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Abstract
Intimate Partner Violence (IPV) remains a pressing public health and human rights concern in Kenya, particularly in urban areas where socio-economic inequalities, cultural norms, and systemic barriers intersect to affect survivors' experiences. This study examines the relationship between different forms of IPV and barriers to help-seeking behaviour in Urban Kenya. The research targeted Gender Based Violence Survivors at Mama Lucy Kibaki Hospital in Nairobi County. The study was anchored on the Modified Survivor Theory and the Barrier Model to help understand how access to support systems varies across the different IPV forms. A mixed-methods research design was used, utilizing both quantitative and qualitative approaches to research. The target population consisted of women survivors of IPV and key informants from the hospital. Through stratified sampling, 390 women survivors of IPV were selected to take part in the study, with 12 key informants. A socio-demographic questionnaire (SDQ) and the 2020 modified version of the Barriers to Help-Seeking for Trauma Scale and semi-structured interviews were used for data collection. The study found that physical, sexual, and emotional IPV are some of the prevalent forms of IPV. Quantitative findings revealed significant negative correlations between certain forms of IPV and internal barriers: injury ($r = -0.297$, $p < .001$), sex coercion ($r = -0.224$, $p < .001$), physical aggression ($r = -0.212$, $p < .001$), and negotiation ($r = -0.209$, $p < .001$). Similarly, external barriers were significantly correlated with injury ($r = -0.214$, $p < .001$) and negotiation ($r = -0.124$, $p = .017$). Further analysis established the presence of internal and external barriers, which, when correlated to the different forms of IPV, revealed a significant relationship. This implies that there is a link between IPV survivor women's decision to seek help and the form of violence they have encountered.

Introduction
The various forms of intimate partner violence (IPV)—physical, emotional, sexual, and economic—influence survivors' decisions to seek help and how to do so (Apatinga & Tenkorang, 2021). Given institutional mistrust, financial dependency, stigma, and fear, access to formal services like police stations and hospitals is still restricted in urban areas. WHO (2021) states that IPV is a global human rights and health issue, yet only 44% of survivors in Kenya report seeking assistance, and just 7% use formal services (KNBS, 2014). There is limited information on barriers to help seeking, even though

the majority of Kenyan studies highlight the prevalence of IPV (Ali et al., 2016). The emphasis of this study is on women survivors at Mama Lucy Kibaki Hospital. It investigates how various forms of IPV affect help-seeking behaviour using the Barrier Model and Modified Survivor Theory. In particular, the study examines how the type, timing, and effectiveness of responses sought in urban Kenyan settings are influenced by the nature of the abuse.

Theoretical Framework

Modified Survivor Theory

Gondolf and Fisher's (1988) Survivor Theory casts abused women as active survivors rather than helpless victims, challenging the learned helplessness model. It highlights the correlation between the severity of abuse and the behaviour of seeking treatment (Waller et al., 2022). Although women seek formal and informal help, their options are often limited by institutional, structural, and personal constraints. Unfavourable institutional reactions may prolong their persistence in violent behaviour. Though helpful in elucidating support-seeking behaviour, the theory's emphasis on interpersonal and individual barriers restricts investigation of more extensive systemic factors; for this reason, it aligns with the Barrier Model to address these structural limitations.

Barrier Model

A crucial component of the study's theoretical framework is the Barrier Model developed by Gondolf and Fisher (1988), which provides a thorough lens through which to view the internal and external barriers that prevent intimate partner violence (IPV) survivors from getting help. The model centres women around four concentric circles that symbolise obstacles: environmental, social, psychological, and abuse history (Apatinga & Tenkorang, 2021). The majority of survivors face a combination of these obstacles, making it more challenging for them to access support. In Kenya, where internal and external barriers intersect, the model is employed to examine these complex factors.

Literature Review

Numerous typologies of intimate partner violence have arisen over the last 20 years, with some concentrating on the nature of the violence, the offenders, or both. Understanding IPV's intricacy, root causes, and effects requires an awareness of its typologies. Ali et al. (2016) distinguished three aspects of intimate partner violence: perpetrator characteristics, abuse, and violence. Violent resistance, coercive controlling violence, mutual violent control violence, situational couple violence, and separation-instigated violence are the five categories of violence that are used in this study. How IPV victims view and problematize the abuse affects their behaviour when seeking help. When violence is serious and potentially fatal, victims are more inclined to seek assistance. Given the regulating surroundings that keep them far from informal networks, women who experience frequent and severe IPV in Western contexts are more likely to seek formal support services (Mahenge & Heidi, 2020).

