

## **Shame, Fear, and Stigma: Understanding Psychosocial Barriers to Help Seeking Behavior among Female Survivors of IPV in Nairobi County**

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### **Abstract**

*In Kenya, and particularly in urban contexts like Nairobi, many women continue to experience Intimate Partner Violence (IPV) yet remain silent or reluctant to seek help. However, help seeking rates among female survivors remain low. This paradox points to deep-rooted psychosocial barriers that point to shame, fear, and stigma. This study sought to identify internal barriers to help seeking behavior among women survivors of IPV. Conducted in one of the hospitals in Nairobi County that provides psychosocial support, this study employed the modified survivor theory as developed by developed by Gondolf and Fisher (1988). The study purposively sampled 390 women survivors and 12 key informants who responded to survey using the 1996 Revised Conflict Tactics Scales-2 (CTS2) and interview guide respectively. A mixed-methods research approach was adopted, integrating both quantitative and qualitative data collection techniques. The positivist philosophy informed the quantitative strand, while the interpretivist philosophy guided the qualitative component. A convergent parallel mixed-methods design was used for data collection and analysis simultaneously. The study findings indicated that internal barriers such as confusion ( $M = 2.342$ ,  $SD = 0.565$ ), shame ( $M = 2.286$ ,  $SD = 0.524$ ) and the fear to be tagged weak ( $M = 2.182$ ,  $SD = 0.324$ ) significantly hindered survivors' help seeking behavior. The qualitative findings depicting personal barriers and family dynamics complemented the quantitative results. The study recommends strengthening survivor-centered services and increasing community awareness to reduce barriers and promote recovery among women survivors.*

**Keywords:** Intimate partner violence, Gender based violence, psychosocial support, internal barriers, stigma

### **Introduction**

Violence against women (VAW), and in particular intimate partner violence (IPV), is a widespread social issue and solemn public health problem (Hellmuth et al., 2014). The term IPV is frequently used to refer to abuse that is committed by a former or current partner, de facto (Swaine, 2018). Intimate Partner violence has constantly become a major issue globally,

particularly in connection to its link with negative health and demographic outcomes (Potter et al., 2020). Intimate partner violence includes sexual violence, physical violence, psychological aggression and stalking by a former or current spouse (Chilanga et al., 2020).

Women subjected to IPV are significantly more probable to report adverse health outcomes such as physical injury, which occurs in 19% to 55% of cases globally, obstetric or gynecological problems such as infections, unwanted pregnancies, and pelvic pain, and adverse pregnancy results like premature labor, low birth weight, miscarriages and fetal distress (McLindon, 2020). In addition, women who have experienced IPV have a high chance of experiencing psychological problems like post-traumatic distress disorder, depression, substance abuse, and suicide attempts (Stewart & Vigod, 2017). However, these physical and mental health implications are reduced by the behavior of looking for help among IPV survivors. Therefore, understanding the behavior of seeking help among female survivors is considered a key step in the healing and recovery process of IPV victims (Ahmadabadi et al., 2020).

Help seeking can be both through formal and informal sources. Formal behavior of seeking help includes seeking help from a psychologist, doctors, counsellors, social workers, lawyers and police, among others, while the behavior of pursuing informal assistance includes getting support from relatives, neighbors, friends, peers and online resources, among others (Malihi et al., 2021). The behavior of seeking help for IPV is distinctly different across developing countries despite the high prevalence of IPV globally. For example, only approximately 35% of IPV victims engaged in help seeking behavior in a study conducted among 31 developing nations. Nearly all the victims who sought help used informal sources, with family members accounting for about 64%. Only 4% of the victims sought help from formal sources (Goodson & Hayes, 2018). Of the country with the highest percentage of victims who seek help, Sierra Leone had the largest (61.20%), while the lowest proportion (17.60%) of survivors looking for help was reported in Mali (Goodson & Hayes, 2018). Only (23.7%) of women survivors of IPV in married relationship were reported to seek help in India. Those who sought help from formal institutions accounted for 1% (Leonardsson & Sebastian, 2017). In Ethiopia, the behavior of seeking help among married women subjected to IPV was between 19.8% to 22.5%, of which less than 10% sought help from formal sources (Handebo et al., 2021; Muluneh et al., 2021).

