 2005; Müller et al., 2004; Thompson et al., 2000). A special case is victimization of men by marital violence, which society has not even defined as a problem and which is clouded by an especially strong tendency to blame the victim (George, 1994).

1.4.2.4 Influences on Treatment Intention·Help-Seeking Trajectories.

This transition is assumed to correspond to goal striving. The efficiency of goal striving depends not only on the volitional strength but also on the situational conditions (George, 1994; Heckhausen, 1987). Three situational conditions are influencing variables of this transition. *Experienced structural barriers.* Structural barriers are diverse and include a lack of providers, a rejection of a request for help or insensitivity for the realities of the help-seeking person, a lack of economic resources, no available transportation, or language or cultural barriers (Fox et al., 2001; Liang et al., 2005). While there is an increasing awareness of the needs of female victims of violence and a growing number of providers addressing those needs, agencies servicing the needs of men with the same experience or low-threshold offers for victims of other traumas like migrants who experienced violence, war, or torture are still rare (Carey-Wood, 1997; Donnelly & Kenyon, 1996; George, 1994; Kaukinen, 2004; Liang et al., 2005). Experienced structural barriers are expected to delay the expression of need and to slowly reduce the volitional strength. The situation is further complicated by the fact that just the same factors that are defining a high traumatization risk (like low-income, belonging to a minority; (Breslau, 2002)) are also barriers to professional help.

Knowledge about institutions. A lack of knowledge about institutions or professionals offering psychosocial care has been shown to be a barrier to help-seeking (Christiana et al., 2000; Meltzer et al., 2000). This lack of knowledge effects not only the assessment of feasibility but also the implementation of the intention to seek help; the more providers the affected persons know of, the more opportunities to act they can perceive.

Interventions of others can create conditions favorable for goal striving or prevent the affected person from taking actions. Prevention by their partners from contacting formal help is of special relevance for victims of domestic violence (Fleury, Sullivan, Bybee, & Davidson, 1998; Fugate et al., 2005). A special category of interventions is the proactive offer of help or referral; by adopting active policies and procedures, hospitals have been able to increase the rate of identification of female domestic violence victims by almost six times (Meichenbaum & Keeley, 2004).

1.5 Implications of the proposed integrative model

The proposed framework highlights that help-seeking is a multilayered process with five stages. This process is influenced by individual, interpersonal, structural, and sociocultural factors that differentially exert their influence on the transitions between the stages. The model can guide research and supply a common ground for research in this population. The

model provides an integrative framework for theory and empirical studies. This is of particular significance in light of the relevance of mental health help-seeking after trauma and the yet small number and low-level of integration of studies. A drawback of the proposed model in this regard is its complexity due to the aim to identify all variables central to the help-seeking process in this specific population. We accepted this complexity as a necessary price for assessing potential starting points for interventions in order to improve care for trauma victims.

Such an integrative model could become a means of communication between the different parties engaged in the field of mental health care. We thus also conceptualized it to guide decisions about measures to improve access to care and guide health policies. Proposing five transition points in the help-seeking process after traumatization, the model specifies five starting points for interventions. Interventions on the highest level aim at increasing resilience and reducing vulnerability. Interventions on the next level support the individual in the perception and definition of the traumatization and are aimed at the acceptance of need and the reduction of denial. Interventions on the third and fourth level should heighten the availability as well as the perceived desirability and feasibility of help-seeking as an effective coping strategy and should reduce implicit and explicit individual barriers. A more emotional path of interventions would be indicated on the third level and a more rational path on the fourth level. Interventions on the fifth level pertain to the more externally located barriers or promoters to action.

The probability of help-seeking increases when the act of seeking help is more private, while the problem necessitating the help is public and the public consensus on help-seeking is high (Wills & DePaulo, 1991). Accordingly, public campaigns including information and advertisements via different media, information sheets, social events, and classroom instructions have been found to increase knowledge about disorders and symptoms, increase willingness to seek professional help, and decrease fear and social distance (Angermeyer & Dietrich, 2006; Jorm, 2000). A campaign based on the model would have to include information relevant for all stages because target groups would be mixed with regard of the help-seeking process. Matching the information to different target groups should at the same time enhance its assimilation and consequently its effect. Relevant elements for such a campaign targeting all transitions are:

1. Psychoeducation about trauma and the impact of trauma in order to increase problem perception and improve problem representation in trauma victims and their social

environment. This would also increase the social network's ability to respond helpfully and to support the affected person.

2. Information normalizing reactions on traumatization and the need for support in order to reduce shame, embarrassment, and stigmatization.

3. Awareness raising for formal psychosocial help systems and information about their offers and access in order to increase cognitive availability of formal help and reduce perceived barriers.

4. Information about effective treatment options and the benefits of interventions in order to increase the desirability of formal help.

A shortcoming of public campaigns is that they can only target those barriers to help-seeking manipulability by information alone. Other influencing variables, like the disruption of trust or feelings of guilt, are part of the posttraumatic syndrome and are the target of specific psychotherapeutic interventions. In order to overcome these barriers, a proactive approach with an institutionalized screening for trauma in all health care settings, information about the disorder at local services, as well as encouragement and referral is promising (Fox et al., 2001; García-Moreno, 2002; Meichenbaum & Keeley, 2004). Training of health practitioners might be necessary to provide screening tools and helpful interventions, to reduce the fear, to open Pandora's box, and uncover problems they are not prepared to handle, and to meet any tendency to react in a potentially harmful way like communicating a lack of time or blaming the victim. Furthermore, while structural barriers only existing in the perception of the individual due to a lack of or false information may be easily reduced by information and a proactive approach alone, this is not possible with existing structural barriers. Fortunately, structural barriers allow direct external control, like increasing the density of psychosocial services for victims of trauma or offering services in the native language. Any development of interventions to improve formal psychosocial help-seeking should therefore include two things: First, just as the sociocultural background and trauma-specific situation of the person are relevant for the help-seeking process itself, no intervention can be developed without careful consideration of the sociocultural context or without sensitivity to the reality of the affected person. Second, help-seeking is not the only way to cope, and alternative ways of coping·like informal help-seeking·should be valued as important and potent reactions an individual can choose for him or herself.

In future studies, e.g. (Schreiber, Renneberg, & Maercker, 2009a) it will be important to systematically target the moderating factors and to establish a thorough understanding of the

intrapsychic processes composing the transition from one level to the other. Studies should not be confined to the definitions of professionals but should include the view of the affected person and target the processes of appraisal and decision making·embracing the individual experience. They should also explore feasible interventions promoting these processes and ensuring an optimal constellation of the moderating factors.

The integrative model developed in this article describes mental health help-seeking after interpersonal traumatization as the result of a decisional process, which is differentially influenced by individual, interpersonal, structural, and sociocultural variables. It can be a starting point for research as well as the development of interventions in this field.

2 Help-seeking Behavior in a Traumatized Sample: Testing an Integrative Model of Seeking Psychosocial Care

Schreiber, V., Renneberg, B., Maercker, A. (Manuscript submitted for publication)

2.1 Abstract

Background While a number of treatment options for stress-related disorders exist today, obstacles to accessing mental health care after interpersonal traumatization may ultimately undermine the efficiency of the available treatment. However, only few empirical studies have investigated help-seeking after interpersonal traumatization. The objective of this study was to test an integrative model of mental health help-seeking after interpersonal traumatization, describing the process of help-seeking and the influencing variables. **Methods** A sample was recruited through a variety of sources and completed an online questionnaire. Regression analysis was used to analyze the data of 115 mainly female participants who had experienced interpersonal violence or another interpersonal traumatization. **Results** The analysis provided support for the validity of the model's four trajectories: interpersonal traumatization - perceived problem, perceived problem - wish for treatment, wish for treatment - treatment intention, and treatment intention - help-seeking. The majority of the model's influencing variables reached siginficance, i.e. social reference, social support, attitude to help-seeking, disrupted interpersonal trust, expected success, victim-offender relationship, experienced structural barriers and interventions of others. **Conclusions** The model offers a valid way to describe the individual help-seeking process and to identify barriers that need to be addresses as well as promoters that can be of use to improve health care for survivors of interpersonal traumatization.

2.2 Introduction

Interpersonal traumatization, especially exposure to physical or sexual violence, may be associated with a specific pattern of mental health problems. The mental disorder observed with the highest prevalence is posttraumatic stress disorder (PTSD), but other disorders are also frequently observed, especially major depression, anxiety disorders, obsessive-compulsive disorder, alcohol and substance abuse, somatization, and sexual dysfunction (Abel, 2001; Kilpatrick & Resnick, 1993; Kilpatrick et al., 2003; Norris & Kaniasy, 1994; Riggs et al., 1995). A number of highly effective treatment options for stress disorders exist today (Bradley et al., 2005; Foa & Meadows, 1997; van Etten & Taylor, 1998) but obstacles

to accessing mental health care may ultimately undermine the efficiency of the available treatment.

In the available studies on help-seeking after interpersonal traumatization only about 11 to 27% of the traumatized individuals sought psycho-social help (Freedy et al., 1994; Fugate et al., 2005; Golding et al., 1988; Mahoney, 1999; Müller et al., 2004; Norris et al., 1990). Moreover, in the cross-sectional epidemiological survey of Amaya-Jackson and colleagues (1999), 21% of individuals with posttraumatic stress did not access mental health care despite their perceived need.

2.3 The Model

We developed an integrative model of mental health help-seeking after interpersonal traumatization to describe the process of help-seeking and to explain the observed gap between self-assessed need and help-seeking (Schreiber, Renneberg, & Maercker, 2009b). The basic model describes the individual process of help-seeking from interpersonal *traumatization* to *perceived problem*, *wish for treatment*, and *treatment intention* to *help-seeking*. We assume that the four trajectories between these variables of the basic model are each influenced by specific variables (see Figure 2).

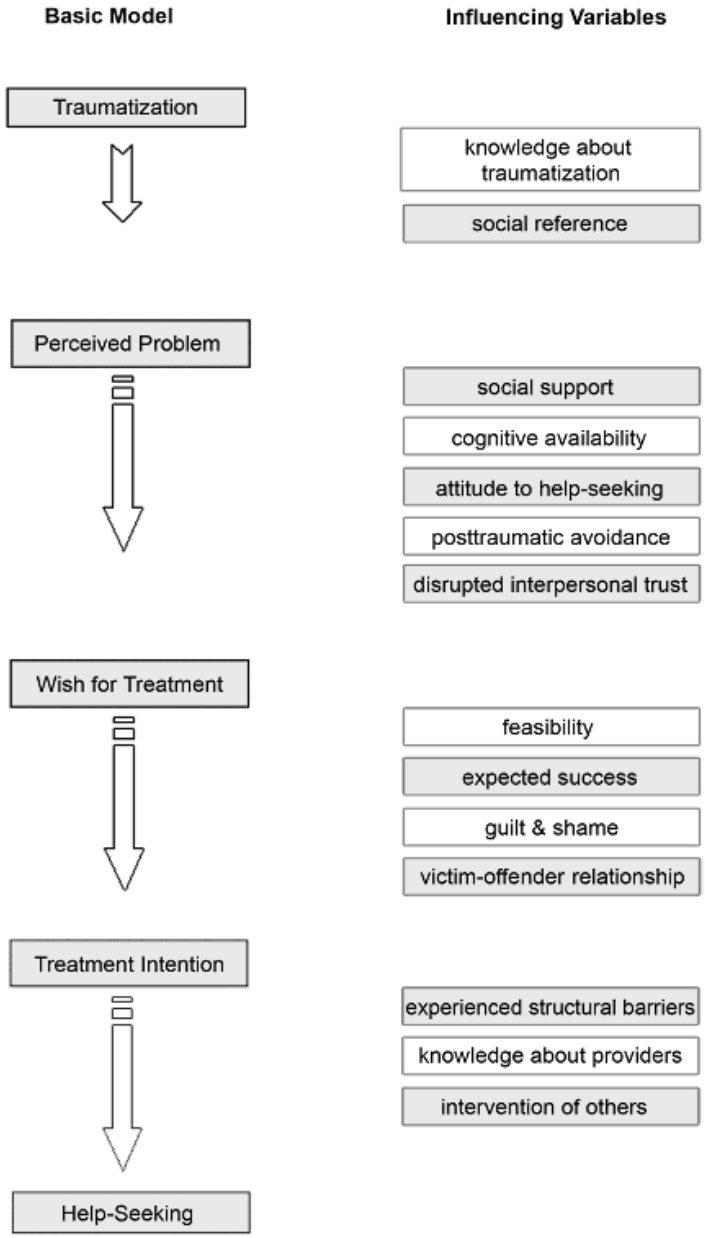
Interpersonal *traumatization* refers to an interpersonal traumatic event overstraining the coping potential of the individual and resulting in a transient or lasting posttraumatic stress reaction. The *traumatization* is transformed into a *perceived problem* by the individual. This includes the cognitive representation of the *traumatization* itself and the experienced worry, suffering, and impairment. The *perceived problem* may give rise to a *wish for treatment*, representing the more emotional idea to seek professional help (like psychotherapy or counseling) in order to cope with the perceived problem. On the basis of this wish a *treatment intention* can be formed. It is the result of a deliberative assessment of the desirability and feasibility of the *wish for treatment*. Only if the individual acts on his or her own intention can *help-seeking* be observed.

The variables influencing the trajectories cover general and trauma-specific, and individual, interpersonal, and sociocultural factors. Two influencing variables are suggested for the *traumatization* to *perceived problem* trajectories. The first is *knowledge about traumatization* which is supposed to be relevant for the conceptualization and organization of the *traumatization* and the appraisal of its meaning. The second variable is *social reference,* which comprises the feedback the affected person receives from his or her social environment

and which he or she may use to make sense of his or her experience in a situation of uncertainty and disruption (Krause et al., 2002).

Figure 2 The trajectories and influencing variables of the integrative model of seeking psychosocial care after interpersonal traumatization.

All variables that were statistically significant are highlighted in grey.



Five variables are suggested to influence the *perceived problem* to *wish for treatment* trajectories. The first is *social support,* which has been shown to have the potential to decrease or increase the use of mental health services (Kimerling & Calhoun, 1994; Kouzis & Eaton, 1998; Liang et al., 2005; Sherbourne, 1988; Wills & DePaulo, 1991). The access to *social support* might be impaired for a traumatized population (Hadeed & El-Bassel, 2006;

Kaniasty & Norris, 1993; Yap & Devilly, 2004) and a negative reaction of the social environment has been associated with the need to disclose and with disclosure to formal support sources (Maercker & Müller, 2004; Starzynski et al., 2005). The second variable is the *cognitive availability* of the possibility of seeking formal help, which can be influenced by advice from acquaintances or professionals and by the presence of psychosocial services in the media or the social environment (Jorm, 2000; Wills & DePaulo, 1991). The third variable is the *attitude to help-seeking* derived from normative beliefs transmitted by the social network and the sociocultural environment of the individual. Mental illness and the need for treatment are often viewed as disgraceful and a sign of weakness (Angermeyer & Dietrich, 2006; Byrne, 2000; Goldney et al., 2000; Wills & DePaulo, 1991) and this may pose a serious obstacle to the provision of mental health care (Sartorius, 2002). The fourth variable is *posttraumatic avoidance* of thinking and talking about the trauma. The wish to avoid trauma-related stimuli may oppose the wish for treatment and impede it (Schwarz & Kowalski, 1992). The last variable is *disrupted interpersonal trust* which is a common reaction to interpersonal violence (LaMothe, 1999). But trust is essential for the willingness to seek care, the expression of feelings, and the exchange of information (Anderson & Dedrick, 1990; Hall et al., 2002).

For the *wish for treatment* to *treatment intention* trajectories, the model suggests four influencing variables. The first is *feasibility*, that is the perception of abilities and resources necessary to seek help, including knowledge about sources of psychosocial care and the perceived structural barriers like lack of time or money (Christiana et al., 2000; Fox et al., 2001; Fugate et al., 2005). The second variable, *expected success*, describes the anticipation that *help-seeking* will lead to a reduction of the *perceived problem*. We anticipate that a strong expectation that receiving psychosocial care will help increases the desirability of *help-seeking*. The third variable is actually a pair of variables, *guilt and shame*, which are common reactions to traumatization, arising from the appraisal of responsibility or a violation of important internal standards (Ehlers & Clark, 2000). Both emotions are expected to reduce the desirability of formal help (Mazza et al., 1996; Mol et al., 2002; Starzynski et al., 2005). The last variable is the *victim-offender relationship.* If the offender is a friend, relative, or partner the assessed desirability of psychosocial care is reduced due to conflicting motives, i.e. due to the wish to protect the offender or to continue the relationship – for the sake of children, financial support, or right of residence, or the fear of revenge (Bui, 2003; Fugate et al., 2005; Müller et al., 2004; Thompson et al., 2000).

Three variables are suggested for the influences on the *treatment intention* to *help-seeking* trajectories. The first is the *experience of structural barriers* like a lack of providers, a rejection of a request for help or a lack of economic resources (Fox et al., 2001; Liang et al., 2005). *Experienced structural barriers* are expected to impede effective *help-seeking* and to slowly reduce the volitional strength of the *treatment intention*. The second is the *knowledge about institutions* the individual possesses; the more providers the affected person knows, the more opportunities he or she has to act. The last variable includes *interventions of others*, which create conditions favorable for or impeding *help-seeking*. These others can be relatives, friends, or other members of the social network, but also (proactive) professionals.

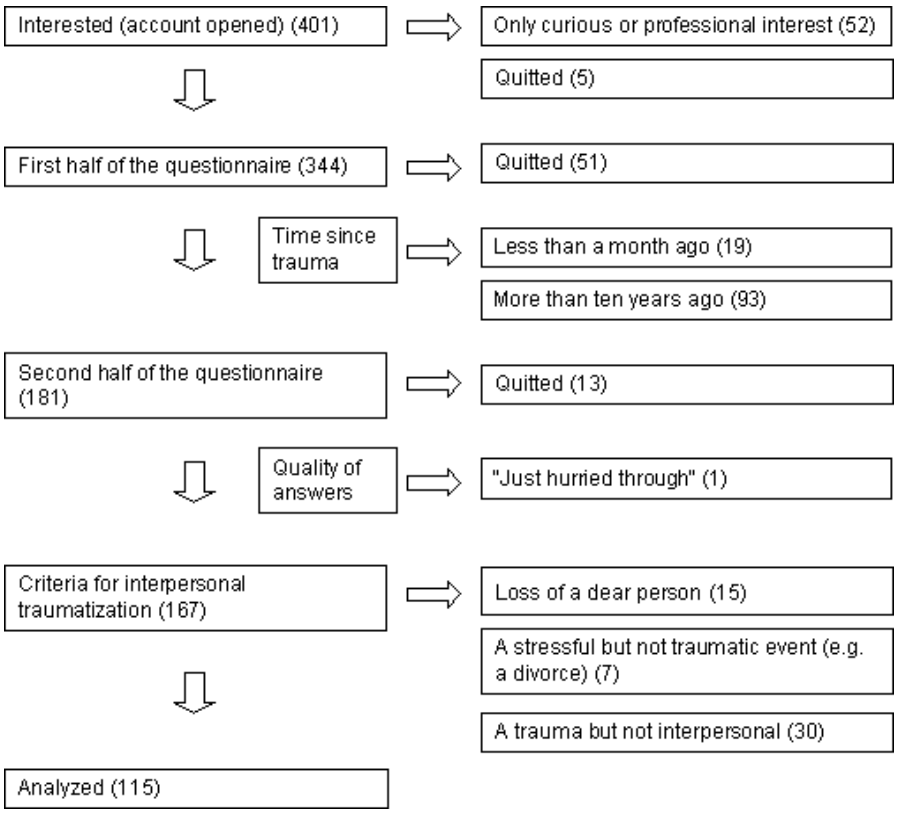
So far, only a few studies have examined help-seeking after traumatization and none has systematically tested a model of help-seeking. The present study puts the integrative model to an empirical test. The aim was: (1) to test the proposed structure of trajectories, and (2) to test the contribution of each influencing variable in a sample with a history of interpersonal traumatization.

2.4 Methods

2.4.1 Participants

Participants were recruited through a variety of sources by informing the sources' users about the study and asking them to participate online. They were informed about the content of the questionnaire, the possibility to quit at any time shoud they feel distressed and about providers of help if needed. The majority came from internet self-help forums (60%), the remainder from other sources on the internet (like other forums and content sites; 23%), and non-internet sources (like physician's offices; 17%). None of the participants received payment for his or her participation, but we provided feedback if wished. An account was created for each participant, so he or she could save his or her data at every point throughout the online questionnaire and continue later. The exclusion criterion was the time elapsed since the trauma: we set ten years as the upper boundary to keep the potential recall bias low. One month was set as the lower boundary to prevent a disturbance of the natural recovery process after the trauma and to allow some time for the process of help-seeking to unfold. 401 persons participated; of those, 115 persons had experienced interpersonal violence or another interpersonal traumatization and completed the questionnaire. Figure 3 shows a flowchart of the participants who dropped out. Participants who quitted in the first or second half of the questionnaire did not differ from the analyzed sample in any of the demographic characteristics nor in any of the independent variables in the basic model.

Figure 3 Flowchart of the participants who dropped out



2.4.2 Questionnaire and Data Reduction

The questionnaire combined diagnostic scales and items from different sources. PTSD was assessed with the Posttraumatic Diagnostic Scale (PDS) (Foa, Cashman, Jaycox, & Perry, 1997); German Version: (Griesel, Wessa, & Flor, 2006), depression was assessed with the depression subscale of the Symptom-Checklist-90-Revised (SCL-90-R) (Derogatis, 1994).

To assess the other variables of the model, items were taken from or based on studies or questionnaires measuring one or some of the model's variables (see next paragraph). If necessary the questions were translated into German or slightly modified for a better fit with the intended construct. For each variable at least three questions were selected and a single score was then calculated from the assigned items. We made sure that the scale-ranges were identical; if necessary, the scores were transformed accordingly, and the resulting scale-ranges were either five or six. Factor analysis was used to confirm the assignment of the items to the variables. The calculation of each variable is described as follows.

The variable *traumatization* was calculated using diagnostic scales: the PDS and the depression subscale of the SCL-90-R. The trauma-list of the PDS was modified to include psychological violence (i.e. threats, coercive tactics, humiliation, isolation) and the frequency

with which each trauma type had been experienced. The time frame for the assessment of the symptoms was set to the period during which the symptom load was the highest. *Traumatization* included symptom load (PTSD as well as depression) and functional impairment during the worst period as well as the severity of the traumatization (number of traumata, number of different traumata, subjective severity).

Perceived problem included the suffering and the subjective impairment resulting from the traumatization as well as the experienced worry (e.g. "When I think about my troubles I get upset") and the perceived relevancy of reducing the troubles. Items were taken from the Revised Illness Perception Questionnaire (IPQ-R) (Moss-Morris et al., 2002) and the short version of the Questionnaire on Psychotherapy Motivation (FPTM-23) (Schulz, Lang, Nübling, & Koch, 2003).

Wish for treatment was calculated from items assessing the strength and frequency of the wish for treatment. This included items like: "There were times when I would have welcomed professional advice for an emotional problem", taken from the scale on Orientations to Seeking Professional Help (Fischer & Turner, 1970).

Treatment intention was calculated from items assessing the strength and frequency of an intention to seek treatment. This included items like: "Have you ever decided to seek help by a professional?".

Help-seeking included three forms of professional mental health services: physicians, psychologists, and counseling/advice. Help-seeking was rated as at least one contact with at least one of the three when seeking help for a mental health problem. It was coded in a dichotomous (yes/no) variable.

Knowledge about traumatization included knowledge about traumata, about PTSD, about depression, and the ability to assign one's own symptoms to the trauma and its consequences.

Social reference was calculated from items asking for the reaction of family and friends (worried or minimizing).

Social support was calculated from the subjective quality of help received from family, friends and/or other trauma-survivors for problems resulting from the traumatization.

Cognitive availability was dropped from the analysis because no satisfying solution for it's assessment within the questionnaire was found.

Attitude to help-seeking included a stoic attitude as well as fear of stigmatization and was calculated from items like: "A person should work out his own problems; getting psychological counseling would be a last resort", "Having been a mental health patient is a blot on a person's life". The items were taken from the scale on Orientations to Seeking

Professional Help (Fischer & Turner, 1970) the Perceived Need for Care Questionnaire (PNCQ) (Meadows, Harvey, Fossey, & Burgess, 2000) and the FPTM-23 (Schulz et al., 2003).

Posttraumatic avoidance was calculated from the diagnostic items of the PDS.

Disrupted interpersonal trust included trust and openness towards professional helpers and was calculated from items like: "A health professional would never mislead you about anything", "I would willingly talk about my problems to a health professional" (taken from Fisher and Turner (Fischer & Turner, 1970) and the scale: General trust in the medical profession (Hall et al., 2002).

Feasibility included perceived structural barriers to help-seeking and the person's own subjective feeling of being (un)able to seek help if wanted (Meadows et al., 2000; Meltzer et al., 2000; Thompson et al., 2004).

Expected success included items like: "Did you think that one of the listed professionals would have been able to help you cope with the experienced trauma and its consequences?" (Fischer & Turner, 1970).

Guilt included items assessing the subjective responsibility for the traumatization, e.g. "I have to accept the responsibility for the event" (taken from the Posttraumatic Cognitions Inventory (PTCI) (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999); German version (Ehlers & Boos, 2000).

Shame included items about trauma-related and reaction-related shame, like: "To talk about it is very embarrassing" (Meltzer et al., 2000).

Victim-offender relationship was coded in three categories, indicating if the offender was a partner or spouse, a family member, or a person of trust like a clergyman or teacher.

Experienced structural barriers was a count of the structural barriers experienced by the participant, e.g. "I asked but didn't get the help" (Meadows et al., 2000; Müller et al., 2004).

Knowledge about providers was a count of the number of providers known to the participant.

