

Co-tailoring a depression intervention with and for Black women survivors of intimate partner violence

Bernadine Y. Waller

Bernadine.Waller@nyspi.columbia.edu

Columbia University Irving Medical Center, Vagelos College of Physicians & Surgeons

Dawn Goddard-Eckrich

Columbia University

Chiamaka Chidi

Teachers College, Columbia University

Ana Stefancic

New York State Psychiatric Institute

Michelle Richardson-Ridley

Kansas University School of Social Welfare

Whitni L. Holland

Howard University

Mosinmiloluwa Adeyemo

Columbia University

Temiloluwa Adeyemo

UC San Diego School of Medicine

Danielle Williams

CONNECT NYC

Sidney H. Hankerson

Icahn School of Medicine at Mount Sinai

Rachel C. Shelton

Columbia University Mailman School of Public Health

Research Article

Keywords: intimate partner violence, depression, adaptation, Black or African American, women, tailoring, implementation science

Posted Date: October 12th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11040477/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License.
[Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Background

Black women experience intimate partner violence (IPV)-related mortality and morbidity at disproportionate rates. With an adverse circuitous relationship between IPV-related femicide and poor psychological health, there is renewed urgency to improve survivors' mental wellbeing. Still, a dearth of depression interventions have been tailored to meet Black survivors' culturally specific needs.

Purpose

To understand the psychosocial needs of Black women IPV survivors and begin tailoring a depression intervention with and for them.

Methods

Forty-six in-depth, semi-structured interviews were conducted across two studies. The first study included data collection among 30 Black women who were help-seeking for IPV-specific services. Theoretical sampling was utilized. Data collection occurred until saturation. Constructivist grounded theory methodology was employed. The second study included data collected from one intervention workgroup. The day-long workgroup drew from a sample of Black survivors, clergy, and providers (n = 16). The PRISMA framework guided the workgroup process, and the first two steps of the ADAPT-ITT Model were completed with the goal of selecting and begin tailoring an intervention for depression.

Results

Nine phases identifying Black survivors' psychosocial help-seeking were found in the data. The first phase identified depression as a pressing concern. This informed the necessity of tailoring an intervention for depression. The workgroup opted to tailor interpersonal counseling for depression, infusing faith and spirituality with psychoeducation within the adapted intervention.

Conclusions

Centering Black women's needs is critical to the continuum of work necessary to improving the mental health and overall wellbeing of Black survivors. Sarah Waller's Help-Seeking model is the first to identify Black IPV survivors' needs. The second study is the first to begin tailoring an intervention for depression with and for Black women IPV survivors.

Background

A dearth of depression interventions center Black women intimate partner violence (IPV) survivors, despite the urgency [1]. IPV is conceptualized as any physical, psychological, sexual, financial abuse and/or controlling behaviors inflicted by a current or former intimate partner [2]. Black women experience the highest IPV-related mortality and morbidity among all racial and ethnic groups of women [3, 4]. A 22-year epidemiological inquiry of femicides found that Black women are murdered on average of 6- and as much as 20-times that of white women, with IPV the underlying factor in half of those murders [5]. *The Lancet Commission on Intimate Partner Violence and Mental Health* identified an adverse circuitous relationship between IPV-related femicide and women's psychological wellbeing [6]. With Black women IPV survivors experiencing profound effects of culturally blunted care [3, 7], it is essential to identify their psychosocial needs, understand the optimal timing of intervention delivery, and tailor interventions to meet their cultural preferences for care. An emerging body of literature points to the necessity of co-tailoring mental health interventions with and for Black women [8, 9]. A dearth of scholarship documents such efforts for Black women IPV survivors [1]. This paper seeks to begin to close that gap. The goal of this project, across two studies, was to identify Black survivors' psychosocial needs, then select and begin tailoring a brief evidence-based intervention (EBI) that addresses this population's most pressing mental health need: depression.

Role of culture in intervention tailoring

Culturally tailored interventions for depression may reduce barriers to treatment while improving acceptability. Depression is commonly experienced by IPV survivors and is the primary cause of disability, globally [1, 10, 11]. An examination of effective structure of intervention delivery for Black women demonstrated the need to account for psychological, social and cultural effects of oppression, Black female identity, healthy relationships and social support experiences [12–14]. Black survivors further uphold power-sharing and communal meaning-making among themselves as an important part of their mental healing process [15]. Social support and connectedness may mitigate the effects of stressors and depressive symptoms among Black survivors and is crucial for intervention tailoring [16]. Other culturally responsive interventions rely on strengths-based approaches to dispel myths, internalized negative beliefs and attitudes [12, 16]. Spirituality also characterizes many Black survivors' cultural experiences. Yet, there remains a paucity of literature concerning faith-based mental health interventions for Black survivors [17, 18]. Incorporating faith-based practices into intervention delivery connects Black survivors to ancestral practices that are culturally aligned and may be vital to increasing uptake and reducing attrition [17]. Importantly, effective intervention design is based upon theoretical development. Theories that identify Black survivors' needs are essential for their survival and lacking in the literature [19]. Importantly, there are no theories that identify Black survivors' nuanced help-seeking process. The goal of this project, across two studies, is to understand the psychosocial needs of Black survivors and begin tailoring an intervention with and for them.

Theoretical Framework

In Study 1, constructs from the transtheoretical model of change (TTM), intersectionality, and agency frameworks were used as sensitizing concepts for theoretical development. The TTM allowed us to explicate survivors' cognitions and behaviors during their IPV help-seeking process according to what phase they were in for seeking help [20]. Intersectionality framework [21] provided the foundation critical for understanding the ways that survivors experience oppression resulting from their each of their marginalized identities, specifically race, class and gender [21]. These identities often intersect and overlap, causing multiple points of marginalization that may further preclude survivors from obtaining immediate crisis assistance [22]. To ensure we account for the creative ways that survivors harness power, specifically, the ways that they employ their power to navigate barriers, we utilized the agency framework which posits that survivors will use non-linear, incremental ways to secure power that may not readily be recognizable by the person inflicting violence [23]. Further details on theoretical development are found in previous research [24].