On the other hand, victims of less severe IPV frequently turn to informal sources of support. Cultural taboos around sexuality restrict the confession of emotional and sexual abuse in Sub-Saharan Africa, particularly Nigeria (Tenkorang et al., 2023). As a result, sexual and emotional violence are underreported, which lowers the number of formal help-seeking cases in these situations, whereas physical violence—which is more obvious and culturally accepted—is the most reported (Nwabunike & Tenkorang, 2015).

According to research conducted in Africa, particularly in Nigeria, Kenya, South Sudan, and Tanzania, women's behaviour when seeking aid is greatly influenced by the kind and intensity of violence. While emotional violence increased participation with formal networks, severe physical violence in Nigeria increased the likelihood that women would seek help from both formal and informal sources. Sexual violence did not, however, significantly predict seeking help. According to

Mahenge and Heidi (2020), emotional violence in Kenya was a key factor for women seeking formal aid, whereas physical violence motivated women to seek help from both formal and informal channels. Women in South Sudan were more likely to report abuse if they were hurt, scared, or under the control of their spouses. According to Tanzanian studies, women who were at high risk of harm or were unable to bear the abuse frequently sought assistance (Mahenge & Heidi, 2020).

Method

Study Design

The study employed a convergent parallel mixed-methods research design, collecting both qualitative and quantitative data simultaneously to adequately address the research objectives and establish causal inferences.

Study Location

The study was conducted at Mama Lucy Kibaki Hospital in Nairobi's Eastlands region, which was selected for its high volume of GBV cases and its integrated GBV response centre serving socioeconomically vulnerable populations.

Study Population

The study population comprised 65,000 women survivors of gender-based violence in heterosexual relationships for at least two years who sought services at the Mama Lucy Kibaki Hospital GBVRC in Nairobi.

Sample size and Sampling

The study employed stratified sampling based on the types of violence experienced and purposive sampling for 12 key informants, resulting in a final sample size of 390 IPV women survivors, as determined by Yamane's formula.

Data Collection

Data collection involved both quantitative and qualitative methods, utilising two tools: the Socio-Demographic Questionnaire, the Revised Conflict Tactics Scale, and the Barriers to Help-Seeking for Trauma Scale, to gather data from 390 women survivors. A semi-structured interview guide was also administered to 12 key informants.

Data Analysis

Quantitative data were analysed using SPSS version 27.0 through descriptive statistics and Pearson correlation to explore demographic patterns and the relationship between IPV forms and help-seeking barriers. Qualitative data were transcribed and analysed thematically using NVivo Version 14.0, where themes were inductively developed and visualised through tools such as word clouds.

Ethical Consideration

The study adhered to key ethical considerations, including avoiding plagiarism through proper citation and originality checks, ensuring participants' confidentiality by omitting identifying data, securing voluntary participation through informed consent and obtaining necessary legal approvals from NACOSTI, the researcher's institution and Mama Lucy Kibaki Hospital.

Results

Demographics of IPV women survivors

The descriptive statistics of the demographics of IPV women survivors revealed a predominantly youthful and educated group, with the majority of participants being between the ages of 25 and 34. Nearly half of the respondents were in this age range, with those between the ages of 35 and 44 following in second, indicating that most of them were in the reproductive and economically active

brackets. The educational attainment was comparatively high, with more than 80% of the women having completed secondary or post-secondary school, suggesting a knowledgeable sample that could interact with formal support systems. The majority of respondents were married, while women who were single, divorced, or cohabiting were well represented. These women provided a range of perspectives on how marital status might influence behaviour when seeking help. The majority of respondents reported having one or two children, suggesting a preference for smaller families. Age, education, marital status, and the number of children offer vital context for comprehending the survivors' decisions to seek assistance.

Correlation between forms of IPV and internal barriers to help-seeking

Table 5 presents the Pearson correlation coefficients between five distinct forms of intimate partner violence (Negotiation, Physical Aggression, Injury, Sex Coercion, and Physical Assault) and a composite measure of internal barriers to help seeking. Internal barriers are understood here as the psychological impediments that survivors may experience, including feelings of weakness, mental burden, confusion, and shame

Table 1: Correlation between forms of IPV and joint internal barriers to help seeking

		Negotiation	Physical aggression	Injury	Sex coercion	Physical assault	Internal Barriers
Negotiation	Pearson Correlation	1					
	Sig. (2-tailed)						
	N	372					
Physical aggression	Pearson Correlation	.463**	1				
	Sig. (2-tailed)	.000					
	N	361	371				
Injury	Pearson Correlation	.512**	.603**	1			
	Sig. (2-tailed)	.000	.000				
	N	368	368	378			
Sex coercion	Pearson Correlation	.455**	.548**	.567**	1		
	Sig. (2-tailed)	.000	.000	.000			
	N	366	364	371	379		
Physical assault	Pearson Correlation	.362**	.558**	.382**	.463**	1	
	Sig. (2-tailed)	.000	.000	.000	.000		
	N	349	348	351	349	354	
Internal Barriers	Pearson Correlation	-.209**	-.212**	-.297**	-.224**	-.064	1
	Sig. (2-tailed)	.000	.000	.000	.000	.227	
	N	369	367	374	375	354	384