Intervention of others was coded in three categories, indicating if the participant had received at least one form of proactive help (by a professional), at least one form of support in help-seeking by family or friends, or if somebody had intervened with his or her help-seeking (Müller et al., 2004).

2.4.3 Procedure

The questionnaire was programmed in PHP and mySQL and the data were stored in a database on the server of the University of Zurich. The questionnaire was embedded in a website containing information about psychological trauma and potential sources of help and

was available online for 16 months. The participants were self-selected and remained completely anonymous throughout the whole procedure, with the exception that they could choose to receive feedback and leave an email address. We downloaded the data regularly and sent feedback as wished.

2.4.4 Data Analysis

To test the model's trajectories, we performed hierarchical regression analyses for the first three and a logistic regression analysis for the last trajectories, where the dependent variable was dichotomous. In the first step the basic variable was included; in the second, all influencing variables were included. To test for moderation we included the product terms of the variables of the basic model and the influencing variables in the last step. The influencing variables in the model were selected due to their relevance for a traumatized population (Schreiber et al., 2009b) and a correlation analysis confirmed the expected dependencies between *traumatization* and the variables. We used residual centering (Little, Card, Bovaird, Preacher, & Candall, 2007) to ensure orthogonality between the basic variable *traumatization* and the influencing variables and to reduce the intercorrelations of the independent variables resulting from their shared dependencies with *traumatization*.

2.5 Results

2.5.1 Participant Characteristics

The sample consisted mainly of female participants (female: n = 107, 93%; male: n = 8, 7%) and differed in several additional characteristics from the general population (Germany and Switzerland). The participants were younger on average (mean 33,9, SD 12,00, range 15-96) and better educated (more than high school: n = 72, 62%), more participants were single (n = 49, 43%) or separated/ divorced (n = 23, 20%) and less were married (n = 14, 12%) than in the average population. Slightly more participants were not religious (n = 40, 34%) and slightly more had a foreign cultural background (n= 22, 20%). All had experienced some form of interpersonal violence or traumatization and most had experienced more than one event (n = 98, 85%) and more than one type of trauma (n = 94, 82%). The event selected as the worst trauma was most frequently sexual assault in adulthood (n = 31, 27%) followed by psychological violence (i.e. threats, coercive tactics, humiliation, isolation) (n = 30, 26%).

Those participants recruited through a self-help forum reported a significantly stronger perceived problem ($T = 2.42$, $p < .05$), wish for treatment ($T= 2.48$, $p < .05$) and treatment

intention (T= 3.85, $p < .01$) than the rest of the sample. This was not unexpected, given that this subsample was actively seeking a form of help at the time of recruitment.

2.5.2 Regression Analyses

2.5.2.1 Traumatization - Perceived Problem Trajectories

Table 2 displays explained variance and regression coefficients for the basic and influencing variables on the *traumatization - preceived problem* trajectories.

The hierarchical regression indicated that *traumatization* (index of the severity of trauma, etc.) is a significant predictor of the *perceived problem* ($R^2 = .41$, $p < .001$). The influencing variables showed significant moderation effects ($\Delta R^2 = .03$, $p < .05$). On this stage the regression coefficients of the *social reference* (attitude of the individual's social network towards the traumatization) and the associated moderator term reached significance ($\beta = .77$, $p < .05$ and $\beta = -.68$, $p < .05$).

Table 2 Summary of hierarchical regression analysis for the traumatization - perceived problem trajectory

Variable	R^2	ΔR^2	B	SE B	B
Step 1	.41**	.41**			
Traumatization			.73	.08	.64**
Step 2	.42**	.01			
Traumatization			.73	.03	.64**
Knowledge about traumatization			.00	.04	.01
Social reference			.05	.04	.10
Step 3	.45**	.03*			
Traumatization			.71	.08	.62**
Knowledge about traumatization			-.18	.16	-.31
Social reference			.40	.16	.77*
Moderator term for Knowledge about traumatization			.10	.09	.31
Moderator term for Social reference			-.18	.08	-.68*

Note: *p < .05, **p < .01.

2.5.2.2 Perceived Problem - Wish for Treatment Trajectories

Results of the hierarchical regression analysis are summarized in Table 3. *Perceived problem* is a significant predictor of the *wish for treatment* ($R^2 = .37$, $p < .001$) and the influencing variables also explain a significant part of the variance of these trajectories ($\Delta R^2 = .13$, $p < .001$).

Table 3 Summary of hierarchical regression analysis for the preceived problem - wish for treatment trajectory

Variable	R^2	ΔR^2	B	SE B	β
Step 1	.37**				
Perceived problem			1.0	.12	.61**
Step 2	.50**	.13**			
Preceived problem			.86	.12	.52**
Social support			.05	.02	.22**
Attitude to help-seeking			-.18	.06	-.20**
Posttraumatic avoidance			.16	.10	.11
Disrupted interpersonal trust			-.27	.09	-.20**
Step 3	.52**	.02			
Preceived problem			.82	.13	.50**
Social support			.09	-07	.36
Attitude to help-seeking			-.33	.26	-.34
Posstraumatic avoidance			.56	.44	.36
Disrupted interpersonal trust			-.37	.37	-.28
Moderator term for Social support			-.02	-03	-.16
Moderator term for Attitude to help-seeking			.07	.10	.19
Moderator term for Posstraumatic avoidance			.03	.15	.05
Moderator term for Disrupted interpersonal trust			-.19	.19	-.31

Note: *p < .05, **p < .01.

The regression coefficients of all influencing variables except *posttraumatic avoidance* reached significance (*social support*: β = .21, p < .01; *attitude to help-seeking*: β = -.20, p < .01; *disrupted interpersonal trust*: β = -.21, p < .01). That is, more *social support* was associated positively with the *wish for treatment* while a negative *attitude to help-seeking* and *disrupted trust* were associated negatively with the *wish for treatment*. No significant moderation was observed.

2.5.2.3 Wish for Treatment - Treatment Intention Trajectories

Results of the hierarchical regression analysis for these trajectories are displayed in Table 4. *Wish for treatment* (R^2 = .64, p < .001) and the influencing variables (ΔR^2 = .07, p < .01) predicted a significant proportion of the variance of the *treatment intention*. Of the regression

Table 4 Summary of hierarchical regression analysis for the wish for treatment - treatment intention trajectory

Variable	R^2	ΔR^2	B	SE B	β
Step 1	.64**				
Whish for treatment			.95	.07	.80**
Step 2	.70**	.07**			
Whish for treatment			.82	.07	.70**
Feasibility			.14	.08	.10°
Expected Success			.23	.07	.21**
Shame			-.02	.06	-.02
Guilt			.00	.07	.00
Victim-offender Relationship					
Partner, Spouse			.10	.13	.04
Family member			-.33	.15	-.12*
Person of trust (e.g. clergyman, teacher)			-.02	.20	-.01
Step 3	.72**	.01			
Whish for treatment			.84	.10	.71**
Feasibility			-.11	.52	-.08
Expected success			.75	.29	.68**
Shame			-.29	.25	-.28
Guilt			.27	.26	.25
Victim-offender relationship					
Partner, spouse			.18	.59	.07
Family member			.02	.68	.01
Person of trust (e.g. clergyman, teacher)			.42	.89	.11
Moderator term for Feasibility			.07	.12	.18
Moderator term for Expected success			-.14	.07	-.48°
Moderator term for Shame			.07	.06	.28
Moderator term for Guilt			-.07	.07	-.26
Moderator term for Victim-offender relationship					
Moderator term for Partner, spouse			-.01	.15.	-.02
Moderator term for Family member			-.08	.17	-.11
Moderator term for Person of trust (e.g. clergyman, teacher)			-.11	.22	-.12

Note: °p > .1, *p < .05, **p < .01.

coefficients *expected success* ($\beta = .21$, $p < .01$) and the offender being a family member ($\beta = -.12$, $p < .05$) reached significance. The expectation of success was positively associated with the *treatment intention*, a closer *victim-offender relationship* was negatively associated with it. The regression coefficient of the perceived *feasibility* showed a trend towards significance ($\beta = .10$, $p < .1$) with more *feasibility* being associated with a stronger intention. No significant moderation was observed.

2.5.2.4 Treatment Intention - Help-Seeking Trajectories

In Table 5 explained variance and regression coefficients for the logistic regression of the *treatment intention - help-seeking* trajectories are depicted. Results indicate that *treatment intention* is a significant predictor of seeking face-to-face help by a professional ($_{N}R^2 = .48$, $p < .001$). The influencing variables showed significant moderation effects ($\Delta_{N}R^2 = .11$, $p < .05$). On this stage the moderator term for *experienced structural barriers* ($B = -.91$, $p < .05$) and the moderator term for *proactive help* ($B = -1.43$, $p < .5$) reached significance.

2.6 Discussion

The aim of the study was to test an integrative model of mental health help-seeking after interpersonal traumatization. We expected that the trajectories and influencing variables of the model could be observed in a sample with a history of interpersonal traumatization. For the predominantely female sample the results of the regression analysis provided support for the validity of all four trajectories suggested in the model.

For the *traumatization - perceived problem* trajectory the basic variable *traumatization* (i.e. the severity of the traumatization, the symptom load and the functional impairment) explained a significant proportion of the variance of the *perceived problem*. The interaction of the influencing variable *social reference* with *traumatization* added significantly to the explained variance over and above *traumatization*, suggesting a moderation of the effect of *traumatization* on the *perceived problem*. For the *perceived problem - wish for treatment* trajectory the basic variable *perceived problem* explained a significant proportion of the variance of the *wish for treatment* and the direct effects of the influencing variables (*social support*, *attitude to help-seeking*, *disrupted interpersonal trust*) added a significant proportion of explained variance, but no moderation was observed. The same was true for the *wish for treatment - treatment intention* trajectory. The last trajectory, *treatment intention - help-seeking*, showed the same pattern as the first with a significant moderator effect of the influencing variables (*experienced structural barriers, intervention of others*).

Table 5 Summary of logistic regression analysis for the treatment intention - help-seeking trajectory

Variable	${}_{N}R^2$	$\Delta_N R^2$	B	SE B
Step 1	.48**			
Treatment intention			1.49**	.29
Step 2	.50**	.02		
Treatment intention			1.54**	.31
Experienced structural barriers			-.19	.32
Knowledge about providers			-.10	.14
Intervention of others				
Proactive help			-.04	.63
Help by friends/ family			.16	.63
Interference by somebody			1.34	.98
Step 3	.61**	.11*		
Treatment intention			3.22**	1.06
Experienced structural barriers			2.59°	1.38
Knowledge about providers			.12	.27
Intervention of others				
Proactive help			4.14°	2.26
Help by friends/ family			2.81	3.23
Interference by somebody			-0.42	3.59
Moderator term for Experienced structural barriers			-.91*	.42
Moderator term for Knowledge about providers			-.10	.10
Moderator term for Intervention of others				
Moderator term for Proactive help			-1.43*	.73
Moderator term for Help by friends/ family			-.84	1.03
Moderator term for Interference by somebody			.45	1.33

Note: °p > .1,*p < .05, **p < .01.

${}_{N}R^2$ = Nagelkerkes R^2, $\Delta_N R^2$ = Change in Nagelkerkes R^2

Most, but not all, influencing variables were supported by significant regression coefficients. On the *traumatization - perceived problem* trajectoriy, *social reference* moderated the effect of the *traumatization* on the *perceived problem*. If the social environment perceived more of a problem the traumatized individual did so too. However, this was primarily true for those with less severe *traumatization*. This is not surprising; if the certainty of one's own judgment increases, social reference becomes less important (Deutsch & Gerard, 1955) and the perception of the problem is likely to become less ambiguous if the problem becomes more and more dominant and obvious. Ruback, Greenberg and Westcott (1984) pointed out the relevancy of others for labeling an event as a crime and determining its seriousness by cuing the victim to a particular `script´ or normative standard and by providing arguments. They suggested this to be of special relevancy for crimes of very high or low seriousness – that is those more difficult to label. However, the results show a reversal of the effect of *social reference* for those with a more severe *traumatization*. This is not fully explained by a reduction in ambiguity. It is possible that less problem perception in the social environment was associated with less concern and support – especially for those who were severely traumatized. Such a lack of social support might not only affect the PTSD symptoms (Andrews, Brewin, & Rose, 2003; Schützwohl, Maercker, & Manz, 1999) but increase the suffering and worry of the affected individual. The other influencing variable on the trajectories, *knowledge about traumatization*, did not reach significance. The formation of the *perceived problem* variable (subjective suffering, worry, and felt impairment) might account for this lack of consistency with the model. *Knowledge about traumatization* is more likely to influence cognitive components of problem representation such as identity and cause (Leventhal, Leventhal, & Contrada, 1998). A more inclusive assessment of problem representation is therefore needed.

On the *perceived problem - wish for treatment* trajectory the regression coefficients of all influencing variables except *posttraumatic avoidance* reached significance. Successful access of *social support* – and not the lack of *social support* – was associated with a stronger wish for professional treatment. This seems to be in contradiction to the observation that a negative reaction of the social environment impedes access to *social support* (Cordova et al., 2005) and increases the desire to disclose (Maercker & Müller, 2004). However, *social support* has been shown to work on *help-seeking* in two possible directions: reducing it (Kimerling & Calhoun, 1994; Kouzis & Eaton, 1998) or increasing it (Liang et al., 2005; Wills & DePaulo, 1991). It is possible that *social support* reduces worry and suffering and consequently *help-seeking* (Andrews et al., 2003; Solomon, Mikulincer, & Avitzur, 1988). However, with a given

perceived problem, such informal help seems not to substitute, but to pave the way to *professional help.* The *attitude to help-seeking* showed a negative relationship with the *wish for treatment*. The stronger a person holds the view that mental health help is stigmatizing and one should cope with one's problems alone, the weaker his or her *wish for treatment* is. The same was true for *disrupted interpersonal trust*. The less trust and openness a person expressed, the weaker was his or her wish for treatment. The lack of significance of *posttraumatic avoidance* might result from confounded variables. Traumatization, PTSD, and possibly even the restrictions resulting from posttraumatic avoidance should increase, while a strong avoidance should decrease the *wish for treatment*. This makes it especially difficult to determine the unique effect of *posttraumatic avoidance*. Residual centering, used to control for confounded variables, is prone to reducing the variance and hence the regression coefficients of *posttraumatic avoidance*. Additionally, high avoidance values might result in non-participation in the survey, so that those who did not seek help due to avoidance are likely to be underrepresented in the sample.

On the *wish for treatment - treatment intention* trajectory, *expected success* and the offender being a family member reached significance and perceived *feasibility* showed a trend towards significance. If the participant reported more faith in the *expected success* of professional mental health help, he also formed a stronger intention to seek help. The same was true for his faith in his own ability to seek help, i.e. the perceived *feasibility*. On the other hand a closer *victim-offender relationship*, i.e. the offender being a family member, reduced the *treatment intention*. *Shame and guilt* failed to show a significant influence on the *treatment intention*. This is in contradiction to numerous studies that indicated these emotions to be barriers to help-seeking (Fugate et al., 2005; Mazza et al., 1996; Mol et al., 2002; Starzynski et al., 2005). In the case of guilt a problem might have been that not much guilt was reported (M = 2.18; SD = 1.14; range 1-6), resulting in an underestimation of the regression coefficient. However, this was not the case for shame (M = 3.08; SD = 1.41; range 1-6).

On the *treatment intention - help-seeking* trajectory, the *experienced structural barriers* and *proactive help* moderated the effect of the intention. For the *experienced structural barriers* the effect of the *treatment intention* was reduced when the person met more barriers. Participants with a strong intention who reported many structural barriers were less successful in help-seeking. Unexpectedly, those with less intention who reported more barriers also sought more professional help compared to those with fewer barriers. In this case the higher proportion of reported barriers is probably a result of a more intense *help-seeking* activity in this subgroup. The positive intervention of others supported *help-seeking*, but only for a

subgroup of the sample. *Proactive help* increased *help-seeking* only for those who reported less intention. Its effect disappeared when the intention to seek help was strong. Contrary to expectation, *knowledge about providers* did not predict *help-seeking*.

On all four trajectories the variables of the basic model seemed to be the driving force. The proportions of explained variance suggest that the influencing variables play a subordinate role and that a person in need of help is likely to seek help, quite irrespective of potential barriers. This is somewhat contradictory to the observation that only a minority of those traumatized actually seek help afterwards, e.g. (Fugate et al., 2005; Norris et al., 1990). There are three possible explanations. (1) It is in fact only such a minority of trauma survivors who need help; all others cope (well) on their own. However, this is not in line with the epidemiologic observations that 24-49% of those sexually assaulted develop a PTSD (let alone all other stress-related disorders) (Breslau, Peterson, Poisson, Schultz, & Lucia, 2004) while only 18-21% seek psychosocial help (Golding et al., 1988; Mahoney, 1999). Furthermore – when asked – 70% of the victims of violent crime who presented at a general hospital expressed the wish to receive counseling or other mental health services (Boccellari et al., 2007). (2) The seeming dominance of the variables of the basic model may be an anomaly resulting from a truncated sample due to the self-selection of the participants. Potential sample effects will be discussed in more detail below. (3) The impression is misleading; the influence of the barriers on each of the trajectories seems to be small but throughout the whole process they add up to a big effect. In fact, post-hoc analyses showed that traumatization alone explains less than 10% of the variance of treatment intention and of help-seeking. On the other hand, all influencing variables taken together explain 35% of the variance of help-seeking.

Some limitations have to be considered in the interpretation of the data and a replication of these results is needed before the model can either be seen as confirmed or changed accordingly. Although the results are mainly consistent with the model, the design of the analysis does not preclude the possibility that another structure might provide a better fit with the data or that relevant variables are missing from the model. Additionally, several limitations on the interpretation of the results have to be noted. First, the sample was self-selected and therefore truncated with regard to the level of traumatization and help-seeking. Severely traumatized subjects and subjects seeking multiple forms of help were overrepresented, while mildly traumatized subjects and subjects not seeking help were underrepresented. This is likely to result in an underestimation of the regression coefficients. Second, the generalization of the results is limited because the sample consisted mainly of

females and those better educated. A replication with a mixed or male sample with less education is necessary to confirm the validity of the model for a male or poorly educated population. Third, the relatively small number of study participants with interpersonal traumatization (n = 115) did not allow for the implementation of an analysis testing the whole model at once, so that we had to resort to stepwise regression analysis of the trajectories. Additionally, while the power was at least .8 for most analyses (Cohen, Cohen, West, & Aiken, 2003) it was only about .7 for the last step on the third trajectories and less for the last step on the fourth trajectories. Studies using larger sample sizes are therefore needed. Fourth, the data are cross-sectional in nature, but the process is longitudinal. Many participants were or had been in treatment and had to recall pre-treatment beliefs, attitudes and experiences. The treatment experiences are likely to influence many of the influencing variables; for example, the fear of stigmatization might abate and the knowledge about traumatization increase. For some variables this might have led to an overestimation and for others to an underestimation of the pre-help values. For this reason a longitudinal study would be a better test of the model; a feasible option would be to limit the sample to recently traumatized subjects and to include a follow-up. Finally, all data was self-reported and it was not possible to confirm, for example, the selection, which kind of trauma the participants experienced, or whether they had received professional help, and of which kind. It is possible that some of the traumatic events were mislabeled and that some of the help was delivered by a non-professional helper. Furthermore, it is possible that some participants made up their data. However, the length of the questionnaire is likely to discourage less serious participants and people participating out of mere interest were given the possibility to indicate this twice. In future studies, additional informants and measures (e.g. interviews) could be used. These limitations suggest that it will be prudent to replicate the findings in additional samples of men and women exposed to interpersonal trauma.

2.7 Conclusion

In summary, the results mainly supported the integrative model of mental health help-seeking after interpersonal traumatization. Further work is needed to determine if those variables which did not reach significance in our sample should be dropped from the model and to compare the structure suggested by the integrative model with other potential solutions. Nevertheless the model offers a valid way to describe the individual help-seeking process and to identify barriers that need to be addresses as well as promoters that can be of use to improve health care for survivors of interpersonal traumatization.

3 Interpersonal traumatization: What keeps survivors from seeking psychosocial help? A qualitative analysis

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3.1 Abstract

Background Despite frequent and serious mental health problems after interpersonal traumatization, only a fraction of those affected by interpersonal violence seek formal help after the event. But what keeps these survivors of trauma from getting care? To address this question a model integrating empirical data and theory was developed describing why survivors of interpersonal violence refrain from or delay mental health help-seeking. This model was tested and revised. **Method** Survivors of interpersonal traumatization and professionals providing help for this population were asked: what would make it easier for those affected by interpersonal traumatization to seek and receive professional help afterwards. A deductive and inductive content analysis of the experiences of 43 survivors of interpersonal traumatization and 16 professionals providing help for this population was carried out. **Results** The analysis suggested a clear distinction of an individual and system level of influencing variables. On the individual level all the model's variables were confirmed and one additional variable was included in the model: denial of the problem. On the system level factors of the help-system, dominant attitudes in society and public knowledge about traumatization and available help were included in the model. **Conclusion** The results confirmed a complex interaction of variables on the individual and system level in the help-seeking process. The effects of the trauma, the experiences of the survivor, the social environment and the system providing the help all play a role in this process.

3.2 Background

Interpersonal traumatization like physical or sexual assault is a common problem in many societies (Breslau et al., 1998; de Jong et al., 2001; Frans, Rimmö, Åberg, & Frederikson, 2005; Kessler et al., 1995; Maercker, Forstmeier, Wagner, Glaesmer, & Brähler, 2008). A high prevalence of mental health problems is observed in survivors of traumatization; first of all post-traumatic stress disorder (PTSD) but also major depression, anxiety disorders, obsessive-compulsive disorder, alcohol and substance abuse, somatization, and sexual dysfunction (Abel, 2001; Kilpatrick & Resnick, 1993; Kilpatrick et al., 2003; Norris & Kaniasy, 1994; Riggs et al., 1995). These consequences of traumatization are associated with functional impairment, a significantly reduced quality of life and high rates of physical health

problems (Alonso et al., 2004; Amaya-Jackson et al., 1999; Breslau, Lucia, & Davis, 2004; d'Ardenne, Capuzzo, Fakhoury, Jankovic-Gavrilovic, & Pribe, 2005; Seville et al., 2003; Zatzick et al., 1997). Nevertheless only a fraction of the traumatized individuals seem to seek psychosocial help, hence a significant proportion of survivors of trauma do not receive the indicated care (Freedy et al., 1994; Fugate et al., 2005; Golding et al., 1988; Mahoney, 1999; Müller et al., 2004; Norris et al., 1990).

To shed light on this problem a model integrating empirical data and theory was developed describing why survivors of interpersonal violence refrain from, delay or engage in mental health help-seeking (Schreiber et al., 2009b). The model outlines individual, interpersonal and sociocultural parameters relevant for seeking psychosocial care. It describes the individual process of help-seeking progressing through four trajectories, each influenced by specific variables. These trajectories are: (1) interpersonal *traumatization* to *perceived problem*, (2) *perceived problem* to *wish for treatment*, (3) *wish for treatment* to *treatment intention* and (4) *treatment intention* to *help-seeking* (see Figure 4 and (Schreiber et al., 2009b) for a conceptualization of the influencing variables).

The model has been tested using data from an online survey of survivors of interpersonal violence from the general population (age range 15–96) (Schreiber et al., 2009a). This quantitative test mainly supported the model but left some questions unanswered: Was the lack of support for some of the proposed influencing variables (e.g. knowledge about traumata and their consequences or feelings of shame and guilt) due to the limitations of the data of this study or should these variables be dropped completely? And does the model capture the main process or are important variables missing? To follow up on these questions we conducted a succeeding study, supplementing the quantitative with a qualitative test of the model.

3.3 Method

3.3.1 Participants

A traumatized sample was drawn from the participants of the online study on help-seeking after traumatization (Schreiber et al., 2009a). Irrespective of having completed the questionnaire, all participants with an interpersonal trauma who had supplied their email address (128 women and 15 men) were contacted. Feedback on their personal responses was provided and they were asked to email a written answer to the open-ended research question included. To ensure anonymity, answers were saved without email address or name and without connection to the existing data from the online questionnaire.

In a second step a sample of professionals working in the field was contacted through the mailing list of a crisis line (Telefonseelsorge), a victim assistance agency for crime victims (Weisser Ring), the National Association of Women's Counseling and Rape Crisis Programs **(**Bundesverband Frauenberatungsstellen und Frauennotrufe) and a psychotherapy newsgroup (Deutschsprachiges Psychotherapie-Forum im Internet DPI e.V.).

3.3.2 Procedure

Two open-ended research questions were emailed to the potential participants. For the traumatized sample the questions were: "What would have made it easier for you to seek professional help after the event?" and "What do you think would make it easier for others to do so?" For the professional sample the questions were: "From your own experience: What do you think would make it easier for somebody who experienced a traumatic event (especially interpersonal violence) to seek and receive professional help afterwards?" and "What would have to change (e.g. in the help-system or in society) to reduce barriers between those seeking and those providing help – and how could that be achieved?".

3.3.3 Data analysis

The qualitative analysis of the answers combined directed, deductive content analysis and conventional, inductive content analysis (Hsieh, & Shannon, (Hsieh & Shannon, 2005); Mayring, (Mayring, 2000)). For the directed analysis aspects of analysis were defined and a set of main- and sub-categories were developed (Crabtree & Miller, (Crabtree & Miller, 1999)) based on the integrative model of mental health help-seeking after traumatization (Schreiber, et al., (Schreiber et al., 2009b)). The model describes the intrapsychic process to help-seeking and the promoters and barriers influencing it. Consequently three aspects of analysis were chosen: variables of the intrapsychic process, barriers to help-seeking and promoters of help-seeking. For each of these variables we formulated a definition, coding rules and examples for the variable's main category, and if necessary for all subcategories. Wherever possible aspects hampering (barriers) or promoting (promoters) help-seeking were differentiated. For example: The social reference includes social reactions which pertain to the acknowledgement (promoter) or ignorance (barrier) of the problem. The consequence of the acknowledgement or ignorance is assumed to be a clearer or diminished understanding of the problem.The resulting coding agenda was assessed for clarity by a co-worker who knew the model but was not too familiar with it. Where necessary the coding agenda was revised.

