

2016

Clinicians' Perceptions of North Carolina's 10-Year Primary Prevention Plan

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Carol Jones

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2016

Abstract

Clinicians' Perceptions of North Carolina's 10-Year Primary Prevention Plan

by

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MA, University of North Carolina at Pembroke, 2006

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

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Abstract

The cost of domestic and intimate partner violence (DIPV) exceeded \$8 billion annually on a national level, and North Carolina spent \$307 million on DIPV and DIPV-related mental health care. Studies have shown a correlation between DIPV, mental illness, and substance abuse. North Carolina was found to have higher than normal risk factors for DIPV. In response, the Centers for Disease Control and Prevention partnered with the North Carolina Coalition Against Domestic Violence (NCCADV) to develop the NCCADV 10-year primary prevention plan. This study investigated clinicians' perceptions of the effectiveness of the plan. Phenomenological thought served as the conceptual framework. A purposive sample of 10 clinicians who worked in the region with DIPV clients in the preceding 12 months responded to semistructured interview questions that investigated their perceptions of whether the 10-year plan had a positive influence on victims and if the plan could potentially impact victims' future mental health and substance use behaviors. Interview data were transcribed, open coded, and thematically analyzed with the aid of qualitative software. Study results indicated that these clinicians believed the plan did not impact DIPV clients' current behaviors and was unlikely to have a future impact. A policy recommendation in the form of a position paper resulted from the findings, which recommended the use of mass media that encompass old and new technologies to promote primary prevention efforts by stakeholders and practitioners for the general public. This study has implications for positive social change in that it may provide knowledge to clinicians and stakeholders at the study site that aids them in understanding and preventing DIPV, in addition to promoting an overall increase in public awareness of the negative effects of DIPV.

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Dedication

I dedicate this study to my three sons, who patiently stood by me night after night, month after month, year after year, as I walked this journey. Jermaine, Christopher, and Benjamin, thank you for your loving support. You demonstrated your love each time you kept the television on low, understood when I had assignments and papers to write, and picked up the slack when I pulled an all-nighter.

This journey started long before I entered this program, and you stood by me all the way. This study is also dedicated to my mother, who is no longer with me but whose voice I heard at times when I needed answers to tough questions, or encouragement to keep going. Thanks, I love you very much, Mom. I dedicate this study to all of the women, men, and children who have experienced domestic and intimate partner violence. I would like you to know there is help available and you no longer have to hide in the shadows or suffer in silence.

Acknowledgments

I would like to acknowledge the people in my life who offered tireless support to make sure that I reached the goal of earning my doctorate in education. Their support and encouragement helped to get me through the days of discouragement and times when I felt like I could not go on. There are many who have contributed to my success, and you each know who you are; I am, and will forever be, eternally grateful.

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Section 1: The Problem

The Local Problem

Currently, few ongoing primary prevention programs exist that are designed to focus the attention of the general public on the reduction of domestic intimate partner violence (DIPV) and related mental-health and substance-abuse issues. Existing programs use secondary and tertiary prevention method to address the needs of victims, perpetrators, and family members after the violence has occurred rather than focusing on primary prevention which targets the issue prior to onset (Spivak et al., 2014).

Nevertheless, without secondary and tertiary prevention programs, victims, family members, and perpetrators could not receive the needed supports afforded by these programs. However, if programs were designed towards prevention, individuals who receive help would recognize the signs associated with DIPV. As such, recognition of warning signs could help to reduce and maybe eventually stop the cycle of violence.

Moreover, the need for prevention is significant in a state identified as having high risk factors for DIPV, and in North Carolina where this study was conducted; instances of DIPV were prevalent enough to warrant intervention from the CDC. Furthermore, common throughout the state is a large multibranch military that is home to men and women who returned from the wars in Iraq and Afghanistan. The CDC recognized the large military presence as a risk factor within the state and studies have shown an increase in domestic violence and related mental-health and substance-abuse concerns among soldiers (McCarroll et al., 2010; Taft, Watkins, Stafford, Street, & Monson, 2011).

The presence of military men and women across the state is not the only concern as instances of DIPV are evident in both the military and nonmilitary populations. Therefore, implementing primary prevention programs statewide could serve to address the needs of those who are at risk as well as to inform the general public. To study the domestic violence issue in North Carolina I decided on a case study design influenced by phenomenology with a purposive sample of clinicians. Clinicians who served DIPV victims, perpetrators, and family members, both military and civilian would provide valuable data. Understanding clinicians' beliefs related to the effects of increased awareness of DIPV victims with mental health and substance abuse would also address a gap in the literature.