In Study 2, the ADAPT-ITT Model [25] was used to begin tailoring a brief evidence-based intervention for depression. ADAPT-ITT is a manualized approach with 8 steps for intervention tailoring. We employed the first two: 1) *Assessment*, specifically interviewing participants to understand and identify needs; and 2) *Decision*, namely identifying which evidence-based intervention to tailor. We then conducted an intervention workgroup to determine which elements of the Black church experience to infuse in the tailored intervention. ADAPT-ITT has historically been applied to tailoring HIV/AIDS and behavioral health interventions [26–28]. For the first time, it will be utilized to tailor a depression intervention for Black survivors. Additional steps of ADAPT-ITT are not reported here but will be included in future publications.

Methods

Interviews were conducted with forty-six participants across two qualitative studies. The first study included 30 Black women help-seeking for IPV-specific services and supports in a large northeastern urban area. Data was collected July-October 2019. Theoretical sampling [29] was utilized to secure participation from individuals help-seeking across a wide range of IPV-specific services, inclusive of the criminal legal, shelter, healthcare, and mental healthcare systems. To account for Black survivors' help-seeking preferences, we also sampled from women survivors help-seeking in Black churches across the same urban area [30]. Constructivist grounded theory methodology [29] (See Fig. 1: Constructivist Grounded Theory Methodology) was employed for analysis, building off of the research team's deep expertise. Six team members have extensive experience with IPV and trauma survivors, five have expertise in advancing mental health equity, and four are experts in community-partnered research. The interview guide may be found in the scholarly literature [BLINDED]. Further details regarding methods for Study 1 are available in prior literature [BLINDED].

The second sample is drawn from a larger formative study with a community agency that provides technical assistance to faith-based organizations, and two Black churches in a large urban area. Sixteen key stakeholders included a purposive sample of 4 Black IPV survivors with distal histories of abuse (e.g. >2 years post-victimization), 4 Black women clergy, 4 lay ministry leaders who support survivors in

religious settings, and 4 clinicians who provide community-based mental health care to Black survivors. Data was collected in March 2023. The PRISMA framework guided the workgroup process [32]. The interview guide for Study 2 may be found as a supplemental file. Inductive-deductive thematic analysis was employed for analysis [33] (See Fig. 2: Inductive-deductive Thematic Analysis).

Inter-views were recorded after obtaining consent and were professionally transcribed. An inductive approach to thematic analysis was utilized [29, 34].

Institutional Review Board approval was obtained prior to commencing each study. Approval for Study 1 was obtained from a university. Approval for Study 2 was obtained from a large BLINDED psychiatric institute. In each study, data was triangulated using demographic and qualitative interviews, and field notes. In Study 1, recruitment occurred until saturation (until no new codes were identified during initial coding) [35]. In Study 2, while the goal was to gather “rich data” from a diverse group of stakeholders, saturation was achieved across sub-group breakout sessions. Specifically, redundancies were identified across sub-groups. Participants were randomly assigned into one of three smaller sub-groups for each of the breakout sessions. Assignments varied for each of the three breakout sessions. Since the first study included theoretical development, we employed all 8 recommended methods to ensure trustworthiness [36]. To ensure validity of the emergent theory, we employed negative case analysis [24].

To ensure transparency in reporting, the Standards for Reporting Qualitative Research (SRQR) [37] was employed. Dedoose [38] and a matrix system [39] were utilized for Study 1 and Study 2, respectively, for data management and analysis. Data for both studies were analyzed using a single coder. For Study 1, the first author (BLINDED) used reflexive journaling to identify biases [40] and discussed them with her advisor (BLINDED). For Study 2, the team (BLINDED) met bi-weekly to review codes and resolve differences in how closely to code to the data. To protect participants’ identities, pseudonyms are used. Table 1 and Table 2 include participant demographics for Study 1 and Study 2, respectively.

Findings

Study 1

Nine themes were identified using from the constructs of TTM, Intersectionality and Agency frameworks as sensitizing concepts. We then identified patterns in the data that documented Black survivors’ psychosocial needs during their IPV help- seeking. The nascent phase-oriented framework (See Fig. 3: Sarah Waller’s Help-Seeking Model) captured survivors’ cognitive and behavioral processes of help-seeking. With the initial phase identifying survivors’ awareness of their victimization and commencing with them reclaiming their power to make their own life choices, the model may be used as a framework to guide intervention development and delivery. Participants in latter phases of help-seeking spoke regarding their earlier experiences of help-seeking. Their recollection, combined with participants who have yet to advance through the latter phases of help-seeking, informed the development of the model’s phases. Participant quotes are found in Table 3.

Phase 1: Awareness – “This kinda threw me”

Most participants in the initial phase of help-seeking described enduring a combination of psychological and severe physical abuse and controlling behaviors. Yet, many did not recognize the abuse as IPV. Most of the women experienced mental health challenges often associated with long-term victimization, namely depression, anxiety, dissociation, and suicidal ideation.

Phase 2: Acknowledgement – “Deal with it”

Most participants within this phase of help-seeking largely relied upon coping mechanisms and resorting to cultural norms elevating privacy and protecting their partner from potential harms from police involvement. Many of the participants recognized the necessity of admitting they were abused as a critical step to securing crisis supports. Acknowledgement was essential even for participants who were not yet ready to obtain assistance within the formal IPV service provision system.

Phase 3: Assessment – “Why am I here?”

Most of the participants in this phase began evaluating the context and trajectory of their relationship. These women’s reflections spanned from existentialist questioning the purpose of their own life to parasuicidal and suicidal ideation. Several participants also indicated they were depressed and anxious about their relationship while a few of the participants noted their heavy reliance upon prayer as a mechanism to alleviate their symptoms.

Phase 4: Enough – “Enough is enough”

This is the phase in which many participants began to shift from cognitive to more action-oriented steps. They were resolute in their determination to make the moves necessary to disrupt their partner’s abusive tirades. While some participants in this phase physically fought their abusive partner as a means of creating boundaries for acceptable behavior, other participants began to identify alternative means of dissuading their partner from further inflicting violence.