Indeed, studies demonstrate that despite the reported experiences of IPV in Kenya, women are likely to seek for help only when IPV appears to be severe. For instance, based on the Kenya Demographic and Health survey (KDHS) (KNBS, 2014), over half of the survivors of IPV that seek help suffer from physical violence. This points to the likelihood of forms of IPV as a determinant to help seeking in the Kenyan context. However, given that help seeking behavior occurs in formal and informal contexts it is important to understand how forms of IPV affect help seeking in these contexts. The existing research in Kenya largely ignores this context thereby limiting the richness and depth of internal and external help seeking barriers. To address these critical knowledge gaps, this study sought to investigate the internal barriers also referred to in this study as psychosocial factors impeding help seeking behavior in women survivors of IPV in Nairobi County, Kenya.

Notably, the service sector linked to IPV operates on the survivor-driven, voluntary model, where survivors can choose to participate at the level and the duration of services that works for them. Resultantly, considering the barriers that may limit the survivors' decisions to engage IPV services is critical to creating equity in providing and accessing services (Semahegn et al., 2019). The decision not to seek help among the women survivors of IPV may be influenced by different reasons globally. For instance, in China (Hu et al., 2020) suggest that barriers to help seeking behaviors are belief in the ability to handle the situation, lack of awareness of sources

of help, the severity of the violence, negative attitude towards seeking help, shame or stigma and control by partners. Amongst the Black, Asian, minority ethnic and immigrant women communities worldwide, women are seen as experiencing barriers that broadly fall under cultural/religious norms and values, immigration and service challenges (Hulley et al., 2022).

Zhang et al. (2019) document that barriers relating to the help seeking behavior of IPV survivors range from survivor demographic characteristics, access challenges, lack of awareness, disclosure consequences, children's well-being, lack of material support/resources, perceived stigma, system failures and personal barriers. Furthermore, Robinson et al. (2020) assert that the decision of survivors to look for support for IPV may be limited by external and internal barriers. Finally, in so far as internal barriers are concerned, Thorvaldsdottir and Halldorsdottir (2022) suggest that these factors relate to individual factors.

The Kenyan Government has ratified several policies and laws for response to and prevention of IPV in the nation. Key among these are the 2006 Sexual Offences Act, the 2010 Constitution of Kenya, the 2001 Children's Act, the 2009 Penal Code, the Prohibition of Female Genital Mutilation Act (2011), and the National Gender and Equality Commission Act (2011) (Kenya National Bureau of Statistics ((KNBS), 2014). In addition, the national policy for prevention and response to gender-based violence in the country (Republic of Kenya, 2014). With existing interventions aimed to enhance survivor support through legal frameworks, awareness campaigns, and the establishment of gender-based violence (GBV) recovery centres, these services are still underutilized. This raises the critical question about the underlying factors hindering women's help seeking behavior some of which this paper addresses.

## **Theoretical Underpinning**

### ***Modified Survivor Theory***

The Survivor theory was developed by Gondolf and Fisher (1988) as a substitute for learnt helplessness. Based on the learnt helplessness approach, as violence victims, women seem to 'give up' when abused (Noelle et al., 2016). As such, they experience psychological paralysis, which subjects them to numerous psychological and physical issues. Women displaying learnt helplessness tend to have self-blame, low self-esteem, depression and guilt. They are also unable to get assistance for their challenges.

On the other hand, the Survivor theory posits that as victims of abuse, women are active survivors rather than helpless victims (Gondolf & Fisher, 1988) cited by Noelle et al. (2016). These women, therefore, actively seek assistance after being subjected to violence. Generally, the level of help seeking in these women is directly proportional to the degree of violence they experience (Waller et al., 2022). Women subjected to violence often seek aid from relatives, friends, community members or self-induced help through faith and spirituality. This survival tendency is not merely an issue for women seeking to assert themselves but for self-transcendence (Dowuona-Hammond et al., 2020). Nevertheless, instead of using the deficit lens to understand survivors, the theory focuses on how barriers limit the individuals in seeking help. Although the theory is important in hypothesizing the obstacles to the behavior of seeking support, barriers are limited to the individual and interpersonal levels, so there is little opportunity to examine how broader social systems structure women's decisions.