In the second step all respondents' answers were read and the first half was coded using the coding agenda. During this process new categories or sub-categories were developed,

whenever those deductively developed were insufficient and consequently the coding agenda was revised again. In the third step the first author coded all answers (including those already coded) using this revised coding agenda. During the coding process problems or 'not-yet-understoods' were noted down as a later starting point of further analysis (Addison, (Addison, 1999)). Subsequently all answers were recoded by the first author and the co-worker. Their recoding-reliability and the intercoder-reliability were already satisfying at this point (Cohens κ .86; Cohens κ .76) (Mayring, (Mayring, 2000)). Nevertheless all 'not-yet-understoods' were discussed together with those noted earlier and the coding agenda was revised and the coding adapted. In the fourth step the model was re- and co-constructed based on the integrative model and the categorized quotes.

3.4 Results

3.4.1 Respondents

Of all 143 survivors of interpersonal traumatization (T) 43 (30 %) answered the questions. The traumata included (continuous) partner violence, physical and sexual abuse during childhood or sexual assault. Sixteen professionals (P) answered the emailed request. Four answers came from staff of the crisis line, four from local branches of the victim assistance agency for crime victims, five from members of the National Association of Women's Counseling and Rape Crisis Programs and three via the psychotherapy newsgroup.

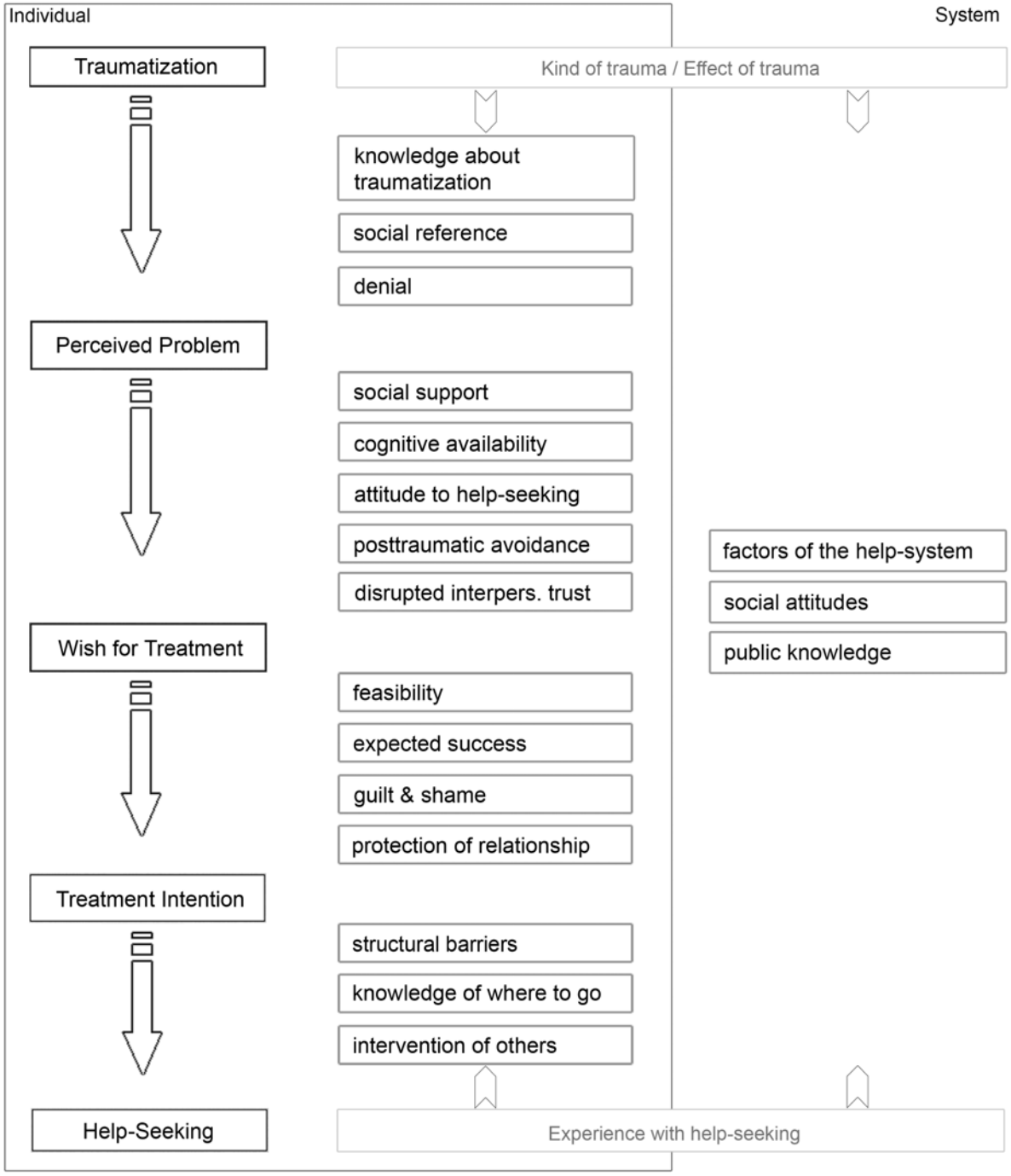
3.4.2 The answers

Written answers differed in length – ranging from a few sentences to a whole page. A typical answer was about 200–300 words long (mean 262, range 43–1074). The answers of the respondents and – to a lesser extent – the professionals contained statements at two levels of abstraction. They described individual experiences as well as subjective theories about what hampered or promoted psychosocial help-seeking. Only a few respondents made a difference between factors which would have helped themselves and those they thought to be helpful for others. A rich set of quotes (about 200) was coded and analyzed.

3.4.3 Barriers and promoters affecting help-seeking after interpersonal violence

Data analysis supported the assumption that help-seeking after interpersonal violence is affected by a multitude of individual, structural and social factors. These factors can be assigned either to the individual process of help-seeking itself, or to the system in which this process is taking place. Figure 4 shows the model's structure and the assignment of the variables to the two levels.

Figure 4 The revised integrative model of help-seeking



3.4.3.1 The system level

The influencing variables at the system level include (1) the *factors of the system providing the help*, (2) the *dominant attitudes in society* regarding interpersonal traumatization, mental health problems and help-seeking, and (3) *public knowledge* about traumatization (about traumata, their consequences and sources of help).

One traumatized respondent captured all three system variables in her answer:

> Help-seeking would have been easier for me if the skepticism which is unfortunately still prevalent in society and this negative touch had not been given or at least not to this extent. […] Only by chance and by a lot of initiative did I learn that something like trauma-therapy exists… Looking back I wished that someone during the prior long and hard time had told me before, so I would have saved nearly a whole precious year! [...] In my opinion it is crucial that this problem and topic is much more openly discussed and made accessible […] especially at prominent places like physicians' offices, hospitals or rehab clinics […]. (T26)

Factors of the help-system

As *structural barriers* the *factors of the help-system* dominated the answers regarding the treatment intention–help-seeking trajectory, but they also turned out to be of special relevance overall. They were seen to influence the *perceived problem* on the first trajectory, the *interpersonal trust*, *cognitive availability* and *attitude to help-seeking* on the second trajectory and the *expected success* and *feasibility* on the third trajectory.

The main issues were: (1) shortage of resources: lack of therapists in the local area, lack of places in therapy, long waiting lists, tight consultation time or restricted counseling hours which do not accommodate disclosure, (2) difficult access to services: formalities or restricted indication, (3) lack of offers for specific problems, (4) helpers' insufficient knowledge about or sensitivity to the problem, (5) negative reactions: blaming, minimization, unresponsiveness, (6) lack of (pro)activity: insufficient referral, networking or support, and (7) insufficient provision of information about the services by the providers. These factors interacted with the drainage of resources resulting from the trauma.

> For me it is the worst of all that I scream for help but nobody takes it seriously. That I have to struggle with public authorities in order to receive help when I already have my hands full with my own problems. Because the psychiatrist doesn't consider it serious enough, I am not allowed a hospital stay. Waiting time for a place in therapy is about two years. Those who can't deal with it themselves fall by the wayside. (T9)

The *structural barrier* most frequently mentioned was long waiting times for therapy or counseling. A traumatized respondent described her experience with the help-system as follows:

> No, no place in therapy vacant, no waiting list, no referral to another therapist. I'm completely down. Sad and disappointed. Though I know of course that it is a stroke of luck if it works out on the first try. But to have achieved so absolutely nothing is very frustrating for me. This feeling of not getting any help, when I've already come this far and asked for it (which took a lot of effort for me to do!). (T41)

Furthermore many respondents (27.9% of the traumatized, n = 12; 37.5% of the professionals, n = 6) described how they/a traumatized person contacted a help-provider and received some form of help but not the help they needed. Such negative experiences with help-seeking may pose a barrier to help-seeking (see paragraph on *experience with help-seeking* below). Here the main issues were: (1) insufficient knowledge about or sensitivity to the problem, (2) minimization of the problem, (3) mismatch between help offered and needed, (3) retrenchment of autonomy, (4) insufficient resilience and mental hygiene of the helpers, (5) lack of referral and networking, and (6) tight consultation time. A traumatized respondent's statement wrapped it up:

> It is not a question of getting ANY help, it has to be the appropriate help. (T23)

The respondents pointed out the importance of low threshold services i.e. services without charges that are easy to reach (via consultation hours, location, phone or e-mail), promptly available and proactive, as well as specific training of the help-providers in care for victims of traumatization to reduce barriers in the actual process of help-seeking.

Attitudes in society

The inclusion of *social attitudes* in the model states more precisely their role in the individual's attitude to help-seeking in particular, and also to the process of help-seeking in general. *Social attitudes* are of relevance for all social variables, i.e. *social reference* and *social support*, but also for the transfer of knowledge and even the wish to talk about the experiences. In addition *social attitudes* were seen to affect the help-system through the relevance ascribed to the problem of interpersonal violence, its victims, and their support-system. But the relationship between the individual level variable *attitude to help-seeking* and the system level variable *social attitudes* is especially close. The fear of the individual of being stigmatized is associated with the culturally transported negative attitude to mental health problems, counseling/therapy and victimization. Therein the social attitude fuels the fear of being stigmatized by others but it also strongly influences the individual's own attitude resulting in self-stigmatization.

The integrative model assumes that – on the individual level – a stoic attitude as well as fear of stigmatization is relevant for a *wish for treatment* to emerge. Both aspects emerged in our respondents' answers while most described a fear of stigmatization in one or another form. Seeking help for a mental health problem was related to 'being mad' or to weakness. Feared stigmatization included self-labeling or self-devaluation and stigmatization through the social

environment. Other respondents wrote how they felt that they had to cope by themselves or that they were afraid of becoming too much determined by others.

> Help-seeking would have been easier for me if […] this negative touch was not given or at least not to this extent. In my case it was certainly further complicated by my temperament or character respectively and by the fact that I usually wangled everything on my own. As I say – true to the maxim: "ME, going to a psychiatrist/psychologist? ME? Rubbish! I'm not out of my head?!! (T26)

Knowledge

In the respondents' answers individual *knowledge about traumatization* turned out to be of prominent relevance. The integrative model proposed that *knowledge about traumatization* is important for the accurate representation of the *traumatization*. This was supported by the respondents, who saw insufficient knowledge about interpersonal traumatization and its consequences as a barrier to accurate problem perception while the availability of knowledge promoted it. But more than the integrative model they emphasized the relevance of *public knowledge* for all trajectories of the process. This was taken into account by including it as a system variable in the model. Multiple processes mediate between this *public knowledge* and the individual help-seeking process (see also Table 6). If knowledge is 'public' it is more likely to be part of the general knowledge an individual already possesses pre-trauma. Furthermore, the respondents made it clear that the active role survivors of traumatization take in help-seeking also includes actively seeking knowledge: on the internet, in forums, in books or in conversations. On the first trajectory between *traumatization* and problem perception they sought knowledge about their problem in order to make sense of their experiences. On the following trajectories information about available forms of help and access to it became relevant, e.g. for the assessment of *feasibility*. The analysis left the question unanswered as to what triggers and maintains such information seeking. Possibly this depends on the antecedent variable of the intrapsychic process, e.g. the strength of the *wish for treatment*, and on the characteristics of the person and her environment, e.g. availability of internet access.

3.4.3.2 The individual level

All the model's influencing variables on the individual level were identified in the respondents' answers plus one variable not yet part of the model: *denial* of the traumatization and/or its consequences. Table 6 provides a summary of the variables and their support by the traumatized and professionals respectively.

In the following section we will elaborate those two variables which turned out to be especially relevant for many respondents over and above knowledge, attitude and structural barriers.

The perceived problem

The lack of a proper representation and understanding of the problem was a frequent theme in the answers (23.3% of the traumatized respondents, n = 10; 37.5% of the professionals, n = 6). Three aspects of problem perception were mentioned: (1) The representation of the event itself, i.e. knowing that this was a potentially traumatic experience, being able to give it a name and being aware of the unrighteousness and seriousness of what happened. Especially problematic was the attribution of the problem to internal instead of external reasons. In particular, victims of partner violence described how they kept blaming themselves for the problem. (2) The representation of the impact of the trauma. Professionals in particular described how suffering was expressed in somatic complaints, perceived only as a problem in a relationship or at least not as a mental health problem. (3) The last aspect regarded the relation of the post-traumatic mental health problems or symptoms experienced to the traumatic event. One respondent described such a lack of association between her trauma and her mental health problems as follows:

> If I had realized that my problems were caused by the long-lasting traumatization and neglect in my childhood and the resulting mechanisms in my marriage (amongst others massive sexual assault for years), I would have acted earlier (and probably more effectively). (T30)

Not all respondents who wrote about difficulties with problem perception gave reasons for it, but those who did, mentioned three reasons on the individual level and associated reasons on the system level. On the individual level insufficient *knowledge about traumatization* and interpersonal violence, *social reference*, and *denial* of the event/violence or its impact hampered problem perception.

Feasibility

Of the influencing variables on the wish for treatment – treatment intention trajectory *feasibility* was addressed most often. In the quotes assigned to *feasibility* four main issues emerged. The first was feeling unable to seek help due to the effects of the trauma, like feeling detached from oneself or reality, feeling too powerless for an undertaking perceived to be exhausting or being too absorbed in one's own problem.

Table 6 Influencing variables on help-seeking after interpersonal traumatization

Variable	**Respondents' descriptions**	**traumatized respondents**		**professional helpers**	
1. Trajectory		%	N	%	N
Knowledge about traumatization	General knowledge about posttraumatic symptoms and about potentially traumatic experiences; information about the condition of other victims; the knowledge that not the person but the situation is 'sick'; more knowledge about intimate partner violence *The affected and others lack knowledge – about traumatization and its consequences, about acute and particularly about complex developments [...] (P10)*	23,3	10	6,25	1
Social reference	Ignorance; disregard; misjudging; open doubts or reproaches; from family, friends and acquaintances, teachers and also from professional help-providers – can even override existent understanding *As I wasn't given the necessary understanding from the people in my direct environment, [...] I started wondering if I might be the problem myself. [...] At home I had a therapist, who […] tried to tell me until the very end that I'm responsible […] I've no longer been able to tell definitely what my problems are and I turned over like a beetle on its back. (T21)*	16,3	7	12,5	2
Denial	Described as defense; denial; repression; negation; denegation; forgetting and pushing to the back of the mind – with the aim of self-defense and an attempt to regain normality *After the event, they try to recover their old life. They tell themselves "it was just a bad dream", "nothing happened to me – I am still alive". They try to prove to themselves that they still have their life under control and it is very difficult to admit that this is (here and there) not the case any more. (P16)*	4,7	2	25	4
Factors of the help-system	Knowledge about traumatization; lack of time, care or sensitivity *[physicians who pharmacologically] treat for hypertension, diarrhea, insomnia, dyspnea etc. or for a somatic complaint paired with anxiety or depression for too long. (P11) It didn't even occur to the physicians and therapists with whom I dealt with that anything like a traumatization exists, even though I touched on the subject several times. […] It would be helpful, if as many people as possible – especially in the mental health field – would know what effect traumatization has and would be sensitized for this problem […] (T30)*	7,0	3	12,5	2
Attitudes in society	Taboos/a veil of silence; dismissing some forms of interpersonal violence as peccadilloes; attribution of accountability for problems in relationships to the women; stigmatization of mental health issues; toughness and violence as an integral part of some subcultures and association of victimization with weakness – influence all factors at the individual level: *knowledge*, *social reference* and *denial*. *As a consequence, trauma survivors perceive themselves as suffering somehow, just not mentally. That would be a sign of weakness. (P11)*	7,0	3	18,75	3

Table 6. continued

Variable	Respondents' descriptions	traumatized respondents		professional helpers	
1. Trajectory		%	N	%	N
Public knowledge	Knowledge about traumatization and its consequences in general but also about interpersonal violence in specifics – it influences problem perception directly but also indirectly through understanding instead of challenging social references *Even today the people in my surroundings don't have the faintest idea what it means to be traumatized. They simply can't imagine it and are/were therefore not helpful. (T43)*	20,9	9	6,25	1
2. Trajectory					
Social support	Empathy, interpersonal acceptance; validation of the traumatization and of the right so seek help and encouragement versus absence of needed support; inability of the affected to make use of available support and open negative reactions; from family members, friends and acquaintances, teachers and also professional help-providers including lawyers *And the reactions as I told it… […] I lost my whole circle of friends, my family called me a bitch and I was threatened to be thrown out of school if I said something like that again. (T19)* *I could have help, but I can't allow anybody to get and be so close to me. […] (T31)*	27,9	12	12,5	2
Cognitive availability	Not knowing about the existence of help for the personal condition, e.g. of trauma-therapy but also not relating knowledge that this help is appropriate for oneself *It also never occurred to me to call a help line, 'that is only for direct rape victims'. (T5)*	9,3	4	6,25	1
Attitude to help-seeking	Fear of stigmatization; feeling that you have to cope by yourself, being afraid of becoming other-directed *The main barrier is the association of psychologist/psychiatry with being insane that is rooted in many cultures. (P14)*	11,6	5	25	4
Post-traumatic avoidance	Wanting to forget and avoiding reminders of the trauma; avoiding feelings or parts of the self altogether; the fear of confronting the trauma *I asked a migrant in a supportive group why she does not come to work through her traumatic experiences and she said: "I don't want to talk or think about it at all". (P14)*	2,3	1	18,75	3
Disrupted interpersonal trust	Having lost trust in all people and feeling that one can trust only oneself but also struggling to trust and experiencing difficulties in gaining trust due to scarce information about the help-provider or to feeling misunderstood, disrespected, manipulated or set under compulsion *I hate physicians and everybody who is interested in me… now I should go into counseling? But why should I trust them of all people????? (T38)*	11,6	5	0	0

Table 6. continued

Variable	**Respondents' descriptions**	**traumatized respondents**		**professional helpers**	
2. Trajectory		%	N	%	N
Factors of the help-system	Long waiting times; negative experiences with the help-system versus profiles of help agencies, which give clear information about the target group, about its offers, staff, and access to the service and a more proactive approach – influences the *disrupted interpersonal trust* and *post-traumatic avoidance* but also for *cognitive availability* and *attitude to help-seeking* *All my prior therapists […] always wanted to find problems in my childhood which did not exist or spread nonsense l[…] How is one supposed to build up trust given that. Next week I take up therapy for the last time, if they talk with me again as if I was retarded, then there's no point in that. (T35)*	18,6	8	25	4
Attitudes in society	Taboos/veil of silence, negative attitude to mental health problems/counseling/therapy/victimization versus tolerance for the problem and the need for help – closely interrelated with *social support* as well as the *attitude to help-seeking.* Also influences the wish to talk about the experiences *Help-seeking would have been easier for me if the skepticism which is unfortunately still prevalent in society and this negative touch had not been given or at least not to this extent. (T26)*	9,3	4	43,75	7
Public knowledge	Knowledge about traumatization, knowledge about the chances and possibilities of professional help for traumatization, what help is available (by law, by the police, by shelters, counseling or therapy) and for whom – important for *social support* and *cognitive availability* *Professional helpers and laymen who are not familiar with the subject are at times not very helpful and make insensitive, degrading comments. (P4)*	2,3	1	31,25	5
3. Trajectory					
Feasibility	Four main influences on feasibility: effects of the trauma; *factors of the help-system; attitudes in society*; available *(public) knowledge* about professional help *Because I haven't got much power to spare I don't want to waste it on the draining search for an appropriate therapist. […] I am disoriented and ultimately I barely move. (T24)*	20,9	9	6,25	1
Expected Success	Diminished by: the perception of the trauma as too severe; the impact of the trauma on the schemata of the self and the world; the inability to trust that the professional can and will help *Another barrier is the attitude: "it does not work and it can't work anyway 'cause it is a bottomless pit". The trauma is perceived as all-embracing and overwhelming. The feeling persists that "my life is and always will be damaged", "it's not going to work out", and "in my case it's chronic anyway". On the one hand this results from the extent of the damage, on the other hand it became part of the self-perception. (P14)*	4,7	2	12,5	2

Table 6. continued

Variable	Respondents' descriptions	traumatized respondents		professional helpers	
3. Trajectory		%	N	%	N
Guilt and shame	Self-induced guilt or shame: *Not having to feel ashamed for it would have helped… especially when you do not belong to the socially marginalized. Violence in a relationship has so far rather been something for "asbo-TV"… you are awfully ashamed and can't make it public. (T27)* Other-induced guilt or shame/Blaming the victim: *"Why did you have to walk through the park at dawn?", "Why did you drink a beer with him – you should have expected that he would want more then", "In for a penny, in for a pound", "You married him!" (P16)*	9,3	4	12,5	2
Protection of the relationship	Wanting to maintain the relationship; believing the partner's promises that things would change *The objection against hospital and complaint was first of all: "I don't want to lose him. If I was lying in hospital he could only visit me for a short time." (T5)*	7,0	3	0	0
Factors of the help-system	Tight schedule; long waiting times; lack of information versus low threshold services; exemption from charges, easy to reach, promptly available and proactive – influences the *feasibility* *It is hell to „just" tell somebody about it – in the 5 minutes a general practicioner dedicates for a patient. (T1)*	18,6	8	31,25	5
Attitudes in society	Consideration of/for the victim and a clear position toward the responsibility of the perpetrator – important to reduce *guilt and shame* *Many women come pretty late – because in our society women are held responsible for the relationship. This leads them to lay the blame on themselves, to think it is their fault: "if only I would have been a little more considerate my husband would not have gone apeshit", "if only I would have made sure that the children are calm…" (P16)*	4,7	2	18,75	3
Public knowledge	Knowledge about the prevalence of victimization through interpersonal violence; knowledge about available forms of help, the access to it and what happens there with regard to methods, content, professional secrecy and autonomy *Second… better information! […] about the different forms of therapy, the possibilities of financing by health insurance, how can I find the appropriate therapist for me etc. In self-help internet forums […] you regularly find threads with the question "how can I find a therapist". (T1)*	7,0	3	12,5	2

Table 6. continued

Variable	Respondents' descriptions	traumatized respondents		professional helpers	
4. Trajectory		%	N	%	N
Structural barriers	Barriers posed by the *factors of the help-system* *No, no place in therapy vacant, no waiting list, no referral to another therapist. I'm completely down. (T41)*	32,6	14	50	8
Knowledge of where to go	Information and referral *I am disoriented and ultimately I barely move. (T24)*	2,3	1	0	0
Intervention of others	Proactive help of professional helpers; active support in help-seeking by family or friends versus being kept from disclosing by always accompanying the victim when she has to see a physician *Usually my ex-husband was with me when I saw a physician. Maybe the physicians should have told him to leave. They did ask me how it happened and I made up something, probably because he was with me all the time. An example: one time we have been at/in the hospital and I was beaten black and blue, especially between my legs (I told them that I fell), in my opinion the physicians must have known that it couldn't have come from falling. I think if they had addressed me alone I would have broken down and told them. (T36)*	14,0	6	6,25	1
Factors of the help-system	Shortage of resources; difficult access to services due to formalities; lack of offerings for specific problems; insufficient knowledge about or sensitivity to the problem; minimization of the problem; lack of referral and networking; little (pro)active support *There are vanishingly view offers of help, the waiting time is unreasonablely long. (P15)* *My past experience showed that traumata were preferably trivialized [by professionals]. (P7)*	39,5	17	68,75	11
Attitudes in society	The *attitudes in society* was seen to affect the help-system through the importance attached to the problem of interpersonal violence, its victims and their support-system. *Higher significance of traumatization in society – more awareness of the problem, more budget. (P2)*	7,0	3	6,25	1
Public knowledge	Knowledge of how to access available forms of help *see T1 above*	4,7	2	12,5	2

traumatized respondents n = 43; professional helpers n = 16

Each respondent mentioning an influencing variable was counted once, even if his/her statements regarding the variable addressed different aspects

One traumatized respondent described some of these issues:

> I believe that – depending on the severity of the disorder - you are not able to become active. It would be the best help if professional helpers approached you. […] For me it is a serious problem not to know what's waiting for me at the psychiatrist/therapist. Because I haven't got much power to spare I don't want to waste it on the draining search for an appropriate therapist. […] I am disoriented and ultimately I barely move. (T24)

The second issue was feeling unable to seek help due to *factors of the system*. Many traumatized respondents regarded it as difficult to gain access to the help-system. The third issue was feeling unable to seek help due to the prevailing *attitudes in society*. It included being under pressure not to talk about things happening 'inside' the relationship or about other things tabooed as well as the dependency of women on men rooted in traditional gender roles. The fourth issue was the relevance of available *(public) knowledge* about professional help for the perceived feasibility. The role of knowledge for the assessed feasibility was usually formulated not as a barrier but as a (potential) promoter. Relevant knowledge included available forms of help, access to it and what happens there with regard to methods, content, professional secrecy and autonomy.