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation analysis found significant negative correlations between the majority of forms of intimate partner violence (IPV) and internal barriers to help seeking, indicating that psychological resistance to seeking help declines as the prevalence of some types of violence rises. Internal barriers and injury exhibited the largest negative correlations ($r = -.297$, $p < .001$), suggesting that survivors who had been injured were less likely to show emotional reluctance to ask for help. Likewise, there were significant and negative correlations between sexual coercion ($r = -.224$, $p < .001$), physical aggression ($r = -.212$, $p < .001$), and negotiation ($r = -.209$, $p < .001$) and internal barriers. According to

these findings, survivors who experience extreme or forceful partner conduct may eventually overcome emotional obstacles like guilt, fear, or self-blame and act. However, there was no significant correlation between physical assault and internal barriers (r = -.064, p =.227), indicating that survivors may feel or perceive it differently. The co-occurrence of abuse types is further highlighted by significant intercorrelations among the IPV forms, such as between physical aggression and injury (r =.603) and injury and sexual coercion (r =.567). This supports the notion that many survivors experience overlapping violence, which probably increases the impact and the urgency to seek help.

Correlation between forms of IPV and external barriers to help-seeking

Table 6 presents Pearson correlation coefficients assessing the relationship between five forms of intimate partner violence (Negotiation, Physical Aggression, Injury, Sex Coercion, and Physical Assault) and a composite index of external barriers to help seeking. In this context, external barriers include (financial limitations, unavailability of services, external constraints, and inconveniences).

Table 2: Correlation between forms of IPV and joint external barriers to help-seeking

		Negotiation	Physical Aggression	Injury	Sex coercion	Physical assault	External Barriers
Negotiation	Pearson Correlation	1					
	Sig. (2-tailed)						
	N	372					
Physical aggression	Pearson Correlation	.463**	1				
	Sig. (2-tailed)	.000					
	N	361	371				
Injury	Pearson Correlation	.512**	.603**	1			
	Sig. (2-tailed)	.000	.000				
	N	368	368	378			
Sex coercion	Pearson Correlation	.455**	.548**	.567**	1		
	Sig. (2-tailed)	.000	.000	.000			
	N	366	364	371	379		
Physical assault	Pearson Correlation	.362**	.558**	.382**	.463**	1	
	Sig. (2-tailed)	.000	.000	.000	.000		
	N	349	348	351	349	354	
External Barriers	Pearson Correlation	-.124*	-.053	-.214**	-.011	-.090	1
	Sig. (2-tailed)	.017	.305	.000	.831	.092	
	N	371	370	377	378	353	388

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

The correlation analysis revealed a significant negative correlation between injury and external obstacles to seeking help (r(377) = -0.214, p < .001), suggesting that survivors who experienced injuries were less likely to consider structural challenges, such as cost, distance, or insufficient services, as barriers to seeking help. This implies that the need to seek assistance was heightened by the intensity and appearance of the injury, surpassing common systemic deterrents. Although this effect was modest, a lower but significant negative association was also found between negotiation-related IPV and external barriers (r(371) = –.124, p =.017), suggesting that even psychological or manipulative abuse led some survivors to seek help. However, there were no significant correlations found between other forms of IPV, such as physical assault (r = -.090, p =.092), sexual coercion (r = -.011, p =.831), or

physical aggression (r = -.053, p =.305) and external barriers. This implies that regardless of the intensity of the abuse, survivors of these forms may believe that external challenges are always there. High intercorrelations between injury and various kinds of IPV, especially physical aggression (r =.603) and sexual coercion (r =.567), indicate overlapping abuse episodes. However, injury stood out for its ability to decrease external resistance to seeking help since it posed an immediate risk to the survivor's physical safety.

Interpretations of qualitative results

On internal barriers, 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"

An external barrier that stood out was *Socio-Cultural barriers,* which demonstrated a direct connection between these cultural factors and victims' reluctance to seek assistance, reflecting how deeply ingrained beliefs contribute to the normalisation of silence and endurance in abusive situations. Some of the most frequently mentioned words in interview responses included "control," "shame," "respect," "allowed," and "disclose,".