Phase 5: Enlist – “Have to speak to someone”

Once here, many participants recruited male family members and close friends for assistance. While some participants enlisted others to dissuade their partner’s continued abuse, several participants relied upon their kinship network to offer a haven of safety while they further assessed their situation and determined a strategy for next steps.

Phase 6: Escalate – “ Call the cops on yo’ ass

Despite efforts to forgo engaging law enforcement, most of the participants in this phase believed their partner’s on-going abuse necessitated escalating to the very entity they noted they wanted to avoid: law enforcement. Some participants indicated this was especially the case when the nature and frequency of

the abuse intensified after attempting a more private means of disclosure and sharing the abuse with their family and friends.

Phase 7: Reject – “There is no help”

All the participants in this phase were generally exasperated after contending with a constellation of barriers that hindered and sometimes precluded their immediate help-seeking efforts. Rather than continue to search for a minority of providers who they believed wanted to help them, as Black women, most of the participants in this phase began to reject formal systems of support and secure alternative pathways for intervention.

Phase 8: Resolve – “Gotta get through the hurdles”

Regardless of the hindrances they encountered, most of the participants in this phase were determined to obtain assistance. For some, their inspiration was the desire to create a healthier home environment for their young children. Other participants had a deep-seated belief that life could be better if they obtained critical aid. Participants in this phase were resolute and determined to get what they needed to improve their overall wellbeing.

Phase 9: Restoration – “Getting my power back”

A journey of rediscovery punctuates this phase of help-seeking. While not all participants advanced to the final phase, all the women who were in the restoration phase had terminated their relationship with the person who inflicted violence. Several participants were employing some form of counseling, whether pastoral or traditional, to guide them in their journey of self-discovery. Importantly, all of the participants discussed reclaiming their sense of self, relishing in their newfound freedom, exploring life and its possibilities, and reconnecting with their family and friends.

Study 2

Findings from Study 1 informed the need to identify and begin tailoring an EBI for depressed Black survivors. Formative work for Study 2 are reported in prior literature [1]. We then convened an intervention workgroup (WG) to understand what participants believe Black survivors needed in an evidence-based intervention (EBI). The workgroup comprised an interdisciplinary team of 16 stakeholders; this included a diverse group of Black women with distal histories of IPV (> 2 years since victimization), including veterans, members of the LGBTQ+ community, and women with a disability; women clergy and lay ministry leaders; and mental health clinicians who treat Black survivors. The larger workgroup was divided into three smaller sub-groups during the 8-hour session that included a one-hour working lunch. Each of the smaller groups reported out to the larger group following each session, with redundancies found across the three groups. The WG completed the initial two phases of the ADAPT-ITT model to begin selecting and co-tailoring an EBI for Black survivors help-seeking in faith-

and/or community-based organizations. Findings are reported in aggregate across participant types unless otherwise noted.

Assessment

Initial discussions included the need for brief interventions that are delivered in a flexible format, specifically in-person or via telehealth. WG participants then reviewed findings from a systematic review of the literature delineating Black survivors' needs, specifically the EBI should be brief (< 6 sessions), infuse faith and/or spirituality, delivered by Black women with histories of IPV in trusted faith- and/or community settings and account for survivors' social context, namely childcare [1]. All participants agreed with systematic review findings.

Decision

The facilitator provided an overview of EBI options for depressed survivors, namely cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT) and interpersonal counseling (IPC). The WG opted to select IPC because of the brevity of its delivery, along with its treatment effectiveness among Black survivors. IPC is a brief (4–6 session), manualized, evidence-based derivative of interpersonal psychotherapy (IPT) [41]. IPT has demonstrated effectiveness in over 100 trials and is recommended by the World Health Organization (WHO). IPC is a brief iteration of IPT, adapted for primary care settings and delivered by lay providers [42]. IPC targets interpersonal problems (e.g. grief, disputes, transitions) [42, 43] while reducing the likelihood of treatment non-adherence typically found among this population [44]. IPC, which is called brief IPT in the literature, has also been found effective in remitting depression among Black survivors [1].

WG participants began initial work of determining which elements of spirituality and the Black church experience to infuse into the tailored intervention across three randomly assigned, sub-group breakout sessions. Sessions were structured to give participants the ability to reflect on the strengths and challenges of the Black church and the ways experiences with faith leaders have helped and harmed survivors before developing strategies for a more healing experience.

Breakout 1: Faith and Spirituality

All WG participants felt it essential to include themes of faith and spirituality, specifically Biblical texts, into the tailored intervention. While generally regarded as a source of support, participants acknowledged that scriptural passages have also been weaponized against survivors. Several participants were adamant about the necessity of unpacking complex texts while putting greater emphasis on passages that validate and uplift survivors. Several also emphasized the importance of reconciling the nuances of complex Biblical characters such as Hagar who, although vilified for having sexual relations with her boss at his wife's request, also exemplifies the experiences of Black survivors'

imperfect womanhood. Other participants indicated the need to clarify passages about submission often misused to encourage survivors to remain in abusive relationships.

All the WG participants also suggested the need to empower survivors. Several also recommended that intervention contain positive messaging and self-talk, as well as story-sharing to create an atmosphere of hope. They suggested taking an informal approach to an intervention that prioritizes hugs and embraces, which is characteristic of Black spiritual spaces. A few of the participants, across participant types, noted that not all women will be religiously affiliated, so the tailored EBI should also reflect this reality. As an alternative, they recommended using spiritually inspired symbols from *Adrinka* and *Ifa Orisha* therapeutic practices. *Adrinka* symbols such as *Sankofa* can emphasize the need to reflect on one's past to guide their future.

Breakout 2: IPV Psychoeducation

All the WG participants were emphatic about including psychoeducation about depression and IPV. Psychoeducation involves providing information designed to raise awareness. Most participants discussed the importance of survivors understanding depression and how it presents among Black women. Of particular concern were the effects of traumatic experiences, risk for subsequent revictimization and negative self-beliefs. A few of the participants noted the danger of depression, especially for Black survivors. Clinician-participants discussed the shame and stigma of poor psychological health compounded with IPV and is also layered with a sense of betrayal that destroys survivors' sense of trust in forming and navigating relationships.