3.4.3.3 Feedforward and feedback

In the previous sections it has been described how the variables at the individual and the system level influence the process unfolding between traumatization and help-seeking. The analysis also highlighted that these variables themselves are influenced by the kind of trauma and its impact on the individual – and by the *experience with help-seeking*.

Traumatization

Different aspects of the *traumatization* affected variables on all four trajectories. While an accident can be well-defined, interpersonal violence is much less clear-cut and many respondents described their difficulties in naming it and how the perception of their environment deviated from their own. This was especially true for psychological violence. On the individual level continuous interpersonal traumatization was ascribed the potential to make the victim insecure in his or her own judgment and to corrode their touch with normality. If the traumatization develops subtly it may also be difficult for the victim to define a limit – for the violence and for the scope for coping alone. The victim might come to think that

> I can't go running for help for any silly argument. (P 16)

The respondents described how the characteristics of the trauma affected the *social support* – with more support for more visible traumata and when the perpetrator was a stranger. Furthermore, interpersonal violence in general and intimate partner violence in particular are tabooed and more responsibility seems to be attributed to its victims.

Some forms of violence are invisible and not mentioned even in the profiles of the agencies, thus reducing the *cognitive availability* of formal help for them. Intimate partner violence also seems to have the potential to wipe out the *cognitive availability* of help-seeking:

> The question 'relationship or help' never occurred to me. Our relationship was the only thing on my mind. (T36)

Experience with help-seeking

Negative experiences with the help-system may also affect variables on each trajectory, especially the victim's *interpersonal trust*, his or her *attitude to help seeking*, perception of the *feasibility* of help-seeking and his or her *expected success*. This complex influence of the experience with help-seeking is illustrated in the following quote:

> Each time a traumatized person has encouraged himself to confide in someone and has had the experience that this person can't help him to understand himself and what happened to him (and to put back straight what is upside down), some part of the context of this encounter turns into a 'barrier' for him, which can hamper seeking help. (P12)

3.5 Discussion

Sixteen professional help-providers and 43 respondents who experienced an interpersonal traumatization answered the question: What would make it easier for somebody who experienced an interpersonal trauma to seek and receive professional help afterwards? The answers were qualitatively analyzed following a deductive approach driven by the integrative model of help-seeking after interpersonal traumatization (Schreiber et al., 2009b) supplemented by inductive analysis (Hsieh & Shannon, 2005; Mayring, 2000). The analysis confirmed that help-seeking is a complex process, combining individual and system-level variables in which the effects of the trauma, the experiences of the victim, the (close and distant) social environment and factors of the help-system interact.

The results mainly supported the integrative help-seeking model. All variables included in the model were described by the respondents. Only one variable of the intrapsychic process, *treatment intention*, was not mentioned at all. This is not surprising given the formulation and aim of the question that directs the attention to the variables influencing the process rather than the process itself. Of those variables influencing the process of help-seeking on the

individual level, *knowledge about traumatization*, *social reference*, *social support*, *cognitive availability*, *attitude to help-seeking*, *feasibility and the structural barriers* turned out to be prevalent. Only one influencing variable that was previously not part of the model was derived from the answers: *denial* of the problem, which was described as being important for the problem perception.

In the literature *denial* is mentioned a few times in relation to traumatization. Fierman and colleagues (Fierman et al., 1993) propose that *denial* is one reason for traumatization being underreported. However, the concept remains vague and has not been studied systematically. Lazarus (Lazarus, 1983) conceptualizes *denial* as a particular coping process involving cognitive manipulations distorting reality with the aim of making the affective response more acceptable. It is motivated by the need to reduce dissonance and to sustain a positive image of the self and by the wish to avoid feared consequences. The cognitive strategies include selective screening, non-attending and inhibiting of threatening or distressing information, and operate without conscious awareness (Shedler, Mayman, & Manis, 1993; Vandereycken, 2005). In relation to trauma, denial as a protective mechanism has been conceptualized as an extension of post-traumatic avoidance (Amdur & Liberzon, 2001; Horowitz, 1993) and an aspect of the avoidance factor (Blake et al., 1995; McFall, Smith, Roszell, Traver, & Malas, 1990). However in our analysis the effects of denial and avoidance are not identical. While avoidance does not affect problem perception, denial is doing just this – it obfuscates the problem.

The qualitative analysis's results suggested completing the picture of the individual help-seeking process through a stronger consideration of the system-level variables. While the original integrative model acknowledged the relevance of the system level, it was not further elaborated. In the revised model this is done by differentiating *factors of the help-system*, *dominant attitudes in society* and *public knowledge*.

This stronger emphasis on the system level is in line with an ecological framework describing the interdependence of individuals and their social environment. Individual responses to traumatic events can thus be conceptualized as the result of complex interactions among individuals, events and sociocultural context. The sociocultural context provides a source of meaning, appraisal and understanding of the event for the victim and for family, friends and help-providers (Lebowitz & Roth, 1994; Tummala-Narra, 2007). The interaction of individual and context influences the psychological response, coping, the availability of informal sources of help as well as access to and comfort with the professional help-system (Harvey, 2007; Ruback, Gupta, & Kohli, 2004; Steury, Spencer, & Parkinson, 2004; Tsun-Yin, 2000). This

view was consistently mirrored in the answers of traumatized as well as professional respondents who described multiple interactions on all trajectories and for most of the influencing variables.

The variable *experience with help-seeking* received strong support in the qualitative answers. In the revised model we conceptualized it more explicitly as a feedback process. The respondents described how the experiences with the help-system influenced help-seeking on all trajectories. Influences were primarily described on or via: *social reference*, *disrupted interpersonal trust*, *expected success*, *feasibility,* and *guilt and shame*. A lack of *expected success* was one of the main barriers in help-seeking for mental disorders (Meltzer et al., 2000). The authors related this to their findings that a high proportion of those seeking professional help did not receive (relevant) treatment and consequently had unsatisfying experiences with help-seeking (Bebbington et al., 2000). Inadequate diagnoses and responses as well as dissatisfaction with the care received have also been identified as problems in the health care of traumatized individuals (van Zelst, de Beurs, Beekman, van Dyck, & Deeg, 2006). Only a fraction of individuals with a traumatic experience or PTSD seem to receive or be referred to appropriate treatment (Davidson, 2001; Frueh et al., 2002; Lecrubier, 2005; Reid & Glasser, 1997). Reasons for this shortfall are seen in the shortage of resources in the help-system (e.g. time constraints, lack of referral networks), barriers to directly assessing trauma (like stigmatization of the topic or fear of offending or triggering strong emotional reactions) and inadequate training (García-Moreno, 2002; Lecrubier, 2005; Magruder, Mollica, & Friedman, 2001; Reid & Glasser, 1997; Sugg & Inui, 1992).

Correspondingly s*tructural barriers* turned out to be the influencing variable mentioned most frequently. Taken together with the system variable *factors of the help-system* structural factors were by far the most dominant. This is contradictory to findings by other studies of mental health help-seeking (Meltzer et al., 2000; Thompson et al., 2004) and also with the quantitative test of the model (Schreiber et al., 2009b) where *factors of the help-system* seemed to play only a secondary role. Meltzer and colleagues (Meltzer et al., 2000) asked for reasons for deciding not to seek help or for turning down help at a single instance: the majority of their respondents gave only one reason (e.g. inconvenient time or location; too embarrassed) but the reasons differed between respondents. Reduced opportunities to seek help due to *factors of the help-system* were not assessed. Thompson and colleagues (Thompson et al., 2004) used a forced choice format and the only structural factor was cost (couldn't afford help). In our preceding, quantitative study we also used closed questions while in the present study we asked "what would make it easier to seek help?" and most

respondents mentioned multiple variables. This procedure might have elicited the mentioning of *factors of the help-system* for three reasons: (1) *factors of the help-system* often occurred as second-order variables influencing the reasons on the individual level (like problem perception), (2) *factors of the help-system* were more important further down the help-seeking process, and (3) *factors of the help-system* often became barriers for further help-seeking during or after the first contact with the system providing the help. In fact, in studies which explicitly asked for 'not seeking a clinician's help after a traumatic event despite wanting to' *factors of the help-system* were frequently mentioned – ranging from perceived lack of time, knowledge or interest of the clinician and the clinician 'not asking', to the wish for more attentiveness, activity and referring on the side of the clinician (Jaycox, Marshall, & Schell, 2004; Mol et al., 2002; Rodríguez, Sheldon, Bauer, & Pérez-Stable, 2001). From the complementary point of view a majority of primary care physicians felt inadequately informed and prepared regarding domestic violence or lacked knowledge in regard of PTSD (Munro, Freeman, & Law, 2004; Reid & Glasser, 1997; Sugg & Inui, 1992).

Several limitations resulted from the study design, especially from securing as much anonymity as possible. The sample was self-selected and the answers of the traumatized respondents were not linked to the existent demographic data. Consequently the characteristics of the sample are unknown and it is not necessarily representative of all traumatized individuals. The design also made it impossible to assess any objective measures of the need for treatment (like the symptom load). If we assumed a need for professional help this was based solely on the self-report of the respondents. On the other hand, self-assessed need is a commonly used indicator of the need for treatment, e.g. (Amaya-Jackson et al., 1999; Mol et al., 2002) and is considered even more relevant for help-seeking than the more objective measures like diagnosis (Andersen, 1995).

3.6 Conclusion

The answers of our respondents revealed interacting influences on help-seeking on the individual and system level. Throughout all trajectories the qualitative analysis confirmed and refined the integrative model of seeking psychosocial care after interpersonal traumatization. All the model's influencing variables were confirmed and remained in the refined model. Changes in the model comprised an emphasis on the indirect effects of the *traumatization* and the *experience with help-seeking* on the influencing variables (e.g. the further reduction of *interpersonal trust* resulting from bad experiences with the help-system) as well as a clear distinction of an individual and system level of influencing variables. On the system level

factors of the help-system like difficult access, *dominant attitudes in society* like blaming of the victim and *public knowledge* about traumatization, its consequences and available help were included in the model. On the individual level *denial* was added to the first step in the process of help-seeking i.e. the traumatization – perceived problem trajectory. The refined model helps to describe the individual help-seeking process and to identify barriers that need to be addressed as well as promoters that can be of use to improving health care for survivors of interpersonal traumatization. Viable interventions targeting such improvement can be developed mainly for the system level and the model can guide the search for and structuring of interventions.

4 Improving access to care – interventions facilitating seeking professional help after interpersonal violence

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4.1 Abstract

Background A serious proportion of the survivors of interpersonal traumatization never accesses mental health care. Obstacles as well as promoters of help-seeking can be found in the system providing the help, in the dominant attitudes in society and in the public knowledge. Interventions targeting theses obstacles and promoters have to be developed if access to mental health care is to be available and open to all who need and want it. **Method** Survivors of interpersonal traumatization and professionals providing help for this population were asked about their experiences, and what would make it easier for those affected by interpersonal traumatization to seek and receive professional help afterwards. A content analysis of their answers was performed and strategies and interventions were extracted. **Results** The respondents proposed a large variety of interventions – with an emphasis on factors of the help-system. The strategies and interventions extracted from the content analysis were assigned to a matrix based on an integrative model of help-seeking after interpersonal traumatization. **Conclusion** Serious efforts to improve access have to account for the complexity of the help-seeking process by concerting diverse strategies, by accompanying evaluation and by careful targeting. The matrix developed in this paper can serve as a guideline to coordinate and target the interventions.

4.2 Introduction

Mental health help-seeking after interpersonal traumatization is hampered by multiple barriers interfering with adequate provision of care for this population (Fugate et al., 2005; Mol et al., 2002; Schreiber et al., 2009b). A reduction of these barriers and the promotion of those factors facilitating help-seeking is needed if access to mental health care is to be available and open to all who need and want it. The development of interventions necessary for improving access to mental health care for survivors of interpersonal violence should be based on theory (Fishbein et al., 2002; Randolph & Viswanath, 2004). An integrative model of seeking psychosocial care after interpersonal violence was developed to provide this theoretical basis (Schreiber et al., 2009b). The model describes the individual help-seeking process as a sequence of trajectories from the experience of an interpersonal *traumatization* to the development of a *perceived problem*, the emergence of a *wish for treatment*, the formation of

a *treatment intention* and finally to the action of *help-seeking*. This process is influenced by variables on the individual level, like the individual's knowledge about traumatization or the social support received. Help-seeking ultimately depends on this individual process, which is in turn influenced by three variables on the system level i.e. *factors of the system providing the help*, the *dominant attitudes in society* and *public knowledge*. As it is difficult to exert direct influence on the variables on the individual level it is the system level which offers viable starting points for improving access to mental health care for survivors of interpersonal violence. In accordance with the integrative model a matrix for interventions can be formulated spanned by the three variables on the system level (i.e. *factors of the system providing the help*, the *dominant attitudes in society* and *public knowledge*) and the four trajectories of the model (i.e. *traumatization* to *perceived problem*, *perceived problem* to *wish for treatment*, *wish for treatment* to *treatment intention* and *treatment intention* to *help-seeking*). Additionally a sublevel for *experience with help-seeking* is included. *Experience with help-seeking* is relevant for all trajectories. Each field of the matrix outlines a starting point for interventions facilitating seeking professional help after interpersonal violence (see Table 7).

In addition to theory, interventions should be based on data suggesting that the intervention is promising, and such data "isn't just numbers. The experience and wisdom of survivors, advocates, educators, and practitioners should be honored as key data sources in the development of [ ] strategies" (Davis, Parks, & Cohen, 2006)p6. Hence, proposals for strategies and interventions facilitating the seeking of professional help after interpersonal violence were extracted by a content analysis of traumatized respondents' and professional helpers' suggestions.

4.3 Method

4.3.1 Participants

A traumatized sample was drawn from the participants of an online study on help-seeking after traumatization (Schreiber et al., 2009a). Irrespective of having completed the questionnaire, all participants with an interpersonal trauma who had supplied their email address (128 women and 15 men) were contacted. Feedback on their personal responses was provided and they were asked to email a written answer to the open-ended research questions included. To ensure anonymity, answers were saved without email address or name and without connection to the existing data from the online questionnaire.

In a second step a sample of professionals working in the field was contacted through the mailing list of a crisis line (Telefonseelsorge), a victim assistance agency for crime survivors (Weisser Ring), the National Association of Women's Counseling and Rape Crisis Programs **(**Bundesverband Frauenberatungsstellen und Frauennotrufe) and a psychotherapy newsgroup (Deutschsprachiges Psychotherapie-Forum im Internet DPI e.V.).

4.3.2 Procedure

Two open-ended research questions were emailed to the potential participants. For the traumatized sample the questions were: "What would have made it easier for you to seek professional help after the event?" and "What do you think would make it easier for others to do so?" For the professional sample the questions were: "From your own experience: What do you think would make it easier for somebody who experienced a traumatic event (especially interpersonal violence) to seek and receive professional help afterwards?" and "What would have to change (e.g. in the help-system or in society) to reduce barriers between those seeking and those providing help – and how could that be achieved?".

4.3.3 Data analysis

The qualitative analysis of the answers combined conventional, inductive content analysis with directed, deductive content analysis (Hsieh & Shannon, 2005; Mayring, 2000) based on the integrative model of mental health help-seeking after traumatization (Schreiber et al., 2009b). Directed content analysis was guided by the matrix spanned by the model's three system-level variables and the four trajectories (see description above and Table 7). In a first step all answers were read by the first author and all interventions identified. In the second step all interventions were sorted in the matrix's fields. In the third step all answers were recoded by the first author and a co-worker. The recoding-reliability and the intercoder-reliability were satisfying (Cohens κ 0.88; Cohens κ 0.79) (Mayring, 2000). Disagreements were discussed and the coding was adapted where necessary. In the last step the main strategies organizing the interventions were formulated.

4.4 Results

4.4.1 Respondents

Of all 143 survivors of interpersonal traumatization (T) 43 (30 %) answered the questions. The traumata included (continuous) partner violence, physical and sexual abuse during childhood or sexual assault. Sixteen professionals (P) answered the emailed request. Four answers came from staff of the crisis line, four from local branches of the victim assistance

agency for crime victims, five from members of the National Association of Women's Counseling and Rape Crisis Programs and three via the psychotherapy newsgroup.

4.4.2 Main strategies for improving access to care

The respondents described interventions addressing all fields of the matrix (see Table 7). Most fields were addressed by the traumatized as well as the professionals, but overall the traumatized respondents described relatively more interventions addressing *public knowledge* and *social attitudes* while the professionals mainly targeted *factors of the help-system*.

The broadest range of interventions was described for improving *factors of the help-system* and these interventions were also most often clearly defined. For *social attitudes* the respondents described directions of change but the interventions remained rather vague. Regarding *public knowledge* the respondents outlined which knowledge is needed and described trajectory-spanning interventions and media for disseminating this knowledge. Table 7 summarizes the main strategies.

In the following paragraph each variable on the system level will be addressed consecutively and the main strategies and constituting interventions will be described. All proposed strategies and interventions are directly related to the respondents' answers and are reported – as far as possible – without bias. We will integrate our findings with the literature on targeting *factors of the system providing the help*, *social attitudes* and *public knowledge*.

4.4.3 Strategies for factors of the help-system

For factors of the help-system the respondents described two kinds of strategies: strategies implemented by the help-system like 'offering help' and strategies targeting the help-system like 'strengthening resources'.

4.4.3.1 Strategies implemented by the help-system

The respondents' suggestions for the help-system could be summarized in ten main strategies, of which five are specific to one of the model's trajectories and five are shared by more than one trajectory.

'Recognizing and naming interpersonal violence and its consequences'

The health care setting is an important place where survivors of violence in need of care can be identified, provided with support and referred if necessary to specialized services. Unfortunately a high proportion of interpersonal traumatization remains undetected – in part because the survivors don't tell anybody about the traumatization, in part due to the difficulties of detecting stress-related disorders due to atypical symptoms, the presentation of

Table 7 Matrix of main strategies for each starting point of interventions

	Variable on the system level				
	Factors of the help-system		**Social attitudes**	**Public knowledge**	
Trajectories	Implemented by the help-system	Targeting the help-system		Content	Media
Traumatization – Perceived problem	Recognizing and naming interpersonal violence and its consequences Providing information and education		Taking interpersonal violence seriously Breaking the taboo to talk about it	Knowledge about interpersonal traumatization	
Perceived problem – Wish for treatment	Providing information and education Being seen and being heard Working with the affiliated Trust building Offering help Working against stigmatization	Better information and training Strengthening resources	Reducing stigmatization of survivors of interpersonal violence, of mental health problems and of help-seeking Promoting an atmosphere of acceptance and support	Knowledge about the existence of formal help Knowledge how to support a victim of interpersonal violence Information normalizing problems and help-seeking after traumatization	Internet Print-media School Training Talks (Health) fairs Primary care Mass media campaigns Existent media coverage
Wish for treatment – Treatment intention	Providing information and education Reducing barriers Offering help		No blaming of the victim/ Assigning responsibility to the offender	Knowledge of what formal help is available and how to access it Knowledge of what to expect of formal help Knowledge about the reasons for interpersonal violence	
Treatment intention – Help-seeking	Reducing barriers Referring and networking Sensitivity and care for special needs		Valuing care for survivors of interpersonal violence	Knowledge of where to go for formal help and how to access it	
Experience with help-seeking	Referring and networking Sensitivity and care for special needs		Valuing care for survivors of interpersonal violence	Knowledge of what to expect of formal help and how to make the most of it	

somatic symptoms or comorbidity (Davidson, 2001; Lecrubier, 2005; Munro et al., 2004), in part because of a lack of sensitivity about the problem.

The main strategy of 'Recognizing and naming interpersonal violence and its consequences' was proposed for targeting the *factors of the help-system* hampering or promoting problem perception. On this first trajectory 'Recognizing and naming interpersonal violence and its consequences' was the strategy suggested most often. Especially traumatized respondents expressed the wish that (primary) care providers should be more sensitive to and knowledgeable about this issue, actively follow up any suspicion of interpersonal violence, thoroughly assess mental health problems and traumatization and correctly diagnose its consequences. Failing to do so was experienced as insensitivity and a lack of competence by the respondents. Thus, they proposed strategies targeting the help-system – awareness raising, education and training as well as more time for consultation – as interventions to promote the identification of traumatization by practitioners. Not only professional help providers in the narrow sense were mentioned in this context, but also the police, teachers, pre-school teachers and social workers from other areas.

While our respondents mentioned a variety of institutions suitable for identifying survivors of violence in need of care, the literature primarily suggests screening as a measure for the primary health-care services – especially general practitioners and emergency and accident departments – but also for antenatal care, other obstetric or gynecological consultation, and mental health-services (García-Moreno, 2002; Ingram, 1994). It is very likely that primary care physicians actually have a special position in regard of identifying traumatization and promoting problem perception. Survivors of trauma show a prominent increase in health care but not in mental health care and primary care physicians are probably the first contact persons in the health system (Davidson, 2001; Kimerling & Calhoun, 1994; Solomon & Davidson, 1997; Stein, McQuaid, Pedrelli, Lenox, & McCahill, 2000; Thompson et al., 2004). A large body of literature suggests the relevancy of – usually universal – screening, e.g. (Cusack, Frueh, & Kathleen, 2004; Davidson, 2001; Lecrubier, 2005). Direct, non-judgmental screening questions seem to be welcomed by most women regardless of whether they had experienced interpersonal violence (Bradley, Smith, Long, & O'Dowd, 2002; Friedman, Sarnet, Roberts, Hudlin, & Hans, 1992; Gielen et al., 2000). In a study of Rodríguez and colleagues (Rodríguez et al., 2001) clinician inquiry appeared to be one of the strongest determinants of disclosure of partner abuse. 85% of those who were directly questioned by a medical clinician about abuse reported that they had disclosed, compared to only 25% of participants who were not asked. Beyond eliciting information, asking can signal interest and

open a space in which the affected person can talk about the problem if and when he or she wishes to do so (García-Moreno, 2002).

‘Providing information and education’

The help-system was proposed for taking over the function of ‘Providing information and education’. The constituting interventions can affect the individual and the system level alike. This main strategy was proposed for three of the four trajectories, for improving the *problem perception* and strengthening the *wish for treatment* as well as the *treatment intention*. There is some overlap with strategies targeting *public knowledge* and only those interventions explicitly named in relation to the help-system will be reported here. For the first trajectory it was suggested that information about interpersonal violence and its consequences should be disseminated at physicians’ offices and (rehab) hospitals where many survivors of trauma are treated for whatever reason. Especially (primary) care providers should provide education and information for each individual indentified as being traumatized in order to promote his or her problem perception and autonomy in help-seeking. In addition cooperation between providers of help and other institutions with the aim to disseminate information was suggested. For the second and third trajectory the main strategy is ultimately the same – only with the focus on the available help, including information about services and providers, as well as information about the benefit of specialized help (see the *public knowledge* section below).

‘Being seen and being heard’

This main strategy was proposed for the second trajectory – it mainly addresses the cognitive availability of help and therefore the likelihood that the affected person will think of help-seeking as a potential way of coping. There is overlap in the interventions for this main strategy and for ‘Providing information and education’. ‘Being seen and being heard’ can be located somewhere between providing information and a proactive approach. One professional respondent described it as: “establishing contact in many small initiatives and continuity in work and presence. Make offerings making it easier for people to come to us in the case of emergency”.

‘Working with the affiliated’

This main strategy was also proposed for the second trajectory. It mainly targets the survivor’s family but also friends or colleagues and aims to improve the social support for a survivor by offering advice and assistance. This can include information fostering understanding and empathy for the affected person, information on how to approach and support him or her and help to cope with the situation.

‘Trust building’

‘Trust building’ was also proposed as a specific strategy in the second trajectory. The measure proposed to help with building trust without yet being in contact with the affected person was to create an internet portal where the therapists or counselors could introduce themselves with a photo and some personal information instead of being “simply a name on a list”.

‘Offering help’

‘Offering help’ and actively asking (screening) questions and following up as suggested in the strategy of ‘Recognizing and naming interpersonal violence and its consequences’ as well as ‘Referring and networking’ can be subsumed under an proactive approach. Such proactive help will differently affect the traumatized individual depending on his or her position in the help-seeking process. It can foster problem perception or a treatment intention but it can also offer a kind of shortcut to help. The respondents pointed out that a proactive approach always has to respect the boundaries of the affected person and that all these interventions presuppose his or her approval.

The proactive main strategy of ‘Offering help’ was proposed for survivors who already perceive a mental health problem and are in the second and the third trajectory. Especially traumatized respondents expressed a wish to be offered help without having to ask for it. This includes help offered in the primary care setting or schools as well as making open offers of help in other settings like public talks or health fairs.

‘Working against stigmatization’

This main strategy targets attitudes on the system and individual level alike. It includes making it clear that the symptoms are not a sign of insanity, abnormality or weakness but a normal reaction to abnormal exogenic factors. This can be done by giving space not only to the symptoms but also to the trauma and its context in the help offered, as well as in the public relations or by politicking to combat the traumatizing conditions (like violence against women or violation of human rights). Another measure against stigmatization can be a lexical approach – using ‘survivor’ instead of ‘victim’, or ‘doctor’ instead of ‘shrink’.

Ingram (1994) also values information that would help to break beliefs which prevent help-seeking – like pointing out that assault is a criminal offence, that the affected is not alone in being treated violently and that he or she does not deserve nor is to blame for the violence.

‘Reducing barriers’

Barriers posed by the help-system were perceived by most respondents. Hence it is not surprising that most interventions were proposed for removing these barriers. While all these interventions were proposed to improve the situation of survivors of interpersonal

traumatization, many affect the mental health system in general. In addition as a strategy implemented by the help-system 'Reducing barriers' has to be supported by strengthening the system's resources.