Studies have shown that in 2003, the National Center for Injury Prevention and Control (NCIPC) and the CDC estimated that issues related to DIPV cost the United States \$8.3 billion, with this cost expected to grow daily. The World Health Organization (WHO, 2005) and the CDC (2008, 2010c) identified DIPV as a public health problem with risk factors specific to (a) education level (CDC, 2005), (b) race (Blitz & Illidge, 2006), and (c) disability (Brodwin & Siu, 2007). Additional risk factors included (a) mental functioning (Cummings, El-Sheikh, Douros, & Buckhalt, 2009; Dodd, 2009), (b) age (Lundy & Grossman, 2009; Owens, Thompson, Shaffer, Jackson, & Kaslow, 2009), and (c) socioeconomic standing (Eckstein & McDonald, 2010).

Identified by the CDC as having higher than normal risk factors for DIPV, North Carolina was selected to develop a statewide plan, the NCCADV 10-year primary prevention plan, to address this growing problem. North Carolina was one of 14 states

recognized by the CDC as having larger than normal populations susceptible to defined violence-related risk factors. In addition, 4 years after the NCIPC and CDC report, the Department of Health and Human Services in North Carolina (NCDHHS) identified approximately 250,000 of its residents as having mental health concerns.

Therefore, the CDC and the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) project sanctioned the NCCADV agency to develop a plan to combat DIPV statewide. The agency would implement the plan for primary prevention strategies to address at-risk populations throughout the state and report on the effectiveness of the aforementioned interventions.

The result was a 10-year primary prevention plan that would focus prevention efforts towards reaching all people in North Carolina from (a) infants to older adults, (b) parents, (c) those in the education and state systems, and (d) those who work in community organizations. The aim of which was to teach citizens of the lasting effects of DIPV on the community with a goal to promote domestic violence prevention, address DIPV issues, and advocate for and sustain healthy North Carolinians (NCCADV, 2010a). As a result, the plan focused on a lifespan approach that addressed the needs of children as young as 3 years of age and adults beyond age 61.

The NCCADV 10-year plan indicated that North Carolina women, men, and children had rates of mental-health-related problems that were higher than the national average (NCCADV, 2010a). In related information, NCDHHS reported that over 7,000 children and 242,000 adults received services in 2007 for mental health, developmental disability, and substance-abuse-related problems (NCDHHS, 2010).

Moreover, the DELTA and CDC organizations sought to alleviate through the 10-year plan, DIPV and related mental health concerns across the state. Also evident within the plan were many concerns that have been outlined in the literature. Studies have shown the impact of DIPV on (a) public health (Abrahams et al., 2009; Afifi et al., 2008; Caetana, Vaeth, & Ramisetty-Miller, 2008; CDC, 2009, 2010c, 2010d; Dahlberg & Butchart, 2005); (b) the mental health of victims and nonvictims (Bent-Goodley & Brade, 2007; Cummings et al., 2009; Dodd, 2009; Holtzworth-Munroe, 2005; Humphreys & Lee, 2006; Lipsky & Caetano, 2007; Outlaw, 2009); and (c) Asian Americans, Hispanics, Native Americans, and African Americans and those of lower socioeconomic standing (Blitz & Illidge, 2006; Eckstein & McDonald, 2010; Hampton, LaTaillade, Darcy, & Marghi, 2008; Hancock, 2006; Lott-Collins & Moore, 2006; Martin et al., 2009; Mascaro, Arnette, Santana, & Kaslow, 2007; Mitchell et al., 2006; Nicolaidis et al., 2010; Watlington & Murphy, 2006).

Definition of the Problem

Mental health professionals in North Carolina who serve clients and their children have witnessed firsthand the impact of DIPV on those who present for treatment. Past research has suggested that clients, children, and communities exposed to DIPV have higher instances of mental health and substance-abuse-related issues than those not exposed to violence (NCCADV, 2010). In many cases, however, mental health professionals have been limited in their ability to reach and treat all who experience violence and associated issues, due to inadequate time and resources, in spite of the aforementioned 10-year plan.

Although there have been many public-health awareness programs in North Carolina (e.g., programs focused on the importance of using seatbelts, cancer prevention initiatives, and antismoking campaigns), there has been little media awareness of DIPV. The DIPV problem in North Carolina did not receive the public attention required to affect change.