Salient to the discussion on psychoeducation was the profound effects of IPV among Black women. Clinician participants believe information about the noxious, intergenerational effects of IPV is important and too often misunderstood, leading to critical missteps that result in a sequela of deleterious proximal and distal outcomes for Black survivors. They noted the intervention should address common myths about IPV, including who is affected and the various forms. Lay ministry leader participants emphasized the need to underscore that abuse is not the result of the survivors' actions, nor does it occur as part of mere conflicts or disagreements. A few of the participants believe intervention should cover the dynamics of power and control in a relationship while dispelling racist stereotypes portraying Black women as angry, aggressive and strong which constrain them from expressing their vulnerability.

Participants also highlighted that it is essential to address blame in IPV. All of the WG participants agreed that the intervention should clarify that IPV is unjustifiable and that survivors are not responsible for their victimization. Rather, the person inflicting harm is accountable. They indicated that survivors should also be informed about the warning signs of IPV, reminded that self-defense may be necessary, and educated about the heightened danger they may encounter when attempting to leave their abusive relationship. Survivor participants emphasized the need to remind survivors that abuse is not love. This is especially important for survivors with childhood exposure to IPV because their earliest memories may include them witnessing abuse within the context of what is supposed to be a loving relationship.

Several participants recommended employing messaging that reminds survivors of their autonomy, purpose for living, and personal strength. A few advocate participants also noted that survivors should be encouraged to prioritize herself and her needs.

Breakout 3: Interpersonal Counseling

During the last breakout session, WG participants concurred that all four problem areas within IPC should be addressed in the intervention. These areas include grief, disputes, transitions, and isolation. All participants acknowledged that survivors mourn the loss of their relationship, along with relational goals and the sense of oneself. Most participants agreed that survivors will inevitably face immense change. Grief could manifest in mourning the loss of the relationship, self, financial stability, and disappointment with God. Many of WG participants stated that this is an imperative since the grieving process could drive survivors to reconnect with their abusive partner.

Disputes involve relational ruptures between survivors and those within their relational networks. Most participants identified with the precarious nature of transition that survivors experience, and the need for them to utilize newfound support systems to acquire skills for healthier relationships. Addressing practical challenges that they will likely face is imperative. Several participants stated that survivors will need support addressing disputes, particularly since some may not have the skills for healthy confrontation. Some participants shared that survivors may also need to learn how to process their complex feelings, redefine healthy and safe sexuality, and reinvent themselves. Several participants also emphasized the critical need to address strategies for overcoming isolation from their family members and close friends.

Discussion

This project, with 46 participants across two studies, was designed to center the needs of an especially vulnerable group of Black women IPV survivors. In Study 1, findings from 30 Black women IPV survivors who were help-seeking in the criminal legal, shelter, health and mental health care systems as well as the Black churches in a large urban area in the northeastern U.S. Study findings reflected patterned data documenting survivors' help-seeking process, Sarah Waller's Help-Seeking Model (Fig. 1). In Study 2, participants indicated the need to tailor IPC for Black survivors help-seeking in faith- and community-based settings. Participants opted to tailor a brief manualized treatment that could be delivered by lay health providers in trusted faith- or community-based settings. They specifically indicated the necessity of continuing to address the problem areas (e.g. grief, disputes, transitions, and isolation) identified in IPC while adding psychoeducation about IPV and depression, infusing faith or spirituality in the tailored intervention.

This study represents a critical advancement in addressing the mental health needs of Black women by centering Black survivors' lived experiences across both theoretical development and intervention adaptation [24]. The creation of Sarah Waller's Help-Seeking Model alongside the collaborative

modification of IPC enriched with spiritual elements and educational components illustrates the power of community driven research methods [18]. To our knowledge this is the first project to center the needs of Black survivors, spanning from theoretical development to intervention tailoring. Our study reveals important insights into the initial design one of the first culturally tailored mental health interventions for depressed Black women who have experienced IPV.

Advancing Theoretical Framework

Waller's Model is a breakthrough model, establishing the first comprehensive framework explicitly created to examine how Black women survivors navigate their journey toward obtaining assistance (mentally and physically) for intimate partner violence. Previous theoretical models have consistently overlooked the complex intersectional realities faced by Black women, failing to capture how race, gender, and survival experiences interact to shape help-seeking behaviors [21]. This innovative framework documents the survivors progress from recognizing their victimization through reclaiming personal autonomy and strength. The model's nine phases: Awareness; Acknowledgement; Assessment; Enough; Enlist; Escalate; Reject; Resolve; Restoration, dives into the intricate relationships between mental health symptoms, community expectations, and available support networks. Depression, anxiety, and suicidal thoughts emerge as central consequences of intimate partner violence, confirming established research documenting the severe psychological burden carried by Black women survivors [45]. Additionally, the model emphasizes that help-seeking behaviors are embedded in cultural contexts and intersectional identities [21]. Black IPV survivors frequently depend on informal support systems and spiritual resources, honoring established community traditions of collective strength and faith-centered recovery [17]. At the same time, maintaining family privacy and shielding partners from criminal legal involvement may delay assistance-seeking and prolong or intensify suffering. These findings emphasize the critical importance of developing interventions that dismantle cultural and systematic barriers such as racism and stigma. It further prioritizes the need to address depression among Black survivors.

Applying the ADAPT-ITT framework to this depression intervention for Black survivors demonstrates innovative utilization of this approach, previously applied primarily to HIV/AIDS and behavioral health interventions [25–27]. The workgroup's organized discussion sessions and focus on IPV education, spiritual meaning-creation, and IPC adaptation establish a reproducible framework for future development initiatives. It is however important that the full the ADAPT-ITT framework be used in future research to fully understand the full potential of Waller's model.

Cultural informed adaptation process

Through authentic engagement with Black women, the collaborative adaptation process produced a modified interpersonal counseling approach incorporating educational content about IPV and depression alongside faith and spiritual components, identified as fundamental for acceptability and sustained participation. This methodology directly addresses limited adoption and poor retention rates due to insufficient cultural resonance [1], building upon established evidence interventions

demonstrating the effectiveness of culturally tailored interventions for Black women experiencing multiple vulnerabilities [46, 47].