## **Literature Review**

Sociocultural and interpersonal influences like class, gender, and cultural aspects also play a significant role for women who have been abused when seeking assistance from family, friends, or other external parties. For instance, the strong emphasis on fear of divorce, family privacy and roles of gender in the African and Asian traditions, which elevate the social status of men, also prevent most women from seeking for assistance outside the family, even when IPV is viewed as a problematic issue. The desire of abused women to look for help can also be determined by their previous experiences, both indirect and direct, with family, friends and formal services (Schrag et al., 2020).

The love for their partners is one of the reasons why IPV survivors fail to seek help. The main explanation is that spousal love compels the survivor to persevere and preserve the relationship in the hope that things will change. Children's issues are considered both a facilitator and a barrier to individuals seeking help due to the fear of being separated from the children and not being with them anymore or losing custody (Lacey et al., 2020). Women may remain in abusive relationships because of their children and particularly the younger ones. The shared goals of women are that children benefit through good education, possess a better future, and their life is much happier in an intact family. Attaining the household goals will also be threatened because of the father's absence and diminished income. Consequently, women with children find it more difficult to leave abusive relationships. The women may also feel that they cannot support their children on their own thus fear for their well-being and safety. While women are accused of separating their children from their fathers or destroying family relations through breakups, they can decide to escape abusive relationships to protect the children (Lacey et al., 2020).

Regarding education, victims with a high education level seek more help than those with low education. However, some studies show the opposite. To explain those discrepancies, several authors demonstrate that the influence of education depends on the type of help seeking. A higher education level is associated with formal help seeking and a lower education level with informal help seeking (Issahaku, 2017; Jethá et al., 2020). Moreover, participants with a high education level seek more help from legal services because they have a better knowledge of their rights (Lacey et al., 2020).

Muuo et al. (2020) identified several barriers to the help seeking behavior of IPV survivors in Dadaab refugee complex. The authors identified the barriers of stigma by family and the community, fear of further violence from perpetrators, feelings of helplessness and insecurity, and being denied entry to service provision premises by guards. Hu et al. (2020) in their study demonstrated that the main reasons for not seeking help among IPV survivors in China include the belief that they could handle the situation by themselves, not knowing to whom they could turn for help, and the belief that the violence experienced was not severe.

A systematic review of barriers to IPV amongst immigrants in the USA revealed several barriers that include: socio-demographic variables and violence characteristics; social isolation and lack of family support; cultural and religious barriers; language and financial barriers; little awareness of available resources; limited use and perceived inefficiency of services; fear of being deported and separated from their children, and psychological barriers (Cuesta-García & Crespo, 2022).

Internal barriers to help seeking behavior has been the subject for many scholars (Robinson et al., 2020; Schrag et al., 2020). For instance, a study conducted in Iran identified six factors that limit the help seeking behavior of IPV survivors self-blame, powerlessness, hopelessness, the need to protect family, and the need to keep such abuse secret from others (Taherkhani et al., 2017). Secrecy was mentioned as a barrier to help seeking for both younger and older women with older women being more reluctant as this would mean discussing private family matters with outsiders. In some cases, hopelessness is reported as a barrier for older women or those who have stayed in abusive relationships for a long time. Finally, family protection is mentioned as a barrier due to the fear that financial support to children will stop or the fear that disclosing the IPV situation may disrupt the relationship between women and adult children due to the length of the marriage (Robinson et al., 2020).

A qualitative study done on understanding the process of help seeking in the Netherlands reported a lack of awareness of the impact of abuse on themselves and fear for their partners as problems that affect help seeking decision of IPV survivors (Prosman et al., 2014). Inhibitive thoughts by women IPV survivors in viewing help seeking behavior as a personal weakness has been cited as a problem (Winter et al., 2020).

Extant literature also points to the role of sociodemographic barriers in help seeking. As regards age, some authors agree that younger victims seek more help than older ones and that older age is associated with a longer delay of disclosure (Anderson & Overby, 2020; Apatinga & Tenkorang, 2021). In a qualitative study on women in Zimbabwe, Chadambuka and Warria, (2021) show that these women are more reluctant to talk about violence than younger women because they think that they will not be trusted and will feel uncomfortable and ridiculous. On the contrary, other studies highlight that older people seek more help (Cuesta-García & Crespo, 2022; Heron & Browne, 2021).