Evidence has shown that centralized within North Carolina are many of the risk factors common to DIPV, such as a large military population residing at Army, Marine, Air Force, Navy, Coast Guard, National Guard, and Reserve posts. And as large numbers of soldiers were deployed and then returned from wars in Afghanistan and Iraq, evidence showed an increase in instances of intimate partner violence (McCarroll et al., 2010). Associated with the growing violence were increased use of substances and mental-health-related concerns for these soldiers and their family members (Eisen et al., 2012).

Within nonmilitary populations in North Carolina, including Whites, Blacks, American Indians, and Hispanics, many individuals have been diagnosed with disabilities, mental illnesses, and substance-abuse-related issues. As previously mentioned, risk factors associated with mental illness and DIPV unique to North Carolina have exacerbated the state's DIPV problem. Among the state's large population of American Indians, for instance, the incidence of DIPV is high due to low socioeconomic standing and limited education (CDC, 2005). Additionally, between 1990 and 2000, the state experienced an increase of 393% in the Latino population (NCCADV, 2010b), a subgroup described in the literature as susceptible to increased partner violence (Hancock, 2006).

Furthermore, the literature indicated that Hispanic women victimized by DIPV used emergency departments at a higher rate than nonHispanics (Lipsky and Caetano, 2007). In a related study, Caetano and Vaeth (2008) reported greater rates of domestic violence victimization by Hispanic men than by men who were not Hispanic, with DIPV rates up to 5 times higher. Subsequently, the aforementioned risk factors presented multiple challenges for health and mental health professionals who worked with members of the DIPV, mental health, and general populations.

Mental health professionals have firsthand lived experiences with DIPV victims. Mental health professionals, in working with individuals in communities, schools, military installations, mental health centers, and private agencies, witness how failure to address DIPV and related mental-health and substance-abuse issues negatively affects the community at large (NCCADV, 2010b). Ongoing primary prevention awareness efforts could serve to educate the public about the negative consequences of DIPV. In addition, primary prevention awareness could challenge erroneous beliefs and dispel long-held myths about DIPV, and alert the public to resources available within the local community.

The lack of primary prevention, the aforementioned risk factors, and mental health issues in North Carolina have influenced a push for a more decisive way to address DIPV within the state. Primary prevention is perceived as key to addressing mental health issues. There is evidence throughout the literature in support of primary prevention as a tool to address public health concerns such as smoking (Buila, 2009; Duke, 2009; Nelson et al., 2008; Vallone et al., 2011).

Thus, the implementation primary prevention programs as a means of addressing DIPV would benefit individuals across the state. Clinicians who have direct contact with victims who suffer from mental illness and DIPV could share their perceptions of victims' responses to primary prevention. Clinicians' responses may provide insight into the effectiveness of the NCCADV 10-year primary prevention plan and other such programs, thereby addressing the gap in the literature.

Although it is true that DIPV in North Carolina has reached levels of concern, to date, there has been a lack of research specifically addressing primary-prevention efforts related to domestic violence that target the general public. For example, of 380 articles found through a multidatabase search using the terms *public health, prevention, United States*, and *not sex*, only two directly addressed the prevention of domestic violence.

Evidence of the Problem at the Local Level

As a mental health clinician, I have experienced the negative impact of DIPV on individual lives as well as the community at large. I have seen from a mental health standpoint how children affected by DIPV (a) may be removed from their homes, (b) may develop poor coping skills, (c) may engage in risky behaviors, and (d) may thus become a burden on society. For many decades, DIPV was seen as a personal problem between individuals in the privacy of their own homes; however, research proved that this was not the case. For example, WHO (2005) and the CDC (2008, 2010c) have identified DIPV as a public health problem with multiple risk factors.

Furthermore, in the last sizable study in 2003 sponsored by the NCIPC, the CDC, and the Department of Health and Human Services (DHHS), based on a National

Violence Against Women survey, it was reported that women 18 years and older experienced about 5.3 million instances of DIPV at a cost of \$5.8 billion annually. These DIPV acts included rape, assault, and stalking. Consequently, of the \$5.8 billion in costs, \$4.1 billion were related to physical and mental health care services (NCIPC, 2003). Although the DIPV burden on the mental health community for women aged 18 years and older was evident in the 2003 study, the overall burden far outweighed these estimates (Bonomi, Anderson, Rivara, & Thompson, 2009; Rivara et al., 2007).