'Reducing barriers' was on the one hand suggested for the help-system to strengthen the *treatment intention* by targeting the survivor's perception of the feasibility of seeking help. On the other hand it directly addresses the structural barriers experienced on the fourth trajectory. Four categories of structural barriers in the help-system were mentioned: (1) choice and availability, (2) costs, (3) ease of access and (4) a lack of information about services and providers. For improving choice and availability (1) proposed interventions were: a network for the procurement of vacant places in therapy, a better allocation of help with more offerings in rural areas and different providers of help in one area, and creating a mobile service visiting areas which do not have adequate resources otherwise. In addition the help-system should offer services for specific populations like adolescents or migrants. With regard to the costs of mental health care (2) the respondents agreed upon the need to help survivors free of charge. For the interventions to increase the perceived ease of access (3) two kinds of offers should be distinguished: offers designed for establishing contact and for crisis intervention and offers of long-term services like therapy. For the first the possibility to remain anonymous, to make contact from home (e.g. via telephone, chat or e-mail) and long consultation hours were suggested. In primary care tight consultation times discouraging disclosure have to be met. Formal regulation of access is more important for long-term services. Of the interventions specifically relevant for becoming active the most important seems to be the prompt availability of help. Offers designed for crisis intervention have to be available immediately – right after the event or decision to ask for help. But long waiting lists are also barriers to long-term services and the importance of reducing waiting times was repeatedly highlighted. Here the strategy 'Strengthen resources' which targets the help-system is of special importance. For another problem of long-term services, namely formal restrictions in regard of access and duration, the formal guidelines were questioned. With regard to the lack of information (4) the discrete main strategy 'Providing information and education' was suggested (see above).

'Referring and networking'

'Referring and networking' can make the difference between a discouraging contact with the formal help-system and one raising hope. It is relevant for overcoming barriers like waiting times, and also for channeling those in need of care from the providers primarily establishing contact and providing crisis intervention to offers of long-term services like therapy.

Providing contact to different follow-on services eases help-seeking and offers choice and autonomy. In addition it becomes important whenever a survivor starts an attempt to seek help but does so with an inadequate provider at first. This is especially true for primary care or other helpers like teachers. Referring the affected person to specialized or specifically qualified services or therapists is seen to significantly heighten their chances of receiving the help they need. Furthermore networking can provide clinicians and other helpers with information about interpersonal traumatization, with training, with a list of possible places for referral and with guidelines for the referral procedure. Three groups of co-operation partners could be identified: primary health care, i.e. hospitals, general practitioners, gynecologists; other help-services, i.e. police, prosecution, fire service, department of family and children's services, social welfare office; and other persons i.e. (pre-school) teachers and social pedagogues. Interventions these groups could take were: sensitively following up indicators of interpersonal violence, providing information about formal help and providers, establishing contact with providers, transferring data to the service which then establishes contact and referring.

The literature also highlights the value of referral and networking (García-Moreno, 2002; Ingram, 1994). Additional benefits of networking are seen in: helping groups to trust one another; promoting a joint effort in providing care; increasing the credibility and impact of the groups' efforts; conserving resources through sharing expenses and reducing unnecessary competition or duplication; and developing, sharing and assessing interventions in different settings (Davis et al., 2006; García-Moreno, 2002; Reid & Glasser, 1997). Networking involving researchers and academics, art organizations, community-based organizations, government and the business sector could also target the other two system variables by awareness raising and public relations, changes in policies and the development and implementation of management plans (Davis et al., 2006).

'Sensitivity and care for special needs'

'Sensitivity and care for special needs' is important for the success of attempted help-seeking. Several interventions targeting the first contact between the affected and the help-provider were proposed. These included: ensuring sufficient time (for relationship building), offering a clear setting, enabling choice (e.g. of the counselor/ therapist), conveying that it is possible to make repeated attempts and providing the opportunity to talk to the help-provider alone, especially for survivors coming to primary care in someone's company. The respondents also proposed interventions for promoting a positive *experience with help-seeking*. The help-system should take into account issues of autonomy, trust, dynamics of relationships, fear of

confrontation, pacing, need for specialized treatment and also vicarious traumatization. To meet the risk of the latter self-awareness, mental hygiene and supervision were called for.

Interventions the respondents proposed for specifically promoting autonomy during help-seeking were: the freedom to choose when, from whom and in which form the affected person wants to accept help, furthermore the freedom to reject an offer or advice and to discontinue a session or to exclude a topic. Practitioners should not offer fast solutions, but help survivors to regain confidence in their abilities to make decisions by supporting their decision-making and respecting their decisions – even when these include "mistakes" like continuing the relationship with the assailant despite the risk of further violence. Furthermore interventions, referral and disclosure of personal data to a third party should solely be carried out with the survivor's fully informed consent (including information what is going to happen as a result of the action). Increasing the perceived control over current health care in relation to trauma in such a way should be related to better adjustment and emotional well-being (Frazier, Berman, & Steward, 2001). Our respondents' view of the significance of respecting the autonomy of and restoring control to the survivor and of building interpersonal trust is shared in the literature on health care after traumatization (Ehlers, 1999; García-Moreno, 2002; Ingram, 1994; Maercker, 2003; Urbanic, 1992).

With regard to specialized treatment the study's respondents very critically assessed the isolated prescription of psychotropic medications. They noted that prerequisites for providing specialized treatment were resources (like time or a network) and competence.

4.4.3.2 Strategies targeting the help-system

A consensus of experts identified relevant domains to explain behavior change of healthcare professionals. These included: knowledge, skills, social/professional role and identity, beliefs about capabilities and about consequences, motivation and goals, environmental context and resources, and social influences (Michie et al., 2005). All these domains can be a starting point for interventions but knowledge and skill are predominant in the literature as well as in our respondents' answers. In the following paragraph we will start with a discussion of the strategy 'Better information and training' proposed by our respondents.

'Better information and training'

Increasing practitioners' competence was frequently called for by our respondents in order to target the reasons for the suboptimal performance in recognizing interpersonal violence and to increase awareness of the problem of traumatization and its consequences (i.e. *problem perception*) as well as to improve access to the help-system and the quality of care.

The respondents repeatedly called for better information and training for (primary) care providers and therapists which might be disseminated in basic and advanced training, continuing education, educational outreach or in-service training, congresses or supervision. As a measure intended to improve 'Referring and networking', training in the respective training facilities was also suggested for potential co-operation partners like the police, the fire service, social welfare office or teachers (see the paragraph on 'Referring and networking' above).

The weight that training was given by the respondents was very similar to the attention this strategy received in the literature (Frueh et al., 2001; García-Moreno, 2002; Munro et al., 2004; Reid & Glasser, 1997). Both sources perceived a need for knowledge about interpersonal traumatization but also about management protocols and referral agencies (Adshead, 1995; Cusack et al., 2004; Munro et al., 2004; Reid & Glasser, 1997; Solomon & Davidson, 1997). Special attention has been paid in the literature to the issue of specific training for screening in the health care setting as well as in non-medical settings (García-Moreno, 2002; Utterback & Caldwell, 1989).

While educating practitioners about interpersonal violence has been found to improve screening practices (Harwell et al., 1998; Parsons, Zaccaro, Wells, & Stovall, 1995; Rodríguez, H.M., McLoughlin, & Grumbach, 1999) sustaining such gains is difficult. Consequently – as García-Moreno (2002) points out – training has to be based on assessment of potential barriers to change, and be sufficiently comprehensive to reduce these potential barriers. These include not only lack of training in the necessary skills but also the effect of stigma, fear of consequences, motivation for screening, and frustration at the perceived lack of responsiveness of patients to their advice (García-Moreno, 2002; Lecrubier, 2005; Magruder et al., 2001; Reid & Glasser, 1997; Sugg & Inui, 1992). Training therefore has to address the values and attitudes of providers, the health system and society and to offer practice-reinforcing strategies like a clear departmental policy and protocols for screening (Grimshaw et al., 2001; Ingram, 1994; Oxman, Thompson, Davis, & Haynes, 1995).

Furthermore Cusack and colleagues (2004) found that there was little follow-up related to the diagnosis and even for patients given a diagnosis of PTSD the treatment focused on other symptoms. Any training in screening should consequently be complemented by training in appropriate response and management. This would at the same time address another barrier to screening: the fear of opening 'Pandora's box', not knowing how to deal with the issues arising (García-Moreno, 2002; Sugg & Inui, 1992).

Psychological forms of interpersonal violence are a special issue with regard to awareness and problem perception. Despite the clues that psychological violence can have a greater impact on health than physical violence (O'Leary, 2004) it is especially unlikely to be identified by the affected and health-providers alike and should be given extra consideration in training and screening (Coker, Smith, Bethea, King, & McKeown, 2000; Rodríguez et al., 2001). Given the neglect of psychological violence in the literature and in research, more work on its consequences and treatment is needed to create a knowledge base for education and training (Basile, Arias, Desai, & Thompson, 2004; Maiuro & O'Leary, 2004).

'Strengthening resources'

Improving resources emerged as an important strategy – especially for the trajectories later in the help-seeking process, as well as for the *experience with help-seeking,* but also for the identification of the problem in the first place.

A shortage of resources was mainly seen in a continuing need for more providers of help – non-governmental organizations and medical services alike. The results of this shortage include a lack of places in care and therapy, long waiting lists and a shortage of consultation time. More time is needed for the identification and management of the problem and especially for immediate crisis intervention. Mental health care in the former East Germany was seen to be in special need of improvement. The respondents highlighted the need for more therapists and counselors qualified for post-trauma care, a contingent of places in therapy available for immediate response and funding for specific services. One respondent suggested that the government should pay for the health care needed by survivors of interpersonal violence – just as it pays for the treatment of the offenders. In addition it was suggested to appoint more psychologists or social workers in schools who are knowledgeable about trauma.

In accordance with the respondents' answers several studies have shown that the perception of a lack of consultation time by the help-seeking or help-provider is a barrier significantly associated with a lack of communication about the traumatization (Davidson, 2001; García-Moreno, 2002; Mol et al., 2002; Rodríguez et al., 2001). Furthermore Munro and colleagues (2004) noted a shortfall in services to which general practitioners could refer for psychological therapies. In their study an overwhelming majority of general practitioners felt that waiting times hindered their clinical practice. The authors (Munro et al., 2004) consequently considered increasing availability and facilitating access to psychosocial services to be important to improving care for survivors of trauma, a view shared by other authors too (Adshead, 1995; García-Moreno, 2002; Gracia, 2004). For non-medical settings

like schools or campuses the formation of response teams and placement of therapists or social workers with special training has been suggested in the literature (Hoefnagels & Mudde, 2000; Utterback & Caldwell, 1989). Such interventions could also be transferred to other institutions like departments or companies – as has been realized for example by German Railways with a focus on traumatic accidents (Gröben).

4.4.4 Strategies for social attitudes

Public attitudes about interpersonal violence and mental health play an important part in shaping the social environment in which the survivors and the help-providers are embedded.

The respondents addressed necessary changes in this variable on the level of general problems or strategies, seldom suggesting any concrete interventions. The main strategies targeting *social attitudes* on the traumatization – perceived problem trajectory were 'Taking interpersonal violence seriously' and 'Breaking the taboo of talking about it'. The respondents called for public relations and open discussion to break the silence and to develop awareness of the issue of interpersonal violence in general and psychological violence in particular. Strategies proposed for the third trajectory were 'Reducing stigmatization of survivors of interpersonal violence, of mental health problems and of help-seeking' and 'Promoting an atmosphere of acceptance and support'. None of the respondents suggested specific interventions for doing so, but strategies promoting public mental health knowledge should also positively affect the prevalent attitude towards them. The main strategy for *social attitudes* on the third trajectory was 'No blaming of the victim/Assigning responsibility to the offender'. Two interventions were proposed. The first demanded of the media to ensure news coverage was not biased towards the offender. The second called on the legal system to impose maximum penalties more often and to take up a clear stance over the issue of interpersonal violence in general and sexualized violence in particular. It was critiqued that sexual harassment is no offense and that a sexual act against the will of the victim has to include (a threat of) physical force to constitute an act of sexual assault. On the last trajectory 'Valuing care for survivors of interpersonal violence' was the main strategy targeting *social attitudes.* It also indirectly targets structural barriers by influencing the allocation of resources to the help-system.

In line with the respondents' answers, work explicitly addressing interventions for changing social attitudes in relation to psychosocial help-seeking after interpersonal traumatization is scarce – an exception is work on the secondary prevention of childhood abuse and on the related issue of primary prevention of interpersonal violence (Kitzinger, 1994). Many of the

main strategies which emerged in our analysis can also be found in this work on violence prevention.

Tolerance or understanding for interpersonal violence as well as 'victim blaming' reduces not only the probability of a known incident being reported but also of social support being offered to the victim, and makes it more difficult for survivors to disclose (Gracia, 2004; Gracia & Herrero, 2006; Weiner, 1980). Negative attitudes towards the disclosure of violence and a taboo against talking about it have been noted as barriers to disclosure in children affected by abuse (Hoefnagels & Mudde, 2000). Challenging these beliefs and attitudes of blame, stigmatization or tolerance for violence, and transmitting the idea of social responsibility, is hence needed not only in regard to primary prevention but also in regard to access to care. In this effort, public education involving local organizations, community groups and academics as well as media campaigns challenging social attitudes towards interpersonal violence are basic tools which have been successfully adopted in the past. Media campaigns against sexual violence and against violence towards women and children have been realized with success in Scotland (Kitzinger, 1994), the Netherlands (Hoefnagels & Mudde, 2000), South Australia (Mugford, 1996), and the US (Gadomski, Tripp, Wolff, Lewis, & Jenkins, 2001), provoking thought, challenging certain misconceptions, triggering the mobilization of action and funding, and making survivors feel less isolated. Additionally a public campaign on interpersonal violence will – by its mere existence – send a signal and break the taboo.

Depending on their aim, campaigns addressing social attitudes to violence should target different groups and the message and interventions should be tailored accordingly. Groups emerging in the respondents' answers as being relevant are the general public, the survivors and their affiliated, professionals who come into contact with survivors in the course of their work like teachers, educators, social workers and the police, but also health professionals who may also harbor negative attitudes interfering with good clinical practice. Furthermore extra care should be exercised when targeting different cultural or ethnical groups – especially cultures where violence (against women) is based in deep-rooted beliefs and attitudes (Gracia, 2004). Designing such campaigns would therefore benefit from a greater research focus on relevant *social attitudes* like victim blaming, tolerance, inhibition, silence, their correlates and distribution in society.

Besides public campaigns, changing policies and legislation as well as organizational practices of institutions (business, government, faith-based organizations, schools, law

enforcement, sports organizations and the media) can have a broad effect on *social attitudes* (Davis et al., 2006).

Another valuable source on *social attitudes* in relation to help-seeking after interpersonal traumatization is the literature about the stigma associated with mental health care. The dynamics of social stigma, the acceptability of support and social role regulation play a crucial role in the way in which individuals – embedded in their communities – interpret, disclose and cope with traumatic events (Steury et al., 2004). Three strategies have been identified to change the social stigma of mental disorders and mental health care: protest, education and contact. Of these only the latter two are supported by research (Corrigan, 2004; Corrigan et al., 2001). Knowledge and education seem to produce relatively broad effects on stigmatization, not only improving attitudes about the disorder targeted and promoting the expectation that persons with mental-behavioral disabilities benefit from medical and psychotherapeutic treatments. In this line public education about trauma and post-traumatic reactions has been proposed as a promising measure to counter stereotypes that people commonly hold about trauma survivors, PTSD and help-seeking in the literature (Gould, Greenberg, & Hetherton, 2007; Mendelsohn & Sewell, 2004). Contact might be difficult to realize in the context of interpersonal violence considering the special need for confidentiality (García-Moreno, 2002), but survivors for whom safety is ensured and who feel up to sharing their story could surely have a greater impact than education alone – especially as individual stories are given more attention and are more vividly recalled (Kitzinger, Philo, Henderson, Saywell, & Beattie, 1999).

4.4.5 Strategies for the public knowledge

We have already discussed the twofold role of knowledge on the system level: for the identification of traumatization and the provision of care in the help-system as well as for countering negative attitudes in society. In addition *public knowledge* about traumatization, its consequences and available help is important in three more ways for the variables on the individual level. First the individual is part of the system and probably shares a substantial percentage of the *public knowledge* which is thus immediately available to him or her for making sense of the experience and deciding what to do about it. Second, *public knowledge* constitutes the knowledge base the affected person can draw upon in search of information in all trajectories. Third, as knowledge available in the social network of the affected, *public knowledge* influences social reactions, i.e. the meaning attached to the traumatization by the social network and the social support. Angermeyer and colleagues (1999) found help-seeking

recommendations to be affected by conceptualization of the problem in terms of its definition, cause and anticipated prognosis and a problem definition in terms of a psychiatric disorder increased the chance of recommending professional help.

4.4.5.1 Content of public knowledge

Our respondents proposed improving *public knowledge* for all trajectories with different content needed as the affected person moves through the process toward help-seeking. Table 7 presents all strategies or in this case categories for each trajectory. In the following paragraph we will elaborate only those categories for which the respondents gave further detail.

'Knowledge about interpersonal traumatization'

Public knowledge called for to improve problem perception encompassed all kinds of knowledge about interpersonal traumatization. In detail the respondents saw a need for knowledge: (1) about post-traumatic symptoms (acute and complex) that would allow them to comprehend their own problems, (2) about the condition of other survivors, (3) about potentially traumatic experiences including less "spectacular" traumata, (4) about the commonness of interpersonal violence and not being alone with one's condition, and (5) about the dynamic of intimate partner violence. A special need for information about psychological violence was observed.

'Knowledge about the existence of formal help'

Public knowledge relevant for the emergence of a *wish for treatment* is mainly information increasing the cognitive availability of help as an option for coping. Therefore knowledge about the existence of formal help is needed. This comprises different forms of help available after interpersonal violence such as therapy, counseling, help lines or women's shelters.

'Knowledge of what formal help is available and how to access it'

This content of *public knowledge* was seen to be primarily relevant for the formation of an intention for help-seeking. Knowledge called for included issues like methods, content, professional secrecy, autonomy and financing but also information about individual providers helping to find the appropriate therapist or counselor for oneself.

4.4.5.2 Media for disseminating information

According to the respondents' answers, the content should be presented in a way that either reaches a broad public or addresses the survivors of trauma and allows direct comparisons with their own situation. Additionally some respondents suggested that specific information about abuse should be provided to children in a suitable way.

Interventions for disseminating information can be used on all trajectories alike. The interventions can be grouped by medium: Internet, print-media, school/training and talks/(health) fairs. For most of the traumatized respondents the internet was an important source of information – but as the study was conducted online this is possibly biased. Information in the internet was considered helpful in the form of: articles dealing with issues around interpersonal violence, specific internet websites/portals, internet forums and banners. Exchange with other survivors of interpersonal violence in particular was described as very helpful. Strengthening the existent self-help structures in the internet might be an economic way to improve available information for the internet-using subpopulation. In terms of print-media posters (in public transportation or other public places) flyers, booklets and also articles on the issue were called for. Physicians' offices and (rehab) hospitals were also mentioned as distributors of information. The usefulness of training for providers of help and their network has been described above; additionally the respondents suggested covering the issue of help available for children and teenagers should be addressed in targeted initiatives at schools or youth facilities. An advantage of such interventions is the higher intensity, potential for interactive activities and opportunities to immediately clarify any remaining questions or even offer help and refer to specialized care. It is important that the sessions are delivered by prepared, competent facilitators or that the teachers conducting the school units are trained appropriately (Lee, Guy, Perry, Sniffen, & Mixson, 2007). Last but not least talks for the general public or specific groups like parents were also suggested as a medium to disseminate information about interpersonal violence and help-seeking, either primarily addressing the issue or in association with related topics (e.g. in day-care centers or schools and possibly in association with other topics like behavioral problems in children or parenting skills).

Many respondents called for more and better public relations without specifying interventions or media. Based on the literature two forms will be discussed in the following: mass media campaigns and the utilization of existent media coverage.

In the effort to improve health behavior mass media campaigns have become a major tool (Randolph & Viswanath, 2004). They have been applied – with more or less success – to a variety of health behaviors, e.g. (Agostinelli & Grube, 2002; Black, Yamada, & Mann, 2002; Farrelly, Niederdeppe, & Yarsevich, 2003; Friend & Levy, 2002; Grilli, Ramsay, & Minozzi, 2002; Jorm, Christensen, & Griffiths, 2006; Marcus & Crane, 1998; Noar, Palmgreen, Chabot, Dobransky, & Zimmerman, 2009; Paykel et al., 1997). To our knowledge only one reported information campaign has targeted psychosocial help-seeking after interpersonal

traumatization so far (Gould et al., 2007). Consequently we will draw on the experiences with mass media campaigns in other fields of health behavior promotion too.

Several important strategies for the design of an information campaign can be identified in the reports and reviews cited above: (1) clearly define and get to know the issue, the long-term goals and the audience; (2) carefully design the messages – use theories, input from those affected/targeted, social marketing tools, pretests and target the message; (3) ensure high message exposure – use multiple channels, utilize media perceived to be reliable, consider new developments in the media and understand the different audiences served by different media; (4) recognize and target other barriers to change – use multiple interventions to create a supportive environment for change; (5) be attentive to relevant processes during the campaign (e.g. changes in policies, media coverage related to the topic); (6) make long-term commitment; (7) use strong research designs for process and outcome evaluation.

Public information campaigns should focus on the knowledge relevant for the first two trajectories – and information where further knowledge can be found if needed. Knowledge relevant for levels three and four can then be made available in low-threshold sources like the internet or through resource-intensive interventions like talks, workshops or help lines.

The need to create a supportive environment for the campaign refers back to the other strategies discussed in this paper. Increased help-seeking is only possible if there are, for instance, adequate offers of care and sufficient places in therapy. In addition complementing a campaign with a telephone helpline has yielded promising results in the context of childhood abuse as well as smoking cessation (Hoefnagels & Mudde, 2000; Owen, 2000). Several help lines providing support for those affected by diverse interpersonal traumata already exist in Germany as well as most other developed countries. Involving these in the campaign would probably increase the campaign's effect on help-seeking as well as the publicity of this form of help.

Besides implementing specific media campaigns, utilizing and influencing existent media coverage should also be considered. Media coverage can strongly influence the ranking of the importance, the perception and understanding of an issue by the public and by policy makers, and can be an important channel for advice, bringing people to seek professional advice too (Jernigan & Wright, 1996; Kitzinger et al., 1999). A review of media coverage on sexual violence (Kitzinger & Skidmore, 1995) confirmed the one-sidedness of media coverage that our respondents criticized concerning interpersonal violence in general. Most items were case-based – leading viewers to hold individuals responsible for causing and resolving their problems instead of government and social institutions (Iyengar & Kinder, 1987). Only some

items targeted primary prevention and seemingly none addressed care for the survivors. In order to change this, it is important to understand that the media has its own agenda, to understand what motivates the media, and how this can be utilized (Jernigan & Wright, 1996). Successful media advocacy means staying in constant touch with the media and taking 'newsworthy' events as an opportunity to provide spokespeople and to put forth data, information and stories about the consequences and available resources of help for the survivors.

4.5 Conclusion

The respondents – traumatized and professionals alike – saw room for improving access to mental health care for survivors of interpersonal violence. They suggested a number of strategies and interventions targeting the three variables on the system level of the integrative model, the *factors of the system providing the help*, the *dominant attitudes in society* and *public knowledge*. These variables interact with each other as well as those on the individual level resulting in some interventions affecting the system and the individual level or more than one variable on the system level.

The majority of proposed interventions were related to *factors of the system providing the help.* This is in line with the emphasis these factors also receive in the discussion of health care for survivors of traumatization in the literature. The scarcity of interventions proposed for targeting the *social attitudes* on the contrary mirrors the scarcity of scientific attention directed to the attitudes towards interpersonal violence in the society, to its correlates and to potential interventions (Gracia & Herrero, 2006; Kitzinger, 1994). However, many of the strategies and interventions increasing *public knowledge* like public relations, media campaigns and informative events are suited not only to the dissemination of information but also to addressing associated attitudes.

Past experiences with such interventions for targeting health behavior change showed only small effect sizes (Harrison, Mullen, & Green, 1992; Snyder et al., 2004) and sizable variation in the effectiveness of individual interventions (Hornik, 2002). Nevertheless enough examples of effective public interventions exist to encourage the pursuit of this approach – though interventions should be taken to maximize the promise of success.

The strategies and interventions proposed in this paper are based on theory and the experience of those affected by interpersonal trauma as well as those professionally providing care for them. Still ongoing process analysis and evaluation should accompany their translation into and implementation in practice, including assessment of the target groups/the affected

persons' experience with and opinion about the intervention. Furthermore because each variable is influenced by connected variables and synergy is to be expected if different interventions are implemented simultaneously (Davis et al., 2006; Lee et al., 2007), the strategies and interventions should not be regarded and implemented in isolation but as a concerted package. Besides coordination and evaluation, targeting is also essential for the success of the intervention. All interventions have to be carefully designed considering the idiosyncrasies of the targeted culture or specific subgroup (Institute of Medicine, 2002). In addition the interventions' effectiveness can be increased if they are not applied by a principle of indiscriminate all-round distribution. The matrix developed in this paper can serve as a guideline to coordinate and target the interventions.