## **Methods**

This study used mixed methods approach to help generate data from IPV survivors and key informants at a selected hospital in Nairobi County to comprehensively address its objective. Convergent parallel research design (also referred to as the 'concurrent' design or the 'concurrent triangulation' design), which involves simultaneously collecting quantitative and qualitative data was employed (Creswell & Creswell, 2017). Using both qualitative and quantitative methods enhanced the findings generated through quantitative data collection methods. For instance, the semi-structured interviews with the key informants improved the causal inferences drawn from the survey with IPV survivors.

This study adopted the pragmatic research philosophy, which focuses on addressing real-world problems through context-appropriate methodologies. Pragmatism aligns with the study's objective by emphasizing practical solutions to understanding barriers to help seeking behavior among survivors of intimate partner violence (IPV). The study population constituted 65,000 GBV women survivors residing in Nairobi County and in a sexual heterosexual relationship for at least two years.

Choosing a sample involves using a sampling procedure (Creswell & Creswell, 2017). This study employed stratified sampling techniques, which are based on the usage of strata, or subsets of the population that have at least one thing in common (Kothari & Garg, 2023). Stratified sampling involved dividing the population into distinct subgroups (or strata) based

on certain characteristics including the type of violence experienced. The sample size was determined using Yamane (1967) formula with a 5% margin error.

$$n = \frac{N}{1 + N(e)^2}$$

Where:

E = error margin (a 5% error margin is acceptable in the research).

$$N = 65,000/1+65,000(0.05^2) = 65,000/163.5 = 397$$

From the formula, a sample size of 390 was drawn. In addition, purposive sampling was used to select 12 key informants.

A socio-demographic questionnaire (SDQ) was developed to collect data relating to respondents' background with the 2020 modified version of Barriers to Help seeking for trauma scale used to assess internal barriers. More so, interview guide was used to gather data from the key informants at the hospital results of which are presented in the next section.

## **Results**

This study purposed to examine psychosocial or internal barriers to help seeking by women survivors of IPV. Some of the identified factors included shame, weakness, confusion, and problem management belief influence their willingness to seek help at GBV centres in Nairobi County. Understanding these psychological hurdles is essential because addressing them can significantly improve survivors' engagement with available services.

### ***Descriptive statistics***

A descriptive analysis was performed on four internal barrier constructs thus Weakness, Problem Management Belief (PMB), Confused, and Shame to determine their overall levels and relative dispersion among women survivors as shown in Table 1.

*Table 1: Internal barriers to help seeking among GBV women survivors*

<b>Descriptive Statistics</b>						
	N	Minimum	Maximum	Mean	Std. Deviation	Coef. of Var.
Weakness	388	1.25	3.63	2.1817	.32388	
Problem Management	387	.75	3.00	2.0452	.58552	
Confused	390	1.00	4.00	2.3423	.56500	
Shame	387	1.00	4.00	2.2862	.52433	
Valid N (listwise)	385					

Table 1 shows that across the sampled women, Confusion registered the highest average intensity ( $M = 2.342$ ,  $SD = 0.565$ ), closely followed by Shame ( $M = 2.286$ ,  $SD = 0.524$ ) on their 1 - 4 scales, indicating that cognitive disorientation and self-conscious distress are the most pronounced internal impediments to help seeking. Weakness scored ( $M = 2.182$ ,  $SD = 0.324$ ) lying just below the midpoint of its 1.25 - 3.63 range, while Problem Management Belief (PMB) was lowest ( $M = 2.045$ ,  $SD = 0.586$ ) on its 0.75 - 3.00 metric, suggesting that survivors harbor somewhat greater doubts about their coping efficacy than about personal vulnerability.

Relative dispersion, as indexed by the coefficient of variation ( $CV = SD/Mean$ ), reveals that PMB is the most heterogenous barrier ( $CV \approx 0.29$ ), followed by Confused ( $CV \approx 0.24$ ) and Shame ( $CV \approx 0.23$ ), whereas perceptions of weakness are comparatively uniform ( $CV \approx 0.15$ ). This pattern implies wide variation in survivors' confidence to manage problems, some feel capable, others highly doubtful, whereas self-perceived weakness is a more consistently shared experience. Taken together, these results underscore that while feelings of confusion and shame are the most salient and variably experienced internal hurdles, enhancing survivors' problem-management beliefs may yield the greatest reductions in psychological resistance to seeking help.