The proposed educational components of the tailored intervention address stigma that often causes isolation and self-blame. Through the informing and covering of misconceptions IPV and explaining connections between trauma and psychological wellbeing [16]. This approach challenges internalized harmful beliefs and shame that survivors' often express while enhancing mental health understanding and promoting empowerment. The proposed tailored intervention recognizes that barriers including economic limitations, childcare needs, and mistrust toward formal health services including mental health, which makes cultural resonant approaches essential for long-term engagement.

The inclusion of faith-based approaches is particularly innovative. While religion is a protective element for Black women [13, 17], few interventions have successfully translated this strength into practical mental health programming for intimate partner violence survivors [13]. Our investigation contributes to the field by establishing a framework with cultural practices that are meaningful and can potentially decrease stigma and improve incidences of violence by incorporating spiritual resources combined with evidence-based therapeutic interventions.

Policy and Practice

Our model's results has implications for policy and practice as it is aimed at enhancing mental health outcomes for Black women, specifically IPV survivors, especially since violence and mental health are crucial social determinants of health. Waller's Model offers a practical framework for timing and customizing interventions according to survivors' changing readiness and psychosocial requirements. The methodology demonstrated in this research confirms the importance of establishing interdisciplinary partnerships including survivors, faith leaders, and clinicians to collaboratively create culturally authentic and sustainable interventions [48]. These partnerships strengthen community investment and build trust—essential elements for mental health service engagement among Black women [9].

Funders and policymakers should facilitate the creation and implementation of culturally adapted evidence-based interventions through targeted funding and resource distribution. This can help address structural obstacles including childcare, transportation, and costs that restrict healthcare access for Black women [11]. Similarly, this proposed adapted intervention can be tested with different service delivery approaches, such as telehealth which can expand the accessibility and effectiveness of this and other tailored interventions. Together, these practice and policy implications represent a move toward equity-centered mental healthcare. By prioritizing historically marginalized perspectives and incorporating cultural contexts, we advance toward reducing disparities and fostering healing for one of the most vulnerable communities.

Future Direction and Priorities

This study underscores the utility of forming collaborative multidisciplinary coalitions with historically marginalized communities to achieve and maintain mental health equity. Furthermore, developing partnerships with additional community sectors and investigating digital delivery approaches may further improve accessibility and impact. Longitudinal investigations could offer insights regarding timing and advancement, supporting intervention customization to survivors' actual experiences.

While our current work focuses on depression, research demonstrates that survivors frequently experience co-occurring posttraumatic stress disorder (PTSD) and anxiety disorders that require comprehensive screening and treatment approaches. Future studies should also explore the integration of evidence-based PTSD and anxiety screening tools into routine care delivery, building on successful models like Project WINGS that have demonstrated effectiveness in identifying and addressing complex trauma presentations among women in community supervision settings [49]. This comprehensive approach to mental health screening and treatment could address the complex psychological experiences of Black women, while maintaining cultural authenticity and community partnership principles. Additionally, future research should also explore this adapted intervention across diverse service settings including primary care, emergency departments, and community-based organizations enhance the model scalability and uptake.

Finally Waller's Model acknowledges the historical trauma of Black women whose intimate partner violence experiences cannot be disconnected from slavery's legacy, systemic racism [6]. The intervention's focus on reclaiming personal power and empowerment, directly confronts these historical disempowerment patterns while strengthening cultural assets and resistance while incorporating culturally specific therapeutic approaches, including Adinkra symbols such as Sankofa, ancestral knowledge and healing practices. This cultural heritage connection can provide powerful strength and identity validation for survivors.

Limitations

Despite our strong framework and findings, our study is not without limitations. First though there was diverse representation within the working groups from the Black community, the study was limited to a specific area so may limit the generalizability of findings to Black survivors in other regions, rural areas and some first-generation Black women as cultural contexts may differ. The sample size for intervention development was relatively small, thus limiting perspectives from a wider group of Black survivors, some of whom may not have engaged with formal services. The focus on depression as a primary outcome of the framework may not have captured the full range of psychological or mental health symptoms and needs of Black women. Future research should consider broadening to include anxiety, PTSD, and substance abuse. Despite these limitations, our findings offer important contributions to the understanding of the mental health challenges. That need to be considered when developing IPV interventions for Black women.

Conclusions

As the first series of studies that focus on understanding the needs of Black women survivors, this work helps inform both theoretical development and the tailoring of interventions that center their specific psychosocial needs. This work helps determine the critical importance of psychoeducation for IPV and depression for this population, and the value of integrating faith-based approaches to enhance acceptability of intervention. Additionally, this work highlights the strength of co-creating and engaging those with lived experience through collaborative multidisciplinary coalitions to enhance the relevance, fit, and effectiveness of mental health interventions. In future work, it will be important to further develop and test these intervention approaches among this key population and further evaluate and refine the theoretical framework elucidated here.

Abbreviations

- ADAPT-ITT: Assessment, Decision, Adaptation, Production, Topical experts, Integration, Training, and Testing
- CBT: cognitive behavioral therapy
- EBI: evidence-based intervention
- HIV/AIDS: Human immunodeficiency virus/ Acquired immunodeficiency syndrome
- IPC: interpersonal counseling
- IPT: interpersonal psychotherapy
- IPV: intimate partner violence
- LGBTQ: lesbian, gay, bisexual, transgender and queer or questioning
- PTSD: posttraumatic stress disorder
- SRQR: Standards for Reporting Qualitative Research
- TTM: transtheoretical model of change
- WG: work group
- WHO: World Health Organization

Declarations

Clinical trial number

not applicable

Ethics approval and consent to participate:

This study was approved by Adelphi University Institutional Review Board (#090618) and NYS Psychiatric Institute (IRB#8340). The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. All participants were informed about the purpose of the study, assured of confidentiality. To ensure an additional level of protection, due to the nature of the study, participants provided verbal recorded consent prior to participation. Participation was voluntary, and respondents could withdraw at any time without consequence. We additionally obtained a Certificate of Confidentiality from the National Institutes of Health. The Certificate of Confidentiality protects participants from compelled disclosure, particularly when participants could be criminal legal system involved.