General discussion

The survivors of interpersonal traumatization run a very high risk to develop servious and lasting psychological problems (Breslau, Peterson et al., 2004; Kessler et al., 1995). However, even though efficient treatment approaches for these problems have been developed in the last decades (Bradley et al., 2005; Foa & Meadows, 1997; van Etten & Taylor, 1998), an alarming proportion of the survivors never engage in mental health help-seeking (Freedy et al., 1994; Fugate et al., 2005; Golding et al., 1988; Kimerling & Calhoun, 1994; Norris et al., 1990). So far, only a few studies have examined mental health help-seeking after interpersonal traumatization. Those which did (Fugate et al., 2005; Mazza et al., 1996; Mol et al., 2002; Müller et al., 2004; Ullman & Filipas, 2001) indicate a number of common reasons for refraining from help-seeking, suggesting that the individual process of help-seeking is subject to specific barriers. In order to improve mental health care for trauma survivors we have to understand those barriers and their relationships. Therefore a model was developed integrating theory on help-seeking in general and the empirical findings on help-seeking after traumatization. The model suggests that the traumatized individual has to proceed through four trajectories: he or she has (1) to perceive and represent the trauma and occuring psychological problems, (2) to develop a wish for care, (3) to form an intention to seek help and (4) to act on this intention. The model describes a number of factors relevant for each of the process's trajectories.

Testing the model

Two studies have been conducted to put the integrative model to an empirical test. The first analyzed data from an online survey of a sample with a history of interpersonal traumatization using regression analysis. The second study analyzed open answers of traumatized respondents and professionals working with survivors using content anlysis. In the following paragraph a summary of each study's results is followed by a comparative dicussion.

The results of the first study provided support for the validity of all trajectories suggested in the model. However not all of the model's variables reached sigificance. For the first trajectory the effect of the *traumatization* on the *perceived problem* was moderated by the *social reference* – the way the social network perceived and reacted to the trauma and its sequelae. The other influencing variable on the trajectory, *knowledge about traumatization*, did not reach significance. On the *perceived problem - wish for treatment* trajectory *social support, attitude to help-seeking* (i.e. a stoic attitude and fear of stigmatization) and *disrupted interpersonal trust* reached significance while *posttraumatic avoidance* of thinking and

talking about the event did not. On the *wish for treatment - treatment intention* trajectory, *expected success* of the treatment and a familial *victim-offender relationship* reached significance. The degree to which the affected individual perceived *help*-seeking to be *feasibile* showed a trend towards significance. Feelings of s*hame and guilt* failed to show a significant influence on the *treatment intention*. On the last trajectory, the influence of the *treatment intention* on *help-seeking* was moderated by the *experienced structural barriers* (like being turned down) and *interventions of others* (like help proactively offered by a professional). *Knowledge about providers* did not significantly predict *help-seeking*.

In the second study all of the model's influencing variables were confirmed. *Knowledge about traumatization*, *social reference*, *social support*, *cognitive availability*, *attitude to help-seeking*, *feasibility and the experienced structural barriers* turned out to be prevalent. Additionally, one influencing variable not previously part of the model was derived from the answers: *denial* of the problem, which was described to be important for the problem perception. Besides this first modification of the model a second modification was suggested by the qualitative analysis. In addition to the model's individual help-seeking process three system level variables appeared to be important: *factors of the help-system* like difficult access to care, *dominant attitudes in society* like blaming of the victim and *public knowledge* about traumatization, its consequences and available help.

Both studies confirmed the model as a whole, but they also showed several different results. Compared to the results of the questionnaire-based statistical test of the model, more variables were supported by the written free answers. This cannot be perceived as a mere statistical phenomenon; some of the variables which did not reach signifcance still received strong support by the respondents. In the following paragraph these differences will be discussed in order of their appearance in the model: *knowledge about traumatization, posttraumatic avoidance, feasibility, guilt and shame and knowledge where to go*.

Knowledge about traumatization on the first trajectory received a strong qualitative support in study two despite a lack of significance in study one. Lacking such knowledge, having no name for the trauma or its sequelae and not being able to define the problem was a barrier to help-seeking for a significant proportion of the traumatized respondents. Knowledge can make the difference between suffering incomprehensibly and understanding the symptoms and their causes. Without it the survivor might not be able to accurately represent his or her problem and consequently might not seek help for it, but this is not equivalent to having no problem and needing no help. Hence the respondents' answers highlighted how *knowledge about traumatization* can become a precondition for the survivors' autonomy and freedom to

choose if they want professional help. The respondents in study two appreciated this relevance of knowledge and described not only how and which knowledge they had lacked, but also how they actively sought knowledge (e.g. in books or the internet) to overcome this barrier. Their discourse strenghtens the variable's position in the revised model.

The evidence for *posttraumatic avoidance* on the second trajectory is less clear. It did not reach significance in study one and in study two was mentioned by only one traumatized respondent (2.3%) and by three professional respondents (18.75%). Hence it might be argued that professionals only expect posttraumatic avoidance to hamper help-seeking; but in the study of Mol and colleagues (2002) about ten to thirty percent of those who experienced an interpersonal traumatization felt that "talking about it makes it worse". Furthermore *posttraumatic avoidance* should be understood to be more than a deliberate decision not to talk about the event. It seems advisable to broaden this view to include less volitional processes like those described by one traumatized respondent (T31: "blocked up deep inside; a very deep inner defense") even though those are much more difficult to grasp. This difficulty may very well be the reason for the lack of empirical support, and further research into the role of avoidance in help-seeking is needed.

Feasibility on the third trajectory only showed a trend to significance in study one but appeared in the answers of 17% of the respondents in study two. The respondents predominantly mentioned barriers to *feasibility*: long waiting time, the difficulty to find an appropriate professional, perceived unresponsiveness of the system and feeling too powerless to engage in help-seeking. Such factors potentially reducing the feasibility were also mentioned as barriers in other studies with victims of traumatization (Fugate et al., 2005; Mol et al., 2002; Rodríguez et al., 2001)). Both sources supported the variable's continuance in the model.

Guilt and shame on the third trajectory missed significance in study one, but it was mentioned by a significant percentage of the respondents in study two (about 10%). Furthermore the respondents elaborated the position of guilt and shame in the model, highlighting the relevancy of the *dominant attitudes in society* (especially the blaming of the victim, the exculpation of the perpetrator and the traditional gender roles) for the development of these feelings. Guilt and shame also found strong support as a barrier to help-seeking in other studies of help-seeking after traumatization (Fugate et al., 2005; Jaycox et al., 2004; Mazza et al., 1996; Mol et al., 2002). In the light of this support the variable was kept in the model.

Knowledge where to go on the last trajectory received only weak support. On the one hand it did not reach significance in the regression analysis and was explicitely mentioned as a barrier

to becoming active by only one traumatized respondent. On the other hand specific information about providers of help was considered important by 6,8% of the respondents. This variable's problem is that it is difficult to assign to one trajectory. Knowledge about formal help is important for the *cognitive availability* (on the second trajectory) and also for assessing *feasibility* and *expected success* (on the third trajectory). The traumatized respondents seemed to need and seek information about potential formal help throughout the whole process of help-seeking. But the kind of information needed probably becomes more and more explicit the closer to action the person gets: from information about the existence of help to information about individual providers of help in the immediate surroundings. On account of this, the variable was kept in the model to prompt further research into the role of knowledge at different points in the process.

The model's implications

After two empirical tests the integrative model should still be perceived as a working model. The studies' limitations – especially the comparatively small sample size –and the differences in the results forbid jumping to conclusions. However, the model is a viable tool to describe the individual help-seeking process and to identify barriers as well as promoters that can be targeted to improve access to health care for survivors of interpersonal traumatization. The last part of this thesis directly addressed the issue of improving access; it described strategies and interventions suggested by survivors of interpersonal violence and professionals working with survivors. Altogether more than twenty main strategies plus associated interventions have been proposed. These main strategies can be assigned to the model's three system variables (i.e. *factors of the help-system, dominant attitudes in society* and *public knowledge*) and shared as well as specific strategies were proposed for the model's four trajectories (*interpersonal traumatization - perceived problem*, *perceived problem - wish for treatment*, *wish for treatment - treatment intention*, and *treatment intention - help-seeking*). The majority of proposed strategies and interventions was related to *factors of the system providing the help* and called for interventions implemented by the help-system (like referring and networking); but in addition interventions targeting the help-system (like improving the professionals' training) were also proposed. While many of these interventions require that the actions of professional helpers are accompanied by structural changes, like an allocation of resources, some can be implemented by every caring professional: like being mindful of interpersonal violence or setting up an internet presence including some personal information.

The diversity of proposed strategies corresponds to the complexity of the individual help-seeking process. Serious efforts to improve access have to account for this by concerting

diverse strategies, by accompanying evaluation and by careful targeting. In order to do this, the model developed in this thesis can serve as a guideline.

Conclusion

Seeking professional help after an interpersonal traumatization is an effective way to deal with its aftermath and can prevent or alleviate chronic mental health problems. However many survivors never engage in such help-seeking. While seeking professional help is the outcome of an individual coping process, refraining from it is not necessarily the individual's free decision. This thesis highlights how help-seeking is influenced by many variables and shows that only some of them are intrinsic. The individual's environment – the society in which he or she was socialized, in which the trauma occurred and in which help-seeking might take place play a major role in help-seeking. Improvement in the survivor's access to care cannot be achieved without changing the way the society and its service providers perceive, approach and care for survivors of interpersonal traumatization. To achieve this the responsible social players should carefully consider the presented clinical, formal and social issues related to providing health care after interpersonal traumatization. In addition further research should not only follow-up on the individual help-seeking process but also evaluate the proposed interventions.

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Appendix

Appendix A Information about the study on the studie's homepage

Wie gehen Menschen mit traumatischen Erlebnissen um?
Wie lässt sich das Hilfsangebot für Menschen nach traumatischen Erfahrungen verbessern?

Unmittelbare und weiterreichende Ziele

Die Studie verfolgt fünf Ziele

1) Erfassung der gesundheitlichen und sozialen Kosten der traumatischen Erfahrung für die Betroffenen im deutschsprachigen Raum.
2) Einschätzung des Bedarfs an professioneller Hilfe – vs. der Verarbeitung ohne professionelle Hilfe
3) Erhebung des Grades, in dem die Betroffenen professionelle Hilfe in Anspruch nehmen, beziehungsweise die Inanspruchnahme verzögern.
4) Identifikation von Einflussfaktoren, welche die Inanspruchnahme professioneller Hilfe durch die Betroffenen begünstigen beziehungsweise behindern.
5) Entwicklung eines Modells, dass die Inanspruchnahme, Aufschiebung oder Ablehnung verschiedener Formen der professionellen Hilfe erklärt

Die Studienleitung

Die Studie wird in Kooperation mit der Freien Universität Berlin und mit der Universität Zürich unter der Leitung von Dipl. Psych. Viola Schreiber, Prof. Dr. Dr. Maercker und PD Dr. Renneberg durchgeführt.

Die Ergebnisse der Studie werden es erlauben:

- ✓ die Bedeutung vorbeugender Maßnahmen zur Minimierung der Risikos einer Traumatisierung zu unterstreichen
- ✓ zukünftige Hilfsangebote möglichst barrierenfrei und ansprechend zu gestalten
- ✓ optimalere Öffentlichkeitsarbeit zu leisten

Damit soll in Zukunft ein leichterer Zugang zu effektiven Hilfsangeboten und damit eine bessere Unterstützung traumatisierter Menschen erzielt werden.

Veröffentlichung der Ergebnisse

Die Ergebnisse der Studie werden so weit wie möglich in Büchern, Zeitschriften oder Zeitungen veröffentlicht. Auch wird auf Tagungen darüber berichtet werden, in denen jene Fachleute zusammenkommen, die wesentlich an der Gestaltung der Hilfsangebote beteiligt sind. Wissenschaftler und Politiker können die Informationen dann für Entscheidungen verwenden, die jedem Betroffenen zu gute kommen.

Inhalte der Befragung

In der Befragung werden grundlegende Informationen zu dem erlebten Trauma selbst erhoben, ergänzt durch Fragen zu den Folgen des Ereignisses für den Teilnehmer/ die Teilnehmerin. Dabei geht es sowohl um Beeinträchtigungen im alltäglichen Leben als auch um psychische und körperliche Beschwerden. Außerdem werden die angewandten Bewältigungsstrategien sowie die tatsächliche Erfahrung mit Hilfsangeboten erfragt.

Teilnahme

Wir hoffen, Ihr Interesse geweckt zu haben und bitten Sie ganz herzlich, uns durch Ihre Mitarbeit zu unterstützen!

Wer kann teilnehmen?

Als TeilnehmerIn ist jeder/ jede angesprochen, der/ die in den letzten 10 Jahren ein gravierendes Ereignis erlebt hat, das sein Leben oder seine Unversehrtheit bedroht hat, oder der Zeuge eines solchen Ereignisses wurde. Ein solches Ereignis könnte beispielsweise ein schwerer Unfall, ein tätlicher Angriff, ungewollte sexuelle Kontakte oder auch eine Naturkatastrophe sein.

Auch wenn Sie sich nicht sicher sind, ob Ihr Erlebnis in die beschriebene Gruppe gehört, können Sie dennoch teilnehmen, da wir uns mit Hilfe ihrer Angaben selbst ein Bild machen können.

Was passiert mit Ihren Daten?

Die Befragung wird gemäß den gesetzlichen Bestimmungen des Bundesdatenschutzgesetzes (BDSG) durchgeführt. Ihre Angaben werden selbstverständlich **vertraulich** behandelt und wir garantieren Ihnen in der Datenerfassung wie –verarbeitung **Anonymität**. Die Erfassung wie auch die Auswertung wird so vorgenommen, dass die Angaben durch eine Code-Nummer, also ohne Namen und Adresse, miteinander verknüpft werden - so dass niemand erfährt, welche Antworten Sie persönlich gegeben haben. Die Ergebnisse der Befragung werden ausschließlich in anonymisierter Form d.h. ohne Namen

und Anschrift dargestellt. Das bedeutet: Niemand kann aus den Ergebnissen erkennen, von welcher Person diese Angaben gemacht worden sind. Es gibt keine Weitergabe von Daten, die Ihre Person erkennen lassen und die Daten werden ausschließlich zu wissenschaftlichen Zwecken verwendet.
Wenn Sie es wünschen, bieten wir Ihnen nach Abschluss der Befragung eine persönliche Rückmeldung über Ihre Ergebnisse.

Wie können Sie teilnehmen?
Sie können direkt online teilnehmen. Die Befragung wird bis zum Oktober 2008 durchgeführt werden.
Das Ausfüllen aller Fragen wird ca. 35-45min in Anspruch nehmen, muss aber nicht am Stück erfolgen.
Sollten Sie an der Befragung online teilnehmen und dabei einen Computer nutzen, auf den auch andere Zugriff haben können diese – wenn sie es darauf anlegen – nachvollziehen, dass Sie diese Seiten im Internet besucht haben. Um dies auszuschließen, können Sie auf dem PC den "Verlauf" (Microsoft Internet Explorer) bzw. die "History" (Netscape Navigator) löschen (über „Extras“, „Internetoptionen“, „Verlauf leeren“). In diesen Verzeichnissen werden die Adressen der aufgerufenen Seiten automatisch gespeichert. Mit dem Löschen wird allerdings der gesamte Speicher gelöscht – nicht nur die fragliche Adresse. Dies sollte in der Regel kein Problem darstellen, da die Adressen ohnehin nur für eine begrenzte Zeit gespeichert werden. Wenn Sie nicht den gesamten Verlauf löschen wollen, suchen sie im „Verlaufs-“ bzw. „Histroy-“Verzeichnis (im Menübalken neben den Favoriten anwählbar) unter „Heute“ die Adresse der fraglichen Seiten und löschen sie nur diese (über Rechtsklick).

Das sollten Sie beachten.
Der Fragebogen wird Fragen zu der Reaktion der Bekannten des Betroffenen, dem erlebten Ereignis, den Folgen des Ereignisses für den Teilnehmer/ die Teilnehmerin und zu den angewandten Bewältigungstaktiken sowie zu tatsächlichen Erfahrung mit Hilfsangeboten umfassen. Die Fragen wurden abstrakt formuliert und fragen nicht nach Details, um die Belastung für die Teilnehmenden so gering wie möglich zu halten. Dennoch kann die Bearbeitung der Fragen - alleine durch die Auseinandersetzung mit dem Thema als unangenehm erlebt werden.

Der Fragebogen bietet die Möglichkeit, nach jeder Fragengruppe auszusteigen und die Bearbeitung zu einem späteren Zeitpunkt fortzusetzen. Nehmen Sie sich also ruhig die Zeit, nach einem möglicherweise belastenden Abschnitt eine Pause einzulegen und planen Sie die Bearbeitung so, dass sie nicht in Zeiten fällt, in denen Sie ohnehin durch ihre Umwelt / ihren Alltag besonderen Belastungen ausgesetzt sind. Bitte entscheiden Sie sich jeweils bewusst, ob die Auseinandersetzung mit dem Thema für Sie aktuell nicht zu viel ist.

Wir wollen uns an dieser Stelle schon einmal bei jedem Teilnehmer, jeder Teilnehmerin bedanken, der / die die Zielsetzung unserer Studie für bedeutsam genug hält, um die Zeit und Kraft für die Bearbeitung des Fragebogens aufzuwenden.

Sie haben noch weitere Fragen?

Wenn Sie noch weitere Fragen zur Studie und der Befragung haben, können Sie gerne eine eMail an V.Schreiber@psychologie.unizh.ch schicken. Ich werde so schnell wie möglich antworten. Diese Anfrage per eMail ist unabhängig von der Teilnahme an der Studie möglich.

Appendix B The online questionnaire

Sehr geehrte Teilnehmerin, sehr geehrter Teilnehmer

Vorab möchten wir Ihnen für Ihre Bereitschaft danken, Zeit und Energie in unser Forschungsprojekt zu investieren.

Alle Angaben, die Sie hier machen, werden selbstverständlich vertraulich behandelt.

Der folgende Fragebogen setzt sich aus mehreren Abschnitten zusammen. Diese können Sie auch zu verschiedenen Zeitpunkten bearbeiten. **Machen Sie also ruhig Pausen und teilen Sie sich die Bearbeitungszeit ein, wie Sie es wünschen.**

Wie bereits angekündigt, können Sie auch eine Rückmeldung zu Ihren persönlichen Ergebnissen erhalten. Mehr dazu am Ende des Fragebogens.

Es ist selbstverständlich, dass alle Vorschriften des Bundesdatenschutzgesetzes eingehalten werden.

Es ist erforderlich, dass Sie alle Fragen bearbeiten.

Bitte antworten Sie in jedem Fall wahrheitsgemäß, da Sie ansonsten die Ergebnisse verfälschen. Niemand wird Ihre Antworten bewerten oder mit Ihnen in Zusammenhang bringen können.

Zu einigen Themen gibt es mehrere ähnliche Fragen. Diese stellen sicher, dass wir keine falschen Schlüsse ziehen, nur weil Sie eine der Fragen anders verstanden haben als wir. Beantworten Sie daher bitte jede Frage unabhängig von den vorherigen so, wie Sie denken, dass es richtig ist.

Vorab die Frage, wo Sie von dieser Befragung gehört haben (Mehrfachnennungen möglich)

- In einer Arztpraxis oder Ambulanz
- In einer Zeitung/ Zeitschrift
- Auf der Seite eines Selbsthilfeforums (z.B. Hilferuf.de)
- Auf einer anderen Internetseite (z.B einem anderen Forum)
- Von einem / einer Bekannten

Möchten Sie an dieser Umfrage

- als Betroffene oder Betroffener ernsthaft teilnehmen
- aus anderen Gründen (z.B. Neugier, wissenschaftliche Interesse) teilnehmen

Ist Ihnen bewusst, dass die Fragen möglicherweise belastende Erinnerungen anregen können – und Sie in diesem Falle jederzeit die Bearbeitung unterbrechen können?

Haben Sie die Informationen zur Hilfsangeboten gelesen, welche Sie bei Bedarf kontaktieren können?

Wenn Sie eine Rückmeldung zu Ihren persönlichen Ergebnissen wünschen, tragen Sie bitte unten Ihre Email-Adresse ein. Auch diese Daten werden selbstverständlich streng vertraulich behandelt. Sie werden nicht zusammen mit Ihren übrigen Daten gespeichert und nach Abschluss der Studie automatisch gelöscht.

Um mögliche Zusammenhänge überprüfen zu können, stellen wir Ihnen im Folgenden einige Fragen zu Ihrer Person.

Geschlecht männlich ☐ weiblich ☐

Alter _____

Was ist Ihr höchster erreichter Schulabschluss? Was aus dieser Liste trifft auf Sie zu?

- ☐ Schule beendet ohne Abschluss
- ☐ Volks- / Hauptschulabschluss oder vergleichbarer Abschluss
- ☐ Realschulabschluss, Mittlere Reife, (Fachschulreife) oder vergleichbarer Abschluss
- ☐ Fachhochschulreife oder vergleichbarer Abschluss
- ☐ Abitur (Hochschulreife) oder Berufsausbildung mit Abitur oder vergleichbarer Abschluss
- ☐ Trifft nicht zu, gehe noch zur Schule

Welchen beruflichen Ausbildungsabschluss haben Sie? Was von dieser Liste trifft auf Sie zu? Bitte nennen Sie den höchsten erzielten Abschluss.

- ☐ Noch keinen Ausbildungsabschluss
- ☐ Keinen beruflichen Ausbildungsabschluss – Hilfsarbeiter oder Anlernberuf
- ☐ Abgeschlossene Lehre oder Berufsfachschulabschluss
- ☐ Weiterbildung zum Meister-, Techniker- oder gleichwertige Weiterbildung
- ☐ Fachhochschulabschluss / Berufsakademie / Hochschulabschluss

Ihr Haushaltseinkommen beträgt ca. brutto monatlich

- ☐ bis 500 €
- ☐ bis 1500
- ☐ bis 2500
- ☐ bis 4000
- ☐ über 4000

Was ist Ihr Familienstand?

- ☐ Single/ ledig / ohne feste Beziehung
- ☐ In fester Beziehung
- ☐ Verheiratet
- ☐ Geschieden
- ☐ Verwitwet

Welcher Religionsgemeinschaft gehören Sie an?

- [ ] Christlich (katholisch / evangelisch)
- [ ] Andere christlichen Religionsgemeinschaft
- [ ] Jüdischer Glauben
- [ ] Islam
- [ ] Andere nicht-christliche Religionsgemeinschaft
- [ ] Keiner Religionsgemeinschaft

Wo wohnen Sie?

- [ ] in einer ländlichen Gegend
- [ ] In einem Dorf
- [ ] In einer Kleinstadt
- [ ] In einer mittel großen Stadt
- [ ] In einer Großstadt

Wo liegen Ihre familiären Wurzeln (Mehrfachnennung möglich)

- [ ] in Deutschland
- [ ] in der Schweiz
- [ ] in einem Land der alten EU (vor der Osterweiterung)
- [ ] in einem ost-europäischen Land oder Russland
- [ ] in der Türkei
- [ ] in einem Land des nahe Ostens
- [ ] in einem asiatischen Land
- [ ] in einem anderen Land

Falls Sie **nicht** in Deutschland/ der Schweiz geboren wurden:

Seit wann leben Sie in Deutschland/ der Schweiz? in Jahren

Bitte stufen Sie ihre Deutschkenntnisse ein

- [ ] Muttersprache
- [ ] fließend
- [ ] gut
- [ ] lückenhaft
- [ ] gering

Im folgenden Abschnitt bitten wir Sie, anzugeben, welcher Art das von ihnen erlebte Ereignis war.

Wir bemühen uns dabei um eine möglichst sachliche Sprache – auch wenn diese sicher nicht ihrem persönlichen Erleben gerecht wird und Ihnen kalt und unpersönlich erscheinen mag. Dies dient dazu, die Belastung für Sie und die anderen TeilnehmerInnen so gering wie möglich zu halten und dabei so genau wie möglich zu sein. Einige der Ereignisse werden durch Beispiele klarer umschrieben um sicherzustellen, dass Sie dasselbe darunter verstehen wie wir. Diese Beispiele enthalten Wörter, die Erinnerungen an das Ereignis anregen können. Bitte entscheiden Sie selbst, ob Sie sich die Beispiele durchlesen oder nicht.

Viele Menschen haben irgendwann einmal in ihrem Leben ein sehr belastendes oder traumatisches Erlebnis oder werden Zeugen eines solchen Ereignisses. Bitte geben Sie für jedes der folgenden Ereignisse an, ob Sie es entweder persönlich oder als Zeuge erlebt haben.

Bitte kreuzen Sie, SELBST an, wenn Sie selbst betroffen waren,

ZEUGE, wenn Sie das Ereignis beobachtet haben oder

NEIN, wenn keines von beidem der Fall war.

Waren Sie sowohl selbst betroffen, als auch Zeuge, so kreuzen Sie bitte beides an. Bitte geben sie außerdem an, wie oft sie das entsprechende Ereignis erlebt haben. Wenn sie es nicht mehr genau wissen, schätzen Sie bitte.

Wenn das Erlebte auf mehrere mögliche Fragen zutrifft, kreuzen Sie bitte alle zutreffenden Antworten an.

Bsp. Sie wurden einmal selbst in einem Kriegsgebiet mit einer Schusswaffe bedroht. Außerdem wurden Sie zu einem anderen Zeitpunkt Zeuge eines gewalttätigen Überfalls auf eine andere Person.