### ***Qualitative data analysis from Key Informants***

This section presents the qualitative analysis of internal barriers to help seeking among women survivors of GBV, drawing on interviews with key informants at the hospital. Interview transcripts were imported into NVivo, where they underwent systematic coding and reflexive thematic analysis. This process allowed for the identification and interpretation of patterns in survivors' psychological and emotional experiences that influence their access to support.

#### ***Personal Barriers to Help Seeking***

Survivors described deep-seated fears, lack of awareness, and anticipated retaliation as key personal reasons for not reporting abuse or accessing services. Many felt that cultural respect for a spouse outweighed their own safety, and some simply did not know where to turn. *On e participant said, "For women, they respect their husbands, so even if I report him, there will be no action. It's a cultural belief." (Personal communication, Participant 3). While others added, "Some victims don't report abuse because they don't even know where to go. More awareness is needed." (Personal communication, Participant 4); "If she goes to the police, what next? He will come back and beat her more." (Personal communication, Participant 2)*

The section aimed to explore the personal reasons that prevent victims of GBV from seeking help. This theme emerged whenever interviewees discussed the challenges victims face in reporting abuse or accessing support services. The responses highlighted key barriers, including cultural beliefs, fear of retaliation, lack of awareness, and perceived inefficacy of reporting mechanisms. The interviews demonstrated a direct connection between these barriers and victims' reluctance to seek assistance, reflecting societal norms and institutional shortcomings that contribute to underreporting of GBV cases. Victims hesitate to seek help due to emotional, social, and logistical challenges. Many, fear judgment, retaliation, or financial loss, while others lack awareness of available services or believe that reporting abuse will not lead to meaningful change. Some of the most frequently mentioned words in the interview responses included "fear," "respect," "afraid," among others as illustrated in the word cloud Figure 1.

tradition  
struggles negatively support  
offered inability provided  
roles judged churches independence  
gender consequences families worse  
scared elder shame **afraid** decide taken  
respected according **fear** taking indulged  
practices affect **respect** controlling unable  
talked dependent belief culturally suffers  
property emotionally outcome  
stigmatized marriage regarded  
told underdog

*Figure 1: Personal barriers facing GBV women survivors seeking help*

From the interviews, respondents were quoted as saying, "For women, they respect their husbands, so even if I report him, there will be no action. It's a cultural belief." (Personal communication, Participant 3).

Another respondent echoed this sentiment, "Some victims don't report abuse because they don't even know where to go. More awareness is needed." (Personal communication, Participant 4).

Additionally, concerns over retaliation were prevalent as indicated by the second respondent. "If she goes to the police, what next? He will come back and beat her more." (Personal communication, Participant 2).

The findings reveal that cultural beliefs about respect and marriage discourage victims from reporting abuse, as they feel it will not be taken seriously. Lack of awareness of support services further prevents victims from seeking help, highlighting the need for community education and outreach programs. Additionally, the fear of retaliation discourages victims from involving authorities, reinforcing a cycle of silence and continued abuse. Another participant emphasizes the role of cultural expectations in perpetuating silence saying, "Women are taught that marriage is sacred, and divorce is shameful. Even in cases of violence, they are expected to endure." (Personal communication, Participant 6).

### ***Relational Dynamics***

The study established that concerns of family ties, social expectations, and cultural beliefs significantly discourage victims of Gender-Based Violence (GBV) from reporting abuse or seeking assistance. Concerns about children's well-being, fear of family judgment, and pressure to maintain family unity often deter victims from quitting abusive relationships. Thematic analysis identified critical factors influencing victims' reluctance, including "children," "family," "disown," "fear," and "shame" as illustrated in the word cloud analysis in Figure 2.