Consent for Publication:

Not applicable.

Competing Interests:

All authors declare that they have no conflicts of interest

Funding:

This work was supported in part by the National Institute of Mental Health [K23MH133979, R36MH116680 and L30MH131137 (Waller)], and [R01MH121590 (Hankerson)]. The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; or decision to submit the manuscript for publication.

Author Contribution

BYW conceptualized, analyzed, wrote, and edited the paper; DGE wrote and edited the paper; CC analyzed, wrote and edited; AS trained RAs on analysis and wrote; MRR analyzed, wrote and edited; WLH wrote and edited; MA wrote; TA analyzed, wrote and edited; DW wrote; SHH edited; RCS wrote and edited.

Acknowledgement

We would like to thank Janet E. Williams for her contribution to this project. Although she passed before this paper made it to publication, her legacy continues. We would also like to thank the NYC Mayor's Office to End Domestic and Gender-Based Violence for their partnership with the foundational study. Importantly, we have deep gratitude to the Black intimate partner violence (IPV) survivors who

courageously shared their stories and trusted us to advance scholarship that elevates the experiences and needs of other Black IPV survivors. Lastly, we would like to thank Milton L. Wainberg for his insight and sharing his PRISSMA Model process.

Data Availability

De-identified data from this study will be made available (as allowable according to institutional IRB standards) by emailing the corresponding author on reasonable request.

References

1. Waller BY, Lee SJ, Legros NC, Ombayo BK, Mootz JJ, Green MC et al. Interventions targeting depression and posttraumatic stress disorder in United States Black women experiencing intimate partner violence: A systematic review. *Trauma, Violence, & Abuse*. 2023;15248380231206113.
2. Leemis RW, Friar N, Khatiwada S, Chen MS, Kresnow M-j, Smith SG et al. The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence. 2022.
3. Center VP. When Men Murder Women: A Review of 25 Years of Female Homicide Victimization in the United States. Washington, D.C.: Violence Policy Center; 2023.
4. Lacey KK, Mouzon DM. Severe Physical Intimate Partner Violence and the Mental and Physical Health of U.S. Caribbean Black Women. *J Womens Health (Larchmt)*. 2016;25(9):920–9. 10.1089/jwh.2015.5293. Epub 2016/02/27.
5. Waller BY, Joseph VA, Keyes KM. Racial inequities in homicide rates and homicide methods among Black and White women aged 25–44 years in the USA, 1999–2020: a cross-sectional time series study. *Lancet*. 2024.
6. Oram S, Fisher HL, Minnis H, Seedat S, Walby S, Hegarty K, et al. The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy. *Lancet Psychiatry*. 2022;9(6):487–524.
7. Waller BY, Johnson KA, Goddard-Eckrich D, Holland WL, Richardson-Ridley M, Wilson AM et al. I Thought I Was Going to Die: Identifying Gaps in the Intimate Partner Violence Service Provision System for Black Women. *J interpers Violence*. 2025:08862605251319020.
8. O'Leary TK, Batti V, Dhindsa S, Krishnan VH, Wilcox L, Woods-Giscombe CL, et al. editors. It was Empowering: Care Pathways a Novel Culturally Informed Inspiration Card Game for Community-Engaged Co-Design with Black American Women and Clinicians. *Proceedings of the Extended Abstracts of the CHI Conference on Human Factors in Computing Systems*; 2025.
9. Waller BY, Giusto A, Tepper M, Legros NC, Sweetland AC, Taffy A, et al. Should we trust you? Strategies to improve access to mental healthcare to BIPOC communities during the COVID-19 pandemic. *Commun Ment Health J*. 2024;60(1):82–6.

10. Friedrich MJ. Depression is the leading cause of disability around the world. *JAMA*. 2017;317(15):1517.
11. Chandan JS, Thomas T, Bradbury-Jones C, Russell R, Bandyopadhyay S, Nirantharakumar K, et al. Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness. *Br J Psychiatry*. 2020;217(4):562–7.
12. Jones LV, Warner LA. Evaluating culturally responsive group work with black women. *Res Social Work Pract*. 2011;21(6):737–46.
13. Hays K, Aranda MP. Faith-based mental health interventions with African Americans: A review. *Res Social Work Pract*. 2016;26(7):777–89.
14. Watson-Singleton NN, Black AR, Spivey BN. Recommendations for a culturally-responsive mindfulness-based intervention for African Americans. *Complementary therapies in clinical practice*. 2019;34:132–8.
15. Marshall-Fabien GL, Miller DB. Exploring ethnic variation in the relationship between stress, social networks, and depressive symptoms among older Black Americans. *J Black Psychol*. 2016;42(1):54–72.
16. Wallace DD, Carlson RG, Ohrt JH. Culturally adapted cognitive-behavioral therapy in the treatment of panic episodes and depression in an African American woman: a clinical case illustration. *J Mental Health Couns*. 2021;43(1):40–58.
17. Chatters LM, Mattis JS, Woodward AT, Taylor RJ, Neighbors HW, Grayman NA. Use of ministers for a serious personal problem among African Americans: findings from the national survey of American life. *Am J Orthopsychiatry*. 2011;81(1):118.
18. Hankerson SH, Wells K, Sullivan MA, Johnson J, Smith L, Crayton LS, et al. Partnering with African American churches to create a community coalition for mental health. *Ethn Dis*. 2018;28(Suppl 2):467.
19. Waller BY, Joyce PA, Quinn CR, Hassan Shaari AA, Boyd DT. I Am the One That Needs Help: The Theory of Help-Seeking Behavior for Survivors of Intimate Partner Violence. *J Interpers Violence*. 2023;38(1–2):288–310.
20. Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. *J Consult Clin Psychol*. 1983;51(3):390.
21. Crenshaw K. Mapping the margins: Identity politics, intersectionality, and violence against women. *Stanford Law Rev*. 1991;43(6):1241–99.
22. Waller BY, Harris J, Quinn CR. Caught in the crossroad: An intersectional examination of African American women intimate partner violence survivors' help seeking. *Trauma Violence Abuse*. 2022;23(4):1235–48.
23. Mahmood S. Feminist theory, embodiment, and the docile agent: Some reflections on the Egyptian Islamic revival. *Readings in the Theory of Religion*. Routledge; 2016. pp. 206–40.
24. Waller B, Goddard-Eckrich D, Kagotho N, Hankerson SH, Hawks A, Wainberg ML. Sarah Waller's help-seeking model: Understanding African American women intimate partner violence survivors' help-