		Nicht erlebt	*Selbst betroffen*	*Zeuge geworden*	*Wie oft?*
3.	*Körperlicher Angriff durch fremde Personen oder jemanden aus dem Familien- oder Bekanntenkreis* *z.B. schlagen, stoßen, kratzen, verbrühen, vergiften, beißen, oder mit einer Waffe oder einem Gegenstand angegriffen werden*	*NICHT*	*SELBST* X	*ZEUGE* X	*2*
6.	*Kampfeinsatz im Krieg oder Aufenthalt in Kriegsgebiet*	*NICHT*	*SELBST* X	*ZEUGE*	*1*

		Nicht erlebt	Selbst betroffen	Zeuge geworden	Wie oft?
1.	Schwerer Unfall, Feuer oder Explosion z.B. Arbeitsunfall, Unfall in der Landwirtschaft, Autounfall, Flugzeug- oder Schiffsunglück	NICHT	SELBST	ZEUGE	
2.	Naturkatastrophe z.B. Wirbelsturm, Orkan, Flutkatastrophe, schweres Erdbeben	NICHT	SELBST	ZEUGE	

3.	Körperlicher Angriff durch fremde Personen oder jemanden aus dem Familien- oder Bekanntenkreis z.B. schlagen, stoßen, kratzen, verbrühen, vergiften, beißen, oder mit einer Waffe oder einem Gegenstand angegriffen werden	NICHT	SELBST	ZEUGE
4.	Sexueller Kontakt im Alter von unter 14 Jahren mit einer Person, die mindestens 5 Jahre älter war bzw. ungewollter sexueller Kontakt im Alter von unter 18	NICHT	SELBST	ZEUGE
5.	Sexuelle Handlungen gegen Ihren Willen unter Gewaltanwendung, Erpressung oder Drohungen – ausgeübt durch fremde Personen oder jemanden aus dem Familien- oder Bekanntenkreis (einschließlich (Ehe-) Partner und Täter des selben Geschlechtes). Auch versuchte sexuelle Übergriffe. z.B. Küssen, intime Berührung ihres Körpers oder Zwang zur intimen Berührung des Körpers des Täters, jegliche Formen der Penetration, Zwang zu ungewollten sexuellen Praktiken	NICHT	SELBST	ZEUGE
6.	Kampfeinsatz im Krieg oder Aufenthalt in Kriegsgebiet	NICHT	SELBST	ZEUGE
7.	Gefangenschaft z.B. Strafgefangener, Kriegsgefangener, Geiselhaft	NICHT	SELBST	ZEUGE
8.	Folter	NICHT	SELBST	ZEUGE
9.	Lebensbedrohliche Krankheit	NICHT	SELBST	ZEUGE
10.	massive Drohungen und systematische seelische Gewalt oder Psycho-Terror durch Personen, denen gegenüber Sie sich ausgeliefert fühlten	NICHT	SELBST	ZEUGE
11.	Anderes traumatisches Ereignis Bitte beschreiben Sie dieses Ereignis: _____ _____	NICHT	SELBST	ZEUGE

Wenn Sie mehrmals JA angekreuzt haben, geben Sie bitte hier die Nummer desjenigen Erlebnisses an, das Sie am meisten belastet hat: _____

Wann hatten Sie dieses schlimmste Erlebnis?

☐	Vor weniger als 1 Monat		
☐	Vor mehr als 10 Jahren		
☐	Zwischen 1 Monat und 10 Jahren und zwar	Monaten	Jahren

Die Fragen auf der folgenden Seite beziehen sich nur auf Personen, die eines der folgenden Erlebnisse als das von Ihnen **am schlimmsten erlebte Ereignis** angegeben haben:

einen körperlichen Angriff, ungewollte sexuelle Handlungen, sexuelle Kontakte unter 18 Jahren, Kriegserfahrungen, Gefangenschaft/ Geiselhaft, Folter oder Psychoterror

Wenn dies nicht für Sie zutrifft, gehen Sie bitte direkt zu den Fragen auf Seite 21.

Bitte beantworten Sie die Fragen FÜR DAS VON IHNEN AM SCHLIMMSTEN ERLEBTE EREIGNIS (wenn Sie nur eines der Ereignisse angekreuzt haben, ist mit „schlimmstes Erlebnis“ dieses Ereignis gemeint).

Wer auch immer die gewaltausübende Person war, wir werden sie im weiteren durchgehend als „Täter“ bezeichnen.

Bitte kreuzen Sie im folgenden jeweils das Zutreffende an (auch Mehrfachnennungen sind möglich)

In welcher **Beziehung** standen bzw. stehen Sie zum Täter bzw. der Täterin oder zu den Tätern?
Er oder sie war bzw. waren:

- ein intimer Partner bzw. Partnerin
- ein Familienmitglied (z.B. Mutter, Vater, Bruder, Schwester, Onkel, Tante, Großvater)
- ein Freund bzw. eine Freundin oder ein Bekannter bzw. eine Bekannte
- eine Person, die eigentlich für Ihren Schutz, Ihre Gesundheit oder für Beratung und Betreuung zuständig sind (z.B. ein Arzt bzw. Ärztin, ein Geistlicher bzw. eine Geistliche, ein Polizist bzw. eine Polizistin...)
- ein flüchtiger Bekannter bzw. eine flüchtige Bekannte
- ein Fremder bzw. eine Fremde

Bevor wir nun weitere Fragen zu den oben angekreuzten Ereignissen stellen, nennen wir einige psychologische Fachbegriffe, die vielen Menschen wenig bekannt sind. Bitte schätzen Sie ein, wie viel Sie darüber wissen.

Wieviel wussten Sie vor Teilnahme an dieser Studie oder Kontakt zu einem professionellen Helfer über typische Folgen von schweren bzw. traumatischen Erfahrungen?

Unter professionelle Hilfe fassen wir:
Ärzte und Ärztinnen
Psychologen und Psychologinnen bzw. Psychotherapeuten und Psychotherapeutinnen
Gesprächspartner und Gesprächspartnerinnen in Beratungsstellen
Gesprächspartner und Gesprächspartnerinnen am Krisentelefon bzw. einer telefonischen Beratung
Gesprächspartner und Gesprächspartnerinnen im Frauenhaus
Seelsorger und Seelsorgerinnen bzw. Pfarrer und Pfarrerinnen bzw. Priester.

Bitte stufen Sie ihren eigenen Kenntnisstand auf der Skala ein.

Wussten bzw. wissen Sie, was ein „Trauma“ ist?

Nein, gar nicht	Recht wenig	Ungefähr	Recht gut	Ja, ganz genau

Wussten bzw. wissen Sie, was eine „Posttraumatischer Belastungsstörung“ ist?

Nein, gar nicht	Recht wenig	Ungefähr	Recht gut	Ja, ganz genau

Wussten bzw. wissen Sie, was eine „Depression“ ist?

Nein, gar nicht	Recht wenig	Ungefähr	Recht gut	Ja, ganz genau

Konnten sie gegebenenfalls auftretende Beschwerden einem dieser drei Begriffe grob zuordnen?

Nein, gar nicht	Recht wenig	Ungefähr	Recht gut	Ja, ganz genau

Im Folgenden finden Sie eine Reihe von Problemen, die Menschen manchmal nach traumatischen bzw. belastenden Erlebnissen haben. Bitte lesen Sie sich jedes der Probleme sorgfältig durch.

Wir möchten erfahren unter welchen Beschwerden Sie momentan leiden. Wählen Sie dafür links diejenige Antwortmöglichkeit aus, die am besten beschreibt, wie häufig Sie IM LETZTEN MONAT von diesen Problemen betroffen waren. Hierfür haben wir eine Auswahl aller Fragen getroffen; bearbeiten Sie nur jene Fragen, neben welchen die Antwortmöglichkeiten abgedruckt wurden.

Außerdem interessieren wir uns für die Zeit seit dem Ereignis, in der es Ihnen insgesamt am schlechtesten ging. Wählen sie dafür rechts die zutreffende Antwortmöglichkeit für diesen Zeitraum.

Die Fragen sollten Sie dabei (soweit möglich) auf Ihr schlimmstes Erlebnis beziehen.

selten = überhaupt nicht oder nur einmal im Monat

manchmal = einmal pro Woche oder seltener

oft = 2 bis 4 mal pro Woche bzw. die Hälfte der Zeit

fast immer = 5 mal oder öfter pro Woche

In den letzen 4 Wochen					Zur Zeit der schwersten Beschwerden			
nie/ selten	manch- mal	oft	fast immer	Hatten Sie belastende Gedanken oder Erinnerungen an das Erlebnis, die ungewollt auftraten und Ihnen durch den Kopf gingen, obwohl Sie nicht daran denken wollten?	nie/ selten	manch- mal	oft	fast immer
				Hatten Sie schlechte Träume oder Alpträume über das Erlebnis?	nie/ selten	manch- mal	oft	fast immer
				War es, als würden Sie das Ereignis plötzlich noch einmal durchleben. oder handelten oder fühlten Sie so, als würde es wieder passieren?	nie/ selten	manch- mal	oft	fast immer
				Belastete es Sie, wenn Sie an das Erlebnis erinnert wurden (fühlten Sie sich z.B. ängstlich, ärgerlich, traurig, schuldig, usw.)?	nie/ selten	manch- mal	oft	fast immer
				Hatten Sie körperliche Reaktionen (z.B. Schweißausbruch oder Herzklopfen), wenn Sie an das Erlebnis erinnert wurden.	nie/ selten	manch- mal	oft	fast immer
gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter der stärksten der genannten Beschwerden?	gar nicht	etwas	stark	sehr stark

In den letzen 4 Wochen					Zur Zeit der schwersten Beschwerden			
nie/ selten	manch- mal	oft	fast immer	Haben Sie sich bemüht, nicht an das Erlebnis zu denken, nicht darüber zu reden oder damit verbundene Gefühle zu unterdrücken?	nie/ selten	manch- mal	oft	fast immer
				Haben Sie sich bemüht, Aktivitäten, Menschen oder Orte zu meiden, die Sie an das Erlebnis erinnern?	nie/ selten	manch- mal	oft	fast immer
				Konnten/Können Sie sich an einen wichtigen Bestandteil des Erlebnisses nicht erinnern?	nie/ selten	manch- mal	oft	fast immer
gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter der stärksten der genannten Beschwerden?	gar nicht	etwas	stark	sehr stark

In den letzen 4 Wochen					Zur Zeit der schwersten Beschwerden			
nie/ selten	manch- mal	oft	fast immer	Hatten Sie deutlich weniger Interesse an Aktivitäten, die vor dem Erlebnis für Sie wichtig waren oder haben Sie deutlich weniger unternommen?	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Fühlten Sie sich Menschen Ihrer Umgebung gegenüber entfremdet oder isoliert?	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Fühlten Sie sich abgestumpft oder taub (z.B. nicht weinen können oder sich unfähig fühlen, liebevolle Gefühle zu erleben).	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Hatten Sie das Gefühl, dass sich Ihre Zukunftspläne und Hoffnungen nicht erfüllen werden (z.B. dass Sie im Beruf keinen Erfolg haben, nie heiraten, keine Kinder haben oder kein langes Leben haben werden).	nie/ selten	manch- mal	oft	fast immer
gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter der stärksten der genannten Beschwerden?	gar nicht	etwas	stark	sehr stark

In den letzen 4 Wochen					Zur Zeit der schwersten Beschwerden			
nie/ selten	manch- mal	oft	fast immer	Hatten Sie Schwierigkeiten ein- oder durchzuschlafen.	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Waren Sie nervös oder schreckhaft (z.B. wenn jemand hinter Ihnen geht).	nie/ selten	manch- mal	oft	fast immer
				Waren Sie reizbar oder hatten Sie Wutausbrüche?	nie/ selten	manch- mal	oft	fast immer
				Hatten Sie Schwierigkeiten, sich zu konzentrieren (z.B. während eines Gesprächs in Gedanken abschweifen; beim ansehen einer Fernsehsendung den Faden verlieren; vergessen, was Sie gerade gelesen haben).	nie/ selten	manch- mal	oft	fast immer
				Waren Sie übermäßig wachsam (z.B. nachprüfen, wer in Ihrer Nähe ist; sich unwohl fühlen, wenn Sie mit dem Rücken zur Tür sitzen; usw.).	nie/ selten	manch- mal	oft	fast immer
gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter der stärksten der genannten Beschwerden?	gar nicht	etwas	stark	sehr stark

Diese Beschwerden zu haben, macht mir Sorgen:

Gar nicht	Kaum	Etwas	Stark	Sehr stark

Hatten Sie jemals das Bedürfnis, fachmännisch geholfen zu bekommen?:

Gar nicht	Selten	Ab und zu	Oft	Sehr oft

Gab es Zeiten, in denen Sie gedacht haben, jetzt gehe ich wirklich zu einem Arzt/ Ärztin, PsychologIn, BeraterIn, SeelsorgerIn?:

Gar nicht	Selten	Ab und zu	Oft	Sehr oft

In den letzen 4 Wochen					Zur Zeit der schwersten Beschwerden			
nie/ selten	manch- mal	oft	fast immer	Empfanden Sie Energielosigkeit oder Verlangsamung in den Bewegungen oder im Denken.	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Waren Sie schwermütig oder niedergeschlagen.	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Hatten Sie das Gefühl, sich für nichts zu interessieren.	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Empfanden Sie Hoffnungslosigkeit angesichts der Zukunft.	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Hatten Sie das Gefühl, dass alles sehr anstrengend ist.	nie/ selten	manch- mal	oft	fast immer
nie/ selten	manch- mal	oft	fast immer	Hatten Sie das Gefühl, wertlos zu sein.	nie/ selten	manch- mal	oft	fast immer
				Empfanden Sie eine Verminderung Ihres Interesses oder Ihrer Freude an Sexualität.	nie/ selten	manch- mal	oft	fast immer
				Hatten Sie Gedanken, sich das Leben zu nehmen.	nie/ selten	manch- mal	oft	fast immer
				Neigten Sie zum Weinen.	nie/ selten	manch- mal	oft	fast immer
				Befürchteten Sie ertappt oder erwischt zu werden.	nie/ selten	manch- mal	oft	fast immer
				Machten Sie sich Selbstvorwürfe über bestimmte Dinge.	nie/ selten	manch- mal	oft	fast immer
				Erlebten Sie Einsamkeitsgefühle.	nie/ selten	manch- mal	oft	fast immer
				Hatten sie das Gefühl, sich zu viele Sorgen zu machen.	nie/ selten	manch- mal	oft	fast immer

gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter Niedergeschlagenheit?	gar nicht	etwas	stark	sehr stark
gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter Zweifeln und negativen Gedanken?	gar nicht	etwas	stark	sehr stark
gar nicht	etwas	stark	sehr stark	Wie sehr litten Sie unter Energie- und Antriebslosigkeit?	gar nicht	etwas	stark	sehr stark

In den letzen 4 Wochen						Zur Zeit der schwersten Beschwerden					
ja					nein	ja					nein
Haben sie angefangen einer der folgenden Substanzen zu Konsumieren oder haben Sie ihren Konsum merklich erhöht? Alkohol, LSD, Acid, Ecstasy, XTC, Angel's Dust, Koks, Kokain, Heroin, Schore, Downers, Grass, Marihuana, Pot, Hasch, Shit, Cannabis, Peace, Pola, Special-K, Vitamin K, Speed											
nie/ selten	manch- mal		oft		fast immer	nie/ selten	manch- mal		oft		fast immer
Haben Sie Alkohol getrunken oder Drogen eingenommen, als Versuch, mit ihren Beschwerden besser fertig zu werden.											

Wie lange haben Sie schon bzw. hatten Sie diese Probleme?

Monate	Jahre

Bitte kreuzen sie an, welche Antwort am besten für Sie zutrifft. Wählen Sie dabei das stärkste Ausmaß, in dem Sie die beschriebene Reaktion bisher erlebt haben.

Wenn ich an meine Beschwerden denke, bekomme ich Angst

Gar nicht	Kaum	Etwas	Stark	Sehr stark

Meine Beschwerden beunruhigen mich:

Gar nicht	Kaum	Etwas	Stark	Sehr stark

Meine Beschwerden zu verringern wäre für mich:

Unwichtig	Kaum wichtig	Etwas wichtig	Wichtig	Sehr wichtig

Haben Sie im Zusammenhang mit dem Ereignis und seinen Folgen jemals den Wunsch verspürt (egal ob Sie ihn umgesetzt haben oder nicht), durch eine kompetente, professionelle Person Rat oder Hilfe zu erhalten?:

Gar nicht	Ein wenig / Ab und zu	Deutlich / Oft	Stark / Immer wieder	Sehr stark / immer

Haben Sie im Zusammenhang mit dem Ereignis und seinen Folgen jemals den Entschluss gefasst (egal ob Sie ihn umgesetzt haben oder nicht), sich für Hilfe durch eine kompetente, professionelle Person zu holen?:

Nein gar nicht	Ja, aber eher halbherzig	Ja, ernsthaft	Ja, fest	Ja, sehr fest

Uns interessiert, wie sie die Möglichkeit professioneller Hilfe einschätzen. Bitte beantworten Sie die Fragen möglichst für den Zeitraum, in dem Sie noch keine Erfahrungen mit einem bestimmten Angebot gemacht hatten. Sollten Sie noch keine Erfahrungen gemacht haben, antworten Sie einfach Ihrer jetzigen Meinung nach.

Unter professionelle Hilfe fassen wir:

Ärzte und Ärztinnen

Psychologen und Psychologinnen bzw. Psychotherapeuten und Psychotherapeutinnen

Gesprächspartner und Gesprächspartnerinnen in Beratungsstellen

Gesprächspartner und Gesprächspartnerinnen am Krisentelefon bzw. einer telefonischen Beratung

Gesprächspartner und Gesprächspartnerinnen im Frauenhaus

Seelsorger und Seelsorgerinnen bzw. Pfarrer und Pfarrerinnen bzw. Priester.

Denken bzw. dachten Sie, dass eine der genannten Personen Ihnen im Umgang mit der erlebten Gewalt und ihren Folgen helfen könnte bzw. hätte helfen können?

Nein, gar nicht	Kaum	Im Großen und Ganzen	Ja	Ja, sehr

Waren bzw. sind Sie zuversichtlich, dass Sie durch fachgerechte Hilfe Erleichterung erfahren würden?

Nein, gar nicht	Kaum	Im Großen und Ganzen	Ja	Ja, sehr

Bitte kennzeichnen Sie die Person, von der Sie sich am ehesten erfolgreiche Hilfe erwarten bzw. erwartet hätten.

Arzt und Ärztin

Psychologe und Psychologin bzw. Psychotherapeut und Psychotherapeutin

Gesprächspartner und Gesprächspartnerin in Beratungsstellen

Gesprächspartner und Gesprächspartnerin am Krisentelephon bzw. einer telefonischen Beratung

Gesprächspartner und Gesprächspartnerin im Frauenhaus

Seelsorger und Seelsorgerin bzw. Pfarrer und Pfarrerin bzw. Priester

Unabhängig von Ihren genannten Erwartungen -

Gab es Zeiten, in denen Sie professionelle Hilfe begrüßt hätten?

Gar nicht	Selten	Ab und zu	Oft	Sehr oft

Haben Sie sich jemals dafür entschieden, Hilfe in Anspruch zu nehmen?

Nein gar nicht	Ja, aber eher halbherzig	Ja, ernsthaft	Ja, fest	Ja, sehr fest

Wussten Sie beim Entscheidungsprozess, wohin Sie gehen können, wenn Sie professionelle Hilfe in Anspruch nehmen wollen, oder hatten sie keine entsprechenden Informationen?

☐ wusste ich
☐ Ich hatte keine Informationen

Wie viele Stellen kennen bzw. kannten Sie, an die sie sich hätten wenden können? _____

Wie sehr stimmen Sie folgender Aussage zu?
Wenn ich gewollt hätte, hätte ich professionelle Hilfe in Anspruch nehmen können:

Gar nicht	Kaum	Etwas	Stark	Sehr stark

Hätten Sie es gerne gehabt, wenn eine Beraterin bzw. ein Berater Sie angerufen bzw. zu Ihnen nach Hause gekommen wäre?

Gar nicht gerne	Weniger gerne	Gerne	Sehr gerne

Im Folgenden möchten wir von Ihnen wissen, in welchem Umfang Sie sich durch die Folgen des Erlebten in verschiedenen Lebensbereichen beeinträchtigt fühlen bzw. gefühlt haben. Es geht dabei um Ihr persönliches Empfinden. Bitte beantworten Sie die Fragen für den Zeitraum, in dem sie sich am stärksten beeinträchtigt gefühlt haben.

Wie sehr fühlten Sie sich durch die Folgen des Erlebnisses bei Arbeit bzw. (Hoch-) Schule bzw. Ausbildung und Haushaltspflichten beeinträchtigt?

Gar Nicht	Kaum	Etwas	Stark	Sehr Stark

Wie sehr fühlten Sie sich durch die Folgen des Erlebnisses in ihren Beziehungen zu Freunden und Familienmitgliedern beeinträchtigt?

Gar Nicht	Kaum	Etwas	Stark	Sehr Stark

Wie sehr fühlten Sie sich durch die Folgen des Erlebnisses in ihrer Unterhaltung und ihren Freizeitaktivitäten beeinträchtigt?

Gar Nicht	Kaum	Etwas	Stark	Sehr Stark

Wie sehr fühlten Sie sich durch die Folgen des Erlebnisses in ihrer allgemeinen Lebenszufriedenheit beeinträchtigt?

Gar Nicht	Kaum	Etwas	Stark	Sehr Stark

Im folgenden Abschnitt werden wir Ihnen noch einmal Fragen zu dem von Ihnen erlebten Ereignis stellen.

Bitte beantworten Sie die folgenden Fragen FÜR DAS VON IHNEN AM SCHLIMMSTEN ERLEBTE EREIGNIS (wenn Sie nur eines der Ereignisse angekreuzt haben, ist mit „schlimmstes Erlebnis“ dieses Ereignis gemeint).

(Anmerkung: Diese Einschränkung mag von Ihnen verständlicherweise als unzureichend empfunden werden. Die Berücksichtigung mehrerer oder gar aller Ereignisse, würde jedoch den Rahmen dieses Fragebogens bei weitem sprengen. Zahlreiche Studien haben gezeigt, dass das am schlimmsten erlebte Ereignis auch die stärksten Folgen für den Betroffenen hat und daher die größte Bedeutung für das Verständnis seiner Reaktionen hat.)

Bitte kreuzen Sie für die folgenden Fragen JA oder NEIN an:

Während des schlimmsten Erlebnisses...

JA	NEIN	... wurden Sie körperlich verletzt?
JA	NEIN	... wurde jemand anders körperlich verletzt?
JA	NEIN	... dachten Sie, dass Ihr Leben in Gefahr war?
JA	NEIN	... dachten Sie, dass das Leben einer anderen Person in Gefahr war?
JA	NEIN	... fühlten Sie sich hilflos?
JA	NEIN	... hatten Sie starke Angst oder waren Sie voller Entsetzen?

Falls Sie verletzt wurden:

Bitte schätzen Sie die Schwere der Verletzung ein. Die angegebenen Beispiele sind dabei nicht verbindlich – schließlich kann jede Form der Verletzung unterschiedliche Ausmaße annehmen. Sie sollen lediglich als Orientierungshilfe für Sie dienen.

Leicht	mittel schwer	Schwer	sehr schwer
z.B. Abschürfungen, blaue Flecken	z.B. Prellungen, flache Schnitte, Verstauchungen, leichte Verbrennungen, leichte Blutungen	z.B. tiefere Schnitte, schwerere Verbrennungen, Muskelrisse, Knochenbrüche, Kopfverletzungen	mit Bedarf zur stationären Behandlung und / oder mit bleibenden Folgen

Bitte versuchen Sie, auf der folgenden Skala anzugeben, als wie schlimm sie das Ereignis erlebt haben. Natürlich kann es für eine solche Aussage keinen für alle gültigen Wert (wie eine Schulnote) geben. Antworten Sie daher einfach nach Ihrem eigenen Empfinden und orientieren Sie sich dabei an den vorgegebenen Extremen.

Auf der Skala entspricht:

1 es war eigentlich nicht so schlimm

10 es war extrem schlimm; ich kann mir nichts schlimmeres vorstellen

1	2	3	4	5	6	7	8	9	10

Im nächsten Abschnitt nennen wir einige Verhaltensweisen, die Menschen nach belastenden Ereignissen anwenden, um besser mit dem Erlebten und möglichen Folgen zurecht zu kommen.

Bitte geben Sie jeweils an, ob Sie diese Möglichkeit genutzt haben und wie hilfreich Sie sie fanden.

	genutzt	nicht-genutzt	wenn genutzt:			
1. Das Zusammensein mit Familienmitgliedern oder Freunden suchen			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
2. Mit Familienmitgliedern oder Freunden darüber sprechen			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
3. Sich von Freunden oder Familien-mitgliedern praktische Hilfe holen			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
4. Sich mit anderen Betroffenen austauschen			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
5. Selbsthilfematerialien verwenden (aus Zeitschriften, Büchern, Internet)			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
6. Sich ablenken – durch Freizeitaktivitäten, Arbeit...			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
7. Sich absichern – z.B. durch einen Selbstverteidigungskurs oder das Mitführen von Reizgas, durch das Vermeiden bestimmter Orte ...			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich
8. Sonstiges (außer professionelle Angebote) und zwar:			sehr hilfreich	hilfreich	wenig hilfreich	nicht hilfreich

Bitte beschreiben Sie gegebenenfalls diese „ sonstige Hilfe“ kurz:

_____

_____

Im Folgenden geht es um Reaktionen und Unterstützung von Familie, Freunden und Bekannten. Bitte geben Sie im Folgenden an, wie sehr die einzelnen Aussagen **auf Sie zutreffen bzw. wie sehr Sie Selbst den Aussagen zustimmen.**

Die meisten Menschen können nicht verstehen, was ich durchgemacht habe.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Irgendwie bin ich seit dem Vorfall nicht mehr „normales“ Mitglied der Gesellschaft.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Bekannten machen sich wegen meiner Beschwerden viele Sorgen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Familie findet meine Reaktion nach dem Vorfall übertrieben.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Die meisten Leute können sich nicht vorstellen, wie schwierig es ist, einfach ein „normales“ Alltagsleben fortzusetzen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Wenn ich verstimmt bin, zeigt sich meine Familie sehr besorgt.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meiner Familie ist es unangenehm, über meine Erfahrungen zu sprechen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Familie zeigte viel Verständnis für meine Verfassung nach dem Vorfall.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Freunde nahmen Anteil an meinen Erfahrungen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Die Reaktionen meiner Bekannten waren hilfreich.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

In den ersten Tagen nach dem Vorfall haben mir viele ihrer Hilfe angeboten.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Freunde haben immer gesagt, dass es ja alles nicht so schlimm sei.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Im nächsten Abschnitt geht es um verschiedene Auswirkungen, die das Erlebte und etwaige Folgebeschwerden auf das Leben der Betroffenen haben kann. Bitte geben Sie an, in wieweit diese Auswirkungen jemals auf Sie zutrafen.