## **Discussion of Results**

Confusion emerged as a critical internal barrier to help seeking, with survivors rating it as the most significant impediment ( $M = 2.34$ ,  $SD = 0.565$ ). This cognitive disorientation stemmed from uncertainty about available actions and a lack of awareness regarding legal or support services (Wambui & Wanjala, 2019). Such confusion is compounded by the stress and psychological toll of IPV, often leaving survivors paralyzed in the face of adversity. In Kenya, the normalization of partner aggression, and inadequate outreach further obscure IPV as a problem requiring intervention (Wambui & Wanjala, 2019). Survivors socialized to endure suffering in marriage may struggle to identify IPV as a justifiable reason to seek help, perpetuating cycles of silence and inaction.

### *Shame*

Shame emerged as the second most prominent internal barrier ( $M = 2.29$ ,  $SD = 0.524$ ), reflecting deep embarrassment, stigma, and fear of social judgment. Interviews with key informants at the GBV centre at the main Hospital revealed survivors frequently invoked disgrace, expressing sentiments such as “speaking up will bring shame to their family” and “marriage is sacred, and divorce is shameful.” These narratives expose intense self-conscious distress, where women feared being labelled as “failures” if they disclosed abuse. Drawing from Goffman’s (1963) theory of stigma, shame functions as a socially sanctioned emotion regulating behavior through the threat of social exclusion. In patriarchal contexts like Kenya, shame is weaponized to enforce women’s silence (Lokot & Bhatia, 2020; Haj-Yahia & Tishby, 2021). Survivors internalize community expectations that marriage must be preserved at all costs, even at the expense of personal safety (Waller et al., 2022).

### *Weakness*

Feelings of weakness were moderately endorsed ( $M = 2.18$ ,  $SD = 0.324$ ). Survivors described how cultural norms portray seeking help as an admission of failure or personal inadequacy. For instance, one participant noted that “*seeking help is seen as weakness,*” reinforcing self-blame and silent endurance. In Kenyan society, as in many patriarchal contexts, women are idealized as stoic and enduring. Intimate partner violence survivors who seek help thus risk being perceived as deviating from these ideals (Musyimi et al., 2020). According to Musyimi et al. (2020), GBV survivors in Nairobi were discouraged from reporting violence to avoid appearing incapable of “handling family matters.”

### *Problem-Management Beliefs*

Problem-management belief (PMB) was identified as the least significant internal barrier among IPV survivors in this study, reflected by the lowest mean score ( $M = 2.05$ ,  $SD = 0.586$ ). This suggests that survivors doubted their ability to independently manage their IPV situations effectively. Survivors commonly perceived formal help as either ineffective or inappropriate, with many opting for informal avenues such as religious counsel. A recurring narrative was reliance on spiritual guidance, encapsulated by advice to “pray and endure,” which often precluded the pursuit of legal or therapeutic support. The study revealed that PMB often reinforced survivors' preference for silent coping strategies, particularly influenced by religious and cultural norms. Survivors expressed concerns about potential stigma or disrupting family harmony, choosing instead to navigate IPV situations privately. These findings resonate with global literature, such as Saint Arnault and Sinko (2022) which documented that, survivors

with high PMB often prioritize internal or faith-based resolutions over formal interventions. Additionally, Gibbs et al. (2020) highlighted similar trends in South Africa, where women cited religious or cultural obligations as reasons for delaying external help seeking.

## **Conclusions**

This study highlights how shame, fear, and stigma function as powerful psychosocial barriers that inhibit help seeking behavior among female survivors of intimate partner violence (IPV) in Nairobi County. Deeply rooted cultural norms, fear of retaliation, social judgment, and internalized blame, contribute to survivors' reluctance to disclose abuse or access support services. These barriers not only silence victims but also perpetuate cycles of violence and emotional harm. Understanding the complex interplay of these psychosocial factors is essential for designing trauma-informed, culturally sensitive interventions that foster trust, empower survivors, and reduce the stigma surrounding IPV. Addressing these barriers is critical to enhancing survivor safety, improving access to justice, and strengthening support systems within the community.

## **Recommendations**

Develop culturally sensitive education campaigns that challenge harmful gender norms, normalize help seeking, and reduce the stigma associated with IPV. Engaging local leaders, religious figures, and survivors as advocates can help shift public attitudes and create supportive environments for women to come forward.

There's need to strengthen survivor-centered support services by expanding access to safe, confidential, and trauma-informed services like counselling, legal aid, and shelter. This will help individuals prioritize the emotional and psychological needs of survivors.

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