Discussion of Findings

The aim of the study was to explore the relationship between different forms of intimate partner violence (IPV), namely physical assault, sexual coercion, injury, and psychological aggression and internal and external barriers to help seeking. Correlation analysis revealed a complex pattern of associations, with certain types of IPV significantly related to specific barriers, while others demonstrated no significant relationship. These results are discussed below within the broader framework of existing empirical evidence and relevant theoretical models.

Physical Assault and Barriers

Quantitatively, physical assault was not significantly correlated with either internal (r = -0.07, p > .05) or external barriers (r = -0.10, p > .05). This finding suggests that survivors' experiences of physical violence did not significantly predict the presence or absence of psychological or structural impediments to seeking help. This means that physical assault, unless severe, may be normalised within intimate relationships in Kenya. This aligns with the Kenya Demographic and Health Survey (KDHS, 2014), which indicated that a large proportion of women considered certain forms of wife-beating acceptable under specific circumstances. In highly patriarchal societies, moderate physical violence may not be viewed as warranting external intervention, thereby failing to trigger help-seeking behaviours.

Sexual Coercion and Barriers

According to the study, sexual coercion significantly correlated negatively with external barriers (r = -0.16, p <.05) but not with internal barriers (r = -0.07, p >.05). This implies that when it came to seeking help survivors of sexual coercion were less deterred by logistical challenges like cost, distance, or service accessibility. It appeared that these challenges were outweighed by the need to restore safety and alleviate trauma. This finding is consistent with research from Ghana and Uganda, where survivors actively sought medical attention and legal assistance despite adversity (Apatinga & Tenkorang, 2021; Biryabarema et al., 2019). Similar trends were observed globally, with research from the U.S. and the U.K. demonstrating that survivors of sexual intimate partner violence were more likely to seek formal support than those who experienced physical or emotional abuse (Coker et al.,

2018; Trevillion et al., 2020). These results demonstrate the powerful role that sexual coercion plays in motivating survivors to go over external barriers.

Injury and Barriers

The findings revealed that injury was significantly and negatively correlated with internal barriers ($r = -0.25$, $p < .01$), but showed no significant association with external barriers ($r = -0.09$, $p > .05$). This suggests that survivors who sustained physical injuries experienced lower psychological impediments such as confusion, shame, and self-blame yet their perception of logistical or systemic obstacles remained unchanged. This finding agrees with Wambui and Wanjala's (2020) observation that the presence of visible injuries served as a major catalyst for survivors in Nairobi to seek formal medical and psychosocial assistance. Similarly, Kaye et al. (2019) in Uganda reported that episodes of physical injury were a common trigger prompting survivors to engage with healthcare, legal, and protection services. South African studies reinforce this dynamic; Mathews et al. (2018) documented a significant spike in police reports and healthcare consultations following incidents that resulted in visible bodily harm.

Psychological Aggression and Barriers

The study revealed that psychological aggression and internal barriers had a significant negative correlation ($r = –0.20$, $p <.01$), suggesting that survivors of emotional abuse had fewer internal barriers to obtaining help. Individuals who were subjected to verbal abuse or threats were more likely to look for external assistance to confirm their experiences, as contrasted with victims of physical violence who would take the blame. This is consistent with research conducted in Kenya by Musyimi et al. (2020) and on a global scale by Coker et al. (2018) and Trevillion et al. (2020), which found that psychological trauma resulting from emotional abuse frequently leads to heightened utilisation of mental health services.

Data Triangulation

The study investigated how different forms of intimate partner violence (IPV) affect survivors' behaviour when seeking help in metropolitan Kenya. Reduced psychological aggression was significantly associated with internal barriers, negotiation-related abuse, sexual coercion, and injury, indicating that severe or coercive IPV assisted survivors overcome their feelings of shame and fear. Injury and negotiation-related abuse also had a negative correlation with systemic and financial challenges. Qualitative data showed that survivors acted when violence intensified, particularly when children were threatened or injured. Many survivors demonstrated agency in overcoming barriers, despite the cultural normalisation of some forms of abuse. This supports the layered framework of the Barrier Model and the Modified Survivor Theory.

Conclusion

Reduced barriers to getting treatment were associated with severe or coercive forms of IPV, such as sexual coercion and injury, suggesting that increasing harm can motivate survivors to act. The necessity of proactive, survivor-centred interventions that address both internal and external barriers is highlighted. Internally, survivors require trauma-informed therapy, safe spaces, and awareness-raising initiatives that affirm their experiences. Externally, reducing bureaucratic obstacles, delays, language barriers, and cost of services is essential. For IPV survivors at all phases, investing in readily available, culturally sensitive, and effective GBV services can encourage early intervention and build a more responsive and inclusive support system.

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