- seeking process. *J Interpers Violence*. 2023;38(11–12):7170–92.
25. Wingood GM, DiClemente RJ. The ADAPT-ITT model: a novel method of adapting evidence-based HIV Interventions. *JAIDS J Acquir Immune Defic Syndr*. 2008;47:S40–6.
 26. Sullivan PS, Stephenson R, Grazer B, Wingood G, Diclemente R, Allen S, et al. Adaptation of the African couples HIV testing and counseling model for men who have sex with men in the United States: an application of the ADAPT-ITT framework. *Springerplus*. 2014;3:1–13.
 27. López CM, Hahn CK, Gilmore AK, Danielson CK. Tailoring cognitive behavioral therapy for trauma-exposed persons living with HIV. *Cogn Behav Pract*. 2020;27(1):70–83.
 28. Garfin DR, Amador A, Osorio J, Ruivivar KS, Torres A, Nyamathi AM. Adaptation of a mindfulness-based intervention for trauma-exposed, unhoused women with substance use disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*; 2023.
 29. Charmaz K. *Constructing grounded theory: sage*; 2014.
 30. Cox K, Diamant J. Black men are less religious than black women, but more religious than white women and men. Retrieved July. 2018;3:2019.
 31. Waller BY, Bent-Goodley TB. I have to fight to get out: African American women intimate partner violence survivors' construction of agency. *J Interpers Violence*. 2023;38(3–4):4166–88.
 32. Wainberg ML, McKinnon K, Mattos PE, Pinto D, Mann CG, de Oliveira CSS, et al. A model for adapting evidence-based behavioral interventions to a new culture: HIV prevention for psychiatric patients in Rio de Janeiro, Brazil. *AIDS Behav*. 2007;11(6):872–83.
 33. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *Int J qualitative methods*. 2006;5(1):80–92.
 34. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Res Psychol*. 2006;3(2):77–101.
 35. Fusch Ph DPI, Ness LR. Are we there yet? Data saturation in qualitative research. 2015.
 36. Lincoln YS, Guba EG. *Naturalistic inquiry: sage*; 1985.
 37. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245–51.
 38. Salmona M, Lieber E, Kaczynski D. *Qualitative and mixed methods data analysis using Dedoose: A practical approach for research across the social sciences*. Sage; 2019.
 39. Stefancic A, Rogers RT, Styke S, Xu X, Buchsbaum R, Nossel I, et al. Development of the first episode digital monitoring mhealth intervention for people with early psychosis: qualitative interview study with clinicians. *JMIR Mental Health*. 2022;9(11):e41482.
 40. Meyer K, Willis R. Looking back to move forward: The value of reflexive journaling for novice researchers. *J Gerontol Soc Work*. 2019;62(5):578–85.
 41. Tandon D, Perry DF, Edwards K, Mendelson T, Panel SA. Developing a Model to Address Mental Health, Substance Use, and Intimate Partner Violence Among Home Visiting Clients. *Health Promot*

- Pract. 2020;21(2):156–9. 10.1177/1524839919886293. PubMed PMID: 31718313.
42. Weissman MM, Hankerson SH, Scorza P, Olfson M, Verdelli H, Shea S, et al. Interpersonal counseling (IPC) for depression in primary care. *Am J Psychother.* 2014;68(4):359–83.
 43. Cort NA, Cerulli C, Poleshuck EL, Bellenger KM, Xia Y, Tu X, et al. Interpersonal psychotherapy for depressed women with histories of intimate partner violence. *Psychological trauma: theory, research, practice. policy.* 2014;6(6):700.
 44. Nicolaidis C, Wahab S, Trimble J, Mejia A, Mitchell SR, Raymaker D, et al. The Interconnections Project: development and evaluation of a community-based depression program for African American violence survivors. *J Gen Intern Med.* 2013;28(4):530–8.
 45. Lacey KK, Parnell R, Mouzon DM, Matusko N, Head D, Abelson JM, et al. The mental health of US Black women: the roles of social context and severe intimate partner violence. *BMJ Open.* 2015;5(10):e008415. 10.1136/bmjopen-2015-008415. Epub 2015/10/21.
 46. Gilbert L, Goddard-Eckrich D, Chang M, Hunt T, Wu E, Johnson K, et al. Effectiveness of a culturally tailored HIV and sexually transmitted infection prevention intervention for Black women in community supervision programs: A randomized clinical trial. *JAMA Netw open.* 2021;4(4):e215226–e.
 47. Goddard-Eckrich D, Henry BF, Sardana S, Thomas BV, Richer A, Hunt T, et al. Evidence of help-seeking behaviors among Black women under community supervision in New York City: a plea for culturally tailored intimate partner violence interventions. *Women's Health Rep.* 2022;3(1):867–76.
 48. Hankerson SH, Wells K, Sullivan MA, Johnson J, Smith L, Crayton L, et al. Partnering with African American Churches to Create a Community Coalition for Mental Health. *Ethn Dis.* 2018;28(Suppl 2):467–74. PubMed PMID: 30202200; PubMed Central PMCID: PMC6128345.
 49. Gilbert L, Shaw SA, Goddard-Eckrich D, Chang M, Rowe J, McCrimmon T, et al. Project WINGS (Women Initiating New Goals of Safety): a randomised controlled trial of a screening, brief intervention and referral to treatment (SBIRT) service to identify and address intimate partner violence victimisation among substance-using women receiving community supervision. *Criminal Behav mental health.* 2015;25(4):314–29.

Tables

Table 1 to 3 are available in the Supplementary Files section.