Moreover, in the fourth quarter of 2010, North Carolina emergency departments saw in excess of 144,000 patients whose primary diagnosis was related to mental illness; more than 80% of those patients were women (NCDHHS, 2010). Also noteworthy was the NCCADV (2010a) 10-year plan, which reported that rates of mental health-related problems in North Carolina were higher than the national average, as well as the NCDHHS report of over 240,000 North Carolina men, women, and children with substance abuse, developmental disabilities, and mental illness (NCDHHS, 2010). As a result, when mental health clinicians observe these issues and address the presenting problem (e.g., substance abuse or mental illness), DIPV is not considered.

As an illustration, more recent studies have shown the impact of DIPV on (a) public health (Abrahams et al., 2009; Afifi et al., 2008; Caetana, Vaeth, & Ramisetty-Miller, 2008; CDC, 2009, 2010c, 2010d; Dahlberg & Butchart, 2005); (b) the mental health of victims and nonvictims (Bent-Goodley & Brade, 2007; Cummings et al., 2009; Dodd, 2009; Holtzworth-Munroe, 2005; Humphreys & Lee, 2006; Lipsky & Caetano, 2007; Outlaw, 2009); and, (c) Asian Americans, Hispanics, Native Americans, and

African Americans and those of lower socioeconomic standing (Blitz & Illidge, 2006; Eckstein & McDonald, 2010; Hampton et al., 2008; Hancock, 2006; Lott-Collins & Moore, 2006; Martin et al., 2009; Mascaro et al., 2007; Mitchell et al., 2006; Nicolaidis et al., 2010; Watlington & Murphy, 2006).

Thus, the effects of DIPV flow into the larger community, and the narrow lenses through which DIPV has been viewed must be expanded. Mental health professionals may be the professionals who are most aware of the consequences of domestic violence. Yet, as a clinician I am aware that any diagnosis found in the Diagnostic and Statistical Manual (DSM) of Mental Illness IV can be applied to victims of domestic violence, given that many victims endure violence for years without treatment.

Altogether, the DIPV problem in North Carolina warranted intervention by agencies outside the state. Past as well as recent studies have shown the need for statewide intervention. However, professionals across the state are in need of support to address this public health issue as they work with clients who may or may not report the violence. In addition, professionals may rely on well established but ineffective methods to address the DIPV issue.

For instance, although many DIPV prevention strategies are available, professionals within the health, mental health, and advocacy communities have standardized the practice of using secondary and tertiary intervention methods to address DIPV. The use of secondary and tertiary intervention methods presents a problem when working with DIPV victims and their families because the abuse has already occurred.

Most of these efforts are carried out after DIPV has taken place rather than being used as a means to prevent it.

Noting the limitations of the standardized use of secondary and tertiary intervention methods in no way minimizes the success of these programs. Many of these programs have addressed the needs of victims or family members by developing intervention strategies. These strategies include but are not limited to (a) coordinated community responses (Holtfreter & Boyd, 2006); (b) domestic violence literature (McFarlane, Groff, O'Brien, & Watson, 2006); (c) media campaigns (Potter, Stapleton, & Moynihan, 2008); and (d) online continuing education (Harris, Novalis-Marine, Ameno, & Surprenant, 2009). Also, despite evidence supporting the effectiveness of secondary and tertiary intervention methods, it should be noted that these programs have sought to change *established* behaviors, attitudes, and beliefs and address an *ongoing* problem rather than preventing it to begin with.

In contrast there has been support for the implementation of primary prevention methods directed toward addressing public attitudes, myths, and behaviors related to DIPV (Campbell & Manganello, 2006; Dahlberg & Butchart, 2005; Potter et al., 2008; Stith, 2006). For example, education awareness programs that target the general public and those at risk of becoming victims could be preventative in nature. These programs could reach a larger audience and have an immediate and lasting impact on the citizens of North Carolina (Ahmed, Koenig, & Stephenson, 2006; NCCADV, 2010b). For instance, WHO (2005, 2010) has offered several recommendations and evidence-based outcomes in support of primary prevention programs that stopped DIPV in its tracks.

Definitions

Comorbidity is defined as existing simultaneously with, and usually independent of, another medical condition (Valderas, 2009). For the purpose of this paper, a *medical condition* is defined as any health-related condition not identified as a mental illness.

Mental illness is defined as

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (American Psychiatric Association, 2000, p. xxxi)

Primary prevention is defined as the obstruction of violence prior to its occurrence (Dahlberg & Butchart, 2005; NCCADV, 2010b).