Wie oft mussten Sie wegen der Folgen des Ereignisses ihrer Arbeit oder Ausbildung fern bleiben?

Gar Nicht	Selten 1 von 10 Tagen	Teilweise 2-3 von 10 Tagen	Oft 4-6 von 10 Tagen	Meistens 7-8 von 10 Tagen	Fast immer 9-10 von 10 Tagen

Wie oft haben Sie wegen des Ereignisse oder seiner Folgen auf die Ausübung von Aktivitäten oder Hobbys verzichtet?

Gar Nicht	Selten 1 von 10 Tagen	Teilweise 2-3 von 10 Tagen	Oft 4-6 von 10 Tagen	Meistens 7-8 von 10 Tagen	Fast immer 9-10 von 10 Tagen

Wie oft konnten Sie Verpflichtungen gegenüber Familie, Freunden oder Kameraden nicht voll nachkommen?

Gar Nicht	Selten 1 von 10 Tagen	Teilweise 2-3 von 10 Tagen	Oft 4-6 von 10 Tagen	Meistens 7-8 von 10 Tagen	Fast immer 9-10 von 10 Tagen

Sie kommen jetzt zum vorletzten Abschnitt des Fragebogens. In diesem geht es um konkrete Hilfsangebote und die von Ihnen tatsächlich in Anspruch genommene professionelle Hilfe.

Ich habe Informationen über Hilfsangebote per Flugzettel oder Postwurf erhalten.

Ja Nein

Ein professioneller Helfer hat mich angerufen, um mir Hilfe anzubieten.

Ja Nein

Ein Arzt, eine Ärztin, TherapeutIn, BeraterIn, oder Geistlicher hat mich von sich aus auf das Ereignis und seine Folgen angesprochen.

Ja Nein

Jemand aus meinem Bekanntenkreis, meiner Familie hat mir geraten, mit Hilfe zu suchen.

Ja Nein

Ein Freund oder eine Freundin hat mir beim Auffinden oder Aufsuchen eines Hilfsangebotes geholfen.

Ja Nein

Jemand hat verhindert, dass ich zu einem Hilfsangebote gehe.

Ja Nein

Ich habe schon einmal um Hilfe gebeten, aber keine erhalten.

Ja Nein

Ich habe Hilfe gesucht, habe aber kein passendes Hilfsangebot gefunden.

Ja Nein

Ich hätte zwar ein passendes Angebot gefunden, aber es war zu weit weg, zu kostspielig, zu zeitaufwendig oder anderweitig unerreichbar.

Ja Nein

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis professionelle Hilfe von einem Arzt oder einer Ärztin in Anspruch genommen?

Ja Nein

Wenn ja: Für welche Art von Problemen waren Sie beim Arzt bzw. bei der Ärztin? (auch Mehrfachnennung)

☐ für emotionale oder psychische Probleme

☐ für körperliche Beschwerden oder für Verletzungsfolgen

☐ für praktische Probleme

In etwa wie oft waren Sie in diesem Zusammenhang beim Arzt bzw. bei der Ärztin? _____

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Besuch und die Unterstützung des Arztes bzw. der Ärztin hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis professionelle Hilfe von einem Psychologen, einer Psychologin oder einem Psychotherapeuten bzw. einer Psychotherapeutin in Anspruch genommen?

Ja Nein

Wenn ja: Für welche Art von Problemen waren Sie bei einem Psychologen, einer Psychologin oder einem Psychotherapeuten bzw. einer Psychotherapeutin?

(auch Mehrfachnennung)

☐ für emotionale / psychische Probleme

☐ für praktische Probleme

In etwa wie oft waren Sie in diesem Zusammenhang bei einem Psychologen, einer Psychologin oder einem Psychotherapeuten bzw. einer Psychotherapeutin? _____

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Besuch und die Unterstützung des Psychologen, der Psychologin, des Psychotherapeuten, der Psychotherapeutin hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis professionelle Hilfe von einer Beratungsstelle in Anspruch genommen?

Ja Nein

Wenn ja: Für welche Art von Problemen waren Sie bei einer Beratungsstelle?
(auch Mehrfachnennung)

☐ für emotionale oder psychische Probleme
☐ für praktische Probleme

In etwa wie oft waren Sie in diesem Zusammenhang bei einer Beratungsstelle? _____

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Besuch und die Unterstützung der Beratungsstelle hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis professionelle Hilfe von einem Krisentelefon, Frauennotruf oder einer telefonischen Beratung in Anspruch genommen?

Ja Nein

Wenn ja: Für welche Art von Problemen haben Sie angerufen? (auch Mehrfachnennung)

☐ für emotionale oder psychische Probleme
☐ für praktische Probleme

In etwa wie oft haben Sie in diesem Zusammenhang angerufen? _____

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Anruf und die Unterstützung des Gesprächspartners bzw. der Gesprächspartnerin hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis professionelle Hilfe von einem Frauenhaus in Anspruch genommen?

Ja Nein

Wenn ja: In etwa wie oft waren Sie in diesem Zusammenhang in einem Frauenhaus? _____

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Besuch und die Unterstützung des Frauenhauses hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis Hilfe von einem Seelsorger, einer Seelsorgerin, einem Pfarrer, einer Pfarrerin oder einem Priester in Anspruch genommen?

Ja Nein

Wenn ja: Für welche Art von Problemen waren Sie bei einem Seelsorger, einer Seelsorgerin, einem Pfarrer, einer Pfarrerin oder einem Priester?

(auch Mehrfachnennung)

☐ für emotionale oder psychische Probleme

☐ für praktische Probleme

In etwa wie oft waren Sie in diesem Zusammenhang bei einem Seelsorger, einer Seelsorgerin, einem Pfarrer, einer Pfarrerin oder einem Priester? _____

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Besuch und die Unterstützung des Seelsorgers, der Seelsorgerin, des Pfarrer, der Pfarrerin oder des Priester hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Haben Sie im Zusammenhang mit dem von ihnen als am schlimmsten erlebten Ereignis professionelle Hilfe von einem anderen Angebot genommen?

Ja Nein

Bitte beschreiben Sie es kurz:

_____
_____
_____
_____

Wenn ja: Für welche Art von Problemen waren Sie dort?
(auch Mehrfachnennung)

☐ für emotionale oder psychische Probleme
☐ für praktische Probleme

In etwa wie oft waren Sie in diesem Zusammenhang dort?

Wie lange lag das Ereignis beim ersten Besuch zurück?

Monate	Jahre

Fanden Sie den Besuch und die Unterstützung des Angebotes hilfreich?

Nicht hilfreich	Wenig hilfreich	Hilfreich	Sehr hilfreich

Dies ist der letzte Abschnitt der Befragung. Bitte nehmen Sie sich die Zeit, auch diesen noch sorgfältig zu bearbeiten – er ist elementar für die Ergebnisse der Studie.

Der Abschnitt umfasst eine bunte Mischung aus Fragen zu verschiedenen Themen. Wundern Sie sich nicht, wenn Ihnen Fragen wie eine Wiederholdung vorheriger Fragen erscheinen, sondern beantworten Sie jede Frage möglichst unabhängig von den anderen. Geben Sie für jede Frage an, inwieweit sie Ihr zustimmen.

Falls sie bereits professionelle Hilfe in Anspruch genommen haben:

Soweit es Ihnen möglich ist, geben Sie bitte an, inwieweit die folgenden Aussagen auf Sie zutrafen, bevor Sie Kontakt zu professionellen Helfern hatten. Wir wissen, dass es schwierig ist, sich an solche Dinge zu erinnern – im Zweifelsfall antworten Sie einfach so, wie sie die Aussagen jetzt sehen.

Psychische Probleme zu haben, ist beschämend.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich kann mir professionelle Hilfe **nicht** leisten.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Jeder erwachsene Mensch sollte versuchen, mit seinen Problemen alleine fertig zu werden.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich bin besorgt, dass der mögliche Helfer mich nicht versteht.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich will grundsätzlich keine professionelle Hilfe.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Das Ereignis passierte Aufgrund der Art und Weise, wie ich mich verhalten habe.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich kann mich auf andere Menschen **nicht** verlassen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Es gibt Probleme, die nicht außerhalb des engen Familienkreises diskutiert werden sollten.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich werde nicht einmal mit der kleinsten Widrigkeit fertig.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Die Haltung einer Person, die bereit ist, mit ihren Konflikten und Ängsten alleine fertig zu werden, ohne auf professionelle Hilfe zurückzugreifen, hat etwas Bewundernswertes.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Anbieter professioneller Hilfe sind zu weit entfernt oder zu schwer zu erreichen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich würde lieber mit bestimmten Problemen leben, als professionelle Hilfe in Anspruch zu nehmen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Es ist sehr beschämend, mit jemandem über ein solches Erlebnis und damit zusammenhängende Probleme zu reden.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Erinnerungen und Beschwerden werden von selbst vorüber gehen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Meine Reaktion zeigt, dass mit mir etwas nicht stimmt.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ein professioneller Helfer würde mich **niemals** über irgend etwas täuschen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Jemand anderes hätte verhindert, dass das Ereignis passiert.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Solche Hilfe in Anspruch genommen zu haben, hinterlässt einen Makel im Leben.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Wie viele Dinge neigen auch emotionale Probleme dazu, sich selbst zu lösen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich habe keine Zeit, professionelle Hilfe in Anspruch zu nehmen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich werde nie mehr normale Gefühle empfinden können.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich fürchte, dass mögliche Helfer mir misstrauen oder mir Vorwürfe machen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich würde einer angemessenen Person bereitwillig intime Dinge anvertrauen, wenn ich denken würde, dass es mir helfen kann.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Andere Menschen sind nicht so, wie sie zu sein scheinen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich würde mich unwohl dabei fühlen, professionelle Hilfe in Anspruch zu nehmen – was würden die Leute über mich denken.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Den meisten Menschen mit seelischen Problemen fehlt es eigentlich nur an Willenskraft und festen Prinzipien.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich vertraue vollkommen den Entscheidungen professioneller Helfer, welche Hilfe am besten für mich ist.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich finde, man sollte stark genug sein, um ohne fremde Hilfe zurecht zu kommen.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Unerwünschte Gedanken, übermäßige Nervosität oder ständige Traurigkeit sind
ein Zeichen dafür, dass man verrückt wird.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

Ich empfinde das Ereignis als Gesprächsthema als sehr beschämend.

Überhaupt nicht	Kaum	Ein wenig	Ziemlich	Genau	Ganz genau

HERZLICHEN DANK FÜR IHRE TEILNAHME!

Da es verschiedene Arten gibt, an einer Umfrage teilzunehmen, wählen Sie bitte eine der folgenden Möglichkeiten :

Ich habe mich nur durch die Fragen hindurchgeklickt.

Ich habe alle Fragen nach bestem Wissen beantwortet.

Ich habe gemerkt, dass es mir zuviel wurde und ich nur noch fertig werden wollte.

Appendix C Letter for the participants of the online study

Sehr geehrte Teilnehmerin, sehr geehrter Teilnehmer,

Sie haben an meiner Umfrage zur Bewältigung belastender Erfahrungen teilgenommen und waren an einer Rückmeldung zu Ihren Angaben interessiert.
Ich habe Ihre Daten gesichtet und möchte Ihnen hiermit die gewünschte Rückmeldung geben.
Ich bitte Sie zu beachten, dass sich diese lediglich auf die von Ihnen gemachten Angaben bezieht und – da ich Sie nicht persönlich kenne – natürlich keine fachliche Meinung von Angesicht zu Angesicht ersetzen kann.

[…]

Abschließend habe ich noch eine Bitte an Sie. Zusätzlich zu meinen Befunde und Interpretation wäre es eine wertvolle Ergänzung, wenn Sie noch ein wenig Zeit finden würden, um mir Ihre persönliche Meinung mitzuteilen:

Was hätte es Ihnen leichter gemacht, sich nach dem Erlebten professionelle Hilfe zu suchen?
Was glauben Sie, würde es anderen Betroffenen leichter machen, Hilfe zu suchen?

Auf Rückfragen antworte ich gerne und schnellst möglich.

Nochmals vielen Dank!
Viola Schreiber

Appendix D Letter for the professionals

Guten Tag,
ich bin Diplom Psychologin und arbeite wissenschaftlich und therapeutisch mit Schwerpunkt im Bereich psychische Traumatisierung. Ich schreibe eine Doktorarbeit an der Freien Universität Berlin (betreut durch Prof. Babette Renneberg von der Freien Universität Berlin und Prof. Andreas Maercker von der Universität Zürich) zur Inanspruchnahme psychosozialer Hilfe nach Traumatisierung abgeschlossen. Im Rahmen dieser Arbeit habe ich im Oktober eine Befragung Betroffener abgeschlossen.
Ich würde diese quantitativen Ergebnisse gerne um Wissen, Ideen und Meinungen Betroffener (Traumatisierter und Helfer) erweitern. Ich werde diese dann qualitativ auswerten und die Ergebnisse in relevanten Fachzeitschriften veröffentlichen.

Dafür würde ich Sie bitten, mir Ihre Erfahrungen und Gedanken zu den folgenden zwei Frage per e-mail zurück zu senden.

> Was denken Sie, würde es Menschen nach belastenden / traumatischen Erfahrungen (insbesondere interpersoneller Gewalt) leichter machen, Kontakt zu einem professionellen Helfer herzustellen bzw. professionelle Hilfe zu erhalten?
>
> Anders ausgedrückt, was müsste sich im System, in der Gesellschaft, im Denken.... ändern und gegebenenfalls wie könnte dies geschehen, damit Barrieren zwischen Traumatisierten und Helfern abgebaut werden?

Die Antworten können von einer Person kommt oder aus einem Brain Storming in Ihrem Team. Sie können auch stichwortartig antworten.

Auf Rückfragen antworte ich gerne und schnellst möglich.
Für Ihre Unterstützung danke ich Ihnen,
Viola Schreiber

Appendix E Sample of an open answer (traumatized responent)

Gerne komme ich Ihrer Bitte nach, auch Ihre beiden Fragen
Was hätte es Ihnen leichter gemacht, sich nach dem Erlebten professionelle Hilfe zu suchen?
Was glauben Sie, würde es anderen Betroffenen leichter machen, Hilfe zu suchen?
zu beantworten.

Für mich persönlich wäre es sicher leichter und einfacher gewesen, Hilfe zu suchen, wenn die in der Gesellschaft leider immer noch großflächig vorhandene Skepsis bzw. dieser "negative Touch" dazu nicht oder nicht in dem Ausmaß gegeben wäre. Erschwert wurde das Ganze bei mir sicher auch durch mein Naturell bzw. meine Persönlichkeit und die Tatsache, dass ich sonst immer alles alleine "auf die Kette" gekriegt habe. Ganz frei gesagt, so nach dem Motto: "...ICH zum Psychiater/Psychologen? ICH???... Nee, Quatsch! Ich bin doch nicht bekloppt?!!!..." Ich hatte mich vorher nie mit solchen Fragen oder Problemen beschäftigen müssen und wollte es auch nicht. Dann musste ich das allerdings. Und habe nur durch Zufall und viel Eigeninitiative erstmalig gehört, dass es so etwas wie Traumatherapie gibt... Im Nachhinein hätte ich mir gewünscht, dass mir irgend jemand in der langen, schweren Zeit vorher davon berichtet hätte, so hätte ich fast ein ganzes wertvolles Jahr gewonnen! Fazit, auch für alle anderen und/oder zukünftig Betroffenen: Meiner Meinung nach wäre es superwichtig, dass diese Problematik und Thematik viel offener diskutiert und zugänglich gemacht wird - hier ist massive Aufklärungs- und Öffentlichkeitsarbeit gefordert!!! Insbesondere an prägnanten Stellen wie Arztpraxen, Krankenhäusern und/oder Rehakliniken, die ja zumeist die allerersten "Auffangstationen" für traumatisierte Patienten sein dürften.

Hier besteht nach meinem Empfinden ein wirklich großer Handlungsbedarf und ich hoffe sehr, dass auch durch Arbeiten wie Ihre ein großer Schritt nach vorne bewegt wird - vielen Dank dafür!

Ich freue mich, wieder von Ihnen zu hören und wünsche Ihnen weiterhin viel Erfolg bei Ihrer wertvollen Arbeit :-)

Herzliche Grüße

Appendix F German summary

Zusammenfassung

Interpersonelle Traumatisierung führt bei den Betroffenen oft zu jahrelangen psychischen Problemen und Folgeerkrankungen; insbesondere zu posttraumatischer Belastungsstörung (PTBS) und Depression. Obgleich für diese Probleme effektive Hilfsangebote und Behandlungsansätze existieren, nimmt die Mehrheit der Betroffenen keine professionelle Hilfe in Anspruch. Um das Verständnis für ihre Nichtinanspruchnahme zu vertiefen, wurde in dieser Dissertation – unter Integration von Theorien zum Gesundheitsverhalten und empirischen Studien zum Inanspruchnahmeverhalten Traumatisierter – ein Modell entwickelt, das den Prozess beschreibt, den ein Betroffener von der Traumatisierung bis zur Inanspruchnahme durchläuft. Dieses Modell gliedert den Prozess des Hilfesuchens in 4 aufeinander aufbauende Phasen: (1) der Herausbildung einer intrapsychischen Repräsentation der erfahrenen Traumatisierung, (2) der Entstehung eines Wunsches nach professioneller Hilfe für das repräsentierte Problem, (3) der Intentionsbildung, tatsächlich Hilfe aufzusuchen und (4) der Umsetzung der Intention. Jeder dieser Phasenübergänge wird von spezifischen Variablen beeinflusst.

(1) Die Repräsentation der Traumatisierung wird geprägt durch das dem Betroffenen verfügbare Wissen über Traumata und ihre Folgen (*Traumawissen*) sowie die Wahrnehmung der Traumatisierung und deren Kommunikation durch seine Umwelt (s*oziale Referenz*).

(2) Die Entstehung eines Wunsches nach professioneller Hilfe wird beeinflusst durch die erhaltene und angenommene *soziale Unterstützung*, die *kognitive Verfügbarkeit* professioneller Hilfe als Bewältigungsoption, die *Einstellung* des Betroffenen zum Hilfesuchen (wie etwa seine Angst vor Stigmatisierung), *posttraumatisches Vermeidungsverhalten* im Sinne der PTBS sowie die *Beschädigung des interpersonellen Vertrauen*s durch die Traumatisierung.

(3) Die Intentionsbildung hängt ab von der *Machbarkeitseinschätzung* des Hilfesuchens, von der Erwartung, durch professionelle Hilfe eine Problemreduktion zu erreichen (*Erfolgserwartung*), von Gefühlen von *Scham und Schuld* sowie von der Art der *Beziehung zum Täter* (z.B. Partner, Familienmitglied, Fremder).

(4) Für die Umsetzung der Intention bedeutsam sind die *strukturbedingten Barrieren*, denen sich der Betroffene auf der Suche nach Hilfe gegenüber sieht, seine *Kenntnisse*

von Hilfsanbietern und die *Intervention Dritter*, welche seine Suche nach Hilfe unterstützen oder behindern können.

Hinzu kommen phasenunspezifische, übergeordnete Variablen: der s*oziodemographische Hintergrund*, die *Kenntnisse zum Thema psychische Gesundheit* sowie die vorangehenden *Erfahrungen* mit der Suche und Inanspruchnahme von professioneller Hilfe.

Dieses Modell wurde in zwei Studien empirisch getestet. Die erste Studie basierte auf der regressionsanalytischen Auswertung der Daten von 115 Überlebenden interpersoneller Traumatisierung, die bei einer Online-Befragung gesammelt wurden. In dieser Studie wurde die Bedeutung der Variablen der vertikalen Achse des Modells (Traumatisierung, Problemrepräsentanz, Wunsch nach Behandlung, Behandlungsintention) für die Suche nach Hilfe bestätigt. Zudem waren folgende Einflussvariablen signifikante Prädiktoren der jeweiligen Phasenübergänge: *soziale Referenz, soziale Unterstützung*, *Einstellung zum Hilfesuchen*, *Beschädigung des interpersonellen Vertrauens*, *Erfolgserwartung*, *Beziehung zum Täter, strukturbedingte Barrieren* und *Intervention Dritter.* Aufgrund der relativ geringen Zahl auswertbarer Datensätze war kein Test der Gesamtstruktur des Modells möglich. Es bleibt damit ungeprüft, ob eine andere Modellstruktur die Datenstruktur treffender wiedergegeben hätte. Auch bedurfte die Nicht-Signifikanz der übrigen Einflussvariablen weiterer Klärung.

Die zweite Studie untersuchte vertiefend die Bedeutung der Einflussvariablen des Modells. Ergänzend zum quantitativen Vorgehen in Studie eins wurden freie Antworten von 43 Teilnehmern der ersten Studie sowie sechzehn professionellen Helfern (Psychotherapeuten und Mittarbeiter von Beratungsstellen und Telefonseelsorge) inhaltsanalytisch ausgewertet. Basierend auf ihrer eigenen Erfahrung antworteten die Teilnehmer auf die Frage: „Was denken Sie, würde es Menschen nach belastenden / traumatischen Erfahrungen (insbesondere interpersoneller Gewalt) leichter machen, Kontakt zu einem professionellen Helfer herzustellen bzw. professionelle Hilfe zu erhalten?“. Alle im Modell angelegten Einflussvariablen wurden auch von den Teilnehmern als relevante Größen genannt. Nicht im Modell enthalten war die Variable: *Verleugnung*, welche sich in der Inhaltsanalyse als Einflussvariable auf den ersten Phasenübergang – d.h. die Problemrepräsentation – abbildete. Aus der Inhaltsanalyse leitete sich weiterhin die Unterscheidung zwischen der bereits im Modell formulierten individuellen Ebene und einer Systemebene aus *Faktoren des Hilfssystems*, *Einstellungen in der Gesellschaft* und *öffentlichem Wissen* ab. Diese Systemebene integrierte die phasenunspezifischen Variablen *soziodemographischer*

Hintergrund sowie *Kenntnisse zum Thema psychischer Gesundheit*. Die Variable *Erfahrungen* mit professioneller Hilfe erhielt im überarbeiteten Modell eine klarere Position als Feedbackvariable.

Die bis zu diesem Punkt erfolgte Modellentwicklung war nicht nur auf die Erarbeitung eines Erklärungs- und Forschungsmodells ausgelegt, sondern auch darauf, Ansatzpunkte für Maßnahmen zur Verbesserung des Zugangs Betroffener zum Versorgungssystem aufzuzeigen. Zu diesem Zweck wurde modellbasiert eine Matrix abgeleitet, in der die vier Phasenübergänge und drei Systemvariablen die möglichen Ansatzfelder aufspannen. Geleitet von dieser Matrix wurden die freien Antworten abschließend noch einer zweiten Auswertung unterzogen. Diese ergab sowohl ansatzfeldspezifische als auch feldübergreifende Strategien und Maßnahmen welche vielfach durch die Anbieter professioneller Hilfe umgesetzt werden können – beispielsweise Vernetzung mit Polizei, Sozialämtern, Krankenhäusern. Oft erfordern die vorgeschlagenen Strategien jedoch ein aufeinander abgestimmtes Vorgehen unter Einbezug weiterer Agenten wie politischer Entscheider oder der Medien.

Das in dieser Arbeit entwickelte Modell besitzt das Potential, quantitative wie auch qualtiative Daten abzubilden und eine Grundlage für Entwicklung und Planung von Strategien zur Verbesserung der Versorgungslage bereit zu stellen. Der Arbeit schafft somit eine Basis sowohl für theoretisch fundierte Grundlagenarbeit als auch für Interventionsenwicklung und –forschung.

Appendix G Publications based on the thesis

Artikel	2009	Schreiber, V., Renneberg, B., & Maercker, A. (2009) Seeking Psychosocial Care after Interpersonal Violence: An Integrative Model. Victims and Violence, 24(3)
	submitted	Schreiber, V., Renneberg, B.& Maercker, A. (submitted) Help-seeking behavior in a traumatized sample: Testing an integrative model of seeking psychosocial care. BMC Public Health
	submitted	Schreiber, V., Renneberg, B.& Maercker, A. (submitted) Interpersonal traumatization: What keeps survivors from seeking psychosocial help? BMC Public Health
	submitted	Schreiber, V., Maercker, A. & Renneberg, B. (submitted) Improving access to care – measures facilitating seeking professional help after interpersonal violence International Journal of Mental Health Systems
Poster	2007	Schreiber, V., Maercker, A., & Renneberg, B. (2007) Traumatisierung und Inanspruchnahme psychosozialer Hilfe. 5. Workshopkongress für Klinische Psychologie und Psychotherapie, Tübingen
	2008	Schreiber, V., Renneberg, B., & Maercker, A. (2008) Ein integratives Modell der Inanspruchnahme psychosozialer Hilfe nach interpersoneller Traumatisierung. 10. Jahrestagung der DeGPT, Basel
	2008	Schreiber, V., Renneberg, B., & Maercker, A. (2008) Mental health help-seeking after interpersonal violence: An integrative model. XXIX International Congress of Psychology, Berlin

Appendix H Curriculum Vitae

Der Lebenslauf ist in der Online-Version aus Gründen des Datenschutzes nicht enthalten.

Erklärung

Hiermit versichere ich, dass ich die vorgelegte Arbeit selbständig verfasst habe. Andere als die angegebenen Hilfsmittel habe ich nicht verwendet.

Die Arbeit ist in keinem früheren Promotionsverfahren angenommen oder abgelehnt worden.

10.Oktober 2009

Viola Schreiber