Figures

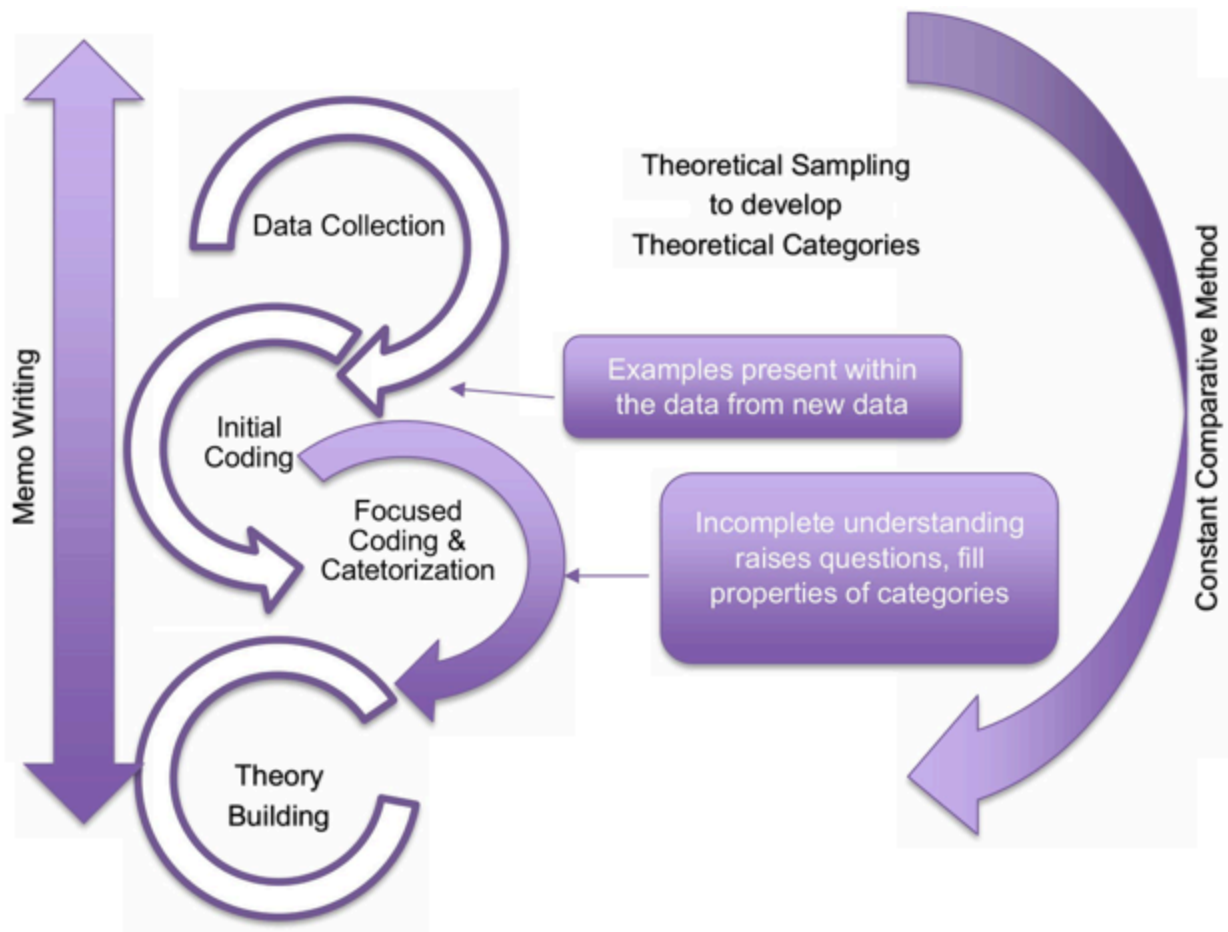


Figure 1

Constructivist Grounded Theory Methodology

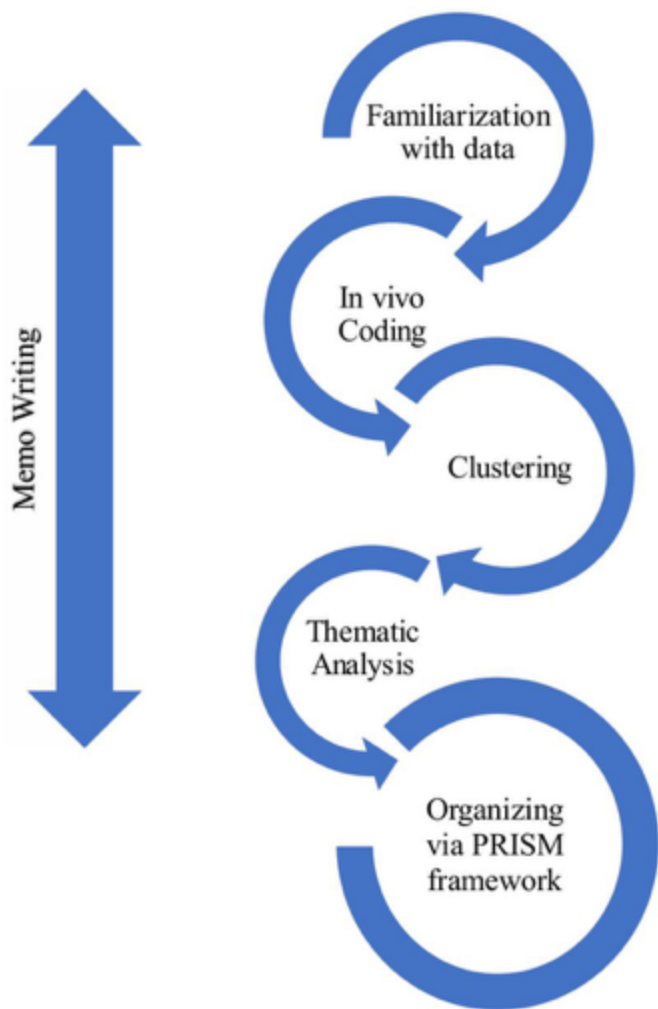


Figure 2

Inductive-Deductive Thematic Analysis



Figure 3

Sarah Waller's Help-Seeking Model

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [SupplementalFile1.IntxWGProtocol.docx](#)
- [floatimage3.png](#)
- [floatimage4.png](#)
- [floatimage6.png](#)