Primary prevention resources: For the purpose of this study, primary prevention tools refer to any public service announcements (PSAs; radio, television, billboards, etc.), programs conducted during or after school, brochures, flyers, pamphlets, or direct and online training programs focused directly on the prevention of DIPV.

A provisional licensed clinician is defined as a counselor in training who is fulfilling state-mandated requirements prior to full licensure.

Significance

During the period of January 1, 2013, through February 18, 2013, NCCADV reported a total of 10 domestic-violence-related fatalities. Of the 2013 figures thus far, six

were murder-suicides, four of which involved spouses or ex-spouses; three were boyfriend- or girlfriend-related incidents; and three involved other family members. During the same period in 2012, there were reports of 11 deaths. In 2011, there were six deaths, and in 2010, there were four deaths. These numbers show an increase in domestic-violence-related deaths over a 3-year period during the first 49 days of the calendar year.

Despite these figures NCCADV annual reports from 2011 and 2012, showed a 15% decrease in total domestic-violence-related fatalities. Still, over 100,000 calls to domestic violence programs were reported during that time, with 60% of callers requesting services. Despite the decrease in fatalities, the numbers of calls and victims who sought services statewide were concerning. Additionally, the NCCADV Comprehensive Homicide Report (2002-2010) for North Carolina indicated that almost 700 lives were lost to domestic violence, and in 2010, the report ranked North Carolina fourth in the nation for homicides against women. Then the North Carolina Department of Administration recorded over 95,000 domestic-violence-related calls for the 2010-2011 reporting year.

Although there is no dollar amount that could equate to the lives lost to domestic violence, tangible costs exist each time a victim is killed. As I have stated, the NCIPC reported nationally, the cost of domestic violence in U.S. dollars exceeded 5 billion, with annual cost that exceed \$4 billion in direct care. Direct care cost; include medical and mental health services, and over \$1 billion in indirect care, described as loss of productivity (2003). When these national averages are taken into account in relation to

the rate of DIPV report in North Carolina, it is not surprising that the CDC recognized the need for a statewide primary prevention plan.

To further illustrate, North Carolina has many of the leading risk factors for domestic violence. Exacerbating these figures has been the number of military men and women returning from combat zones, some of whom have faced their own mental health and substance abuse issues. Domestic violence within North Carolina's borders has been an ongoing problem that has often intensified during times of war.

Clinicians who reside in close proximity to the military installation and who work with military families have increased concerns for soldiers, their families, and the community at large. The concerns of clinicians in relation to DIPV and soldiers returning from war was validated by the NCCADV Homicide Report (2011) which revealed that current or former soldiers allegedly committed 10% of domestic violence fatalities during the 2011 reporting year. And, as soldiers continued to deploy in support of the conflicts in Iraq, Afghanistan, and other parts of the world, the potential for marital and family conflicts increased.

To conclude, as a researcher and a clinician who worked with members of the military and civilian sectors, I sought to explore and understand clinicians' beliefs about how the NCCADV's 10-year primary prevention plan had impacted DIPV victims. Clinicians in this study would provide feedback on questions related to primary prevention, a DIPV prevention strategy advanced by the CDC. Clinicians would also respond to questions on their beliefs about the aim of the plan at eradicating DIPV and its harmful effects. Such as, individuals identified as engaging in high-risk behaviors, those

not at risk, and nonEnglish-speaking residents who were expected to benefit from efforts to eradicate DIPV, which was noted as a significant problem within the state. Despite the numerous issues mentioned and the need to address each issue, this study focused specifically on how the NCCADV 10-year primary prevention plan may have impacted DIPV citizens with mental health and substance abuse issues. The study also focused on how DIPV could be addressed and prevented through public awareness programs.

Guiding/Research Questions

To facilitate an understanding of how DIPV victims relate to primary prevention, I sought the expertise of mental health clinicians who worked directly with the DIPV population. Clinicians' perceptions of victims' responses to primary prevention provided insight into the effectiveness of the NCCADV 10-year primary prevention plan and other such programs, addressing the gap in the literature. In consideration of the current culture of domestic violence and subsequent mental-health-related issues in North Carolina, the following questions were presented for exploration.

1. What are mental health clinicians' perceptions of positive influences from the NCCADV 10-year primary prevention plan on DIPV victims diagnosed with mental illness or substance abuse issues?
2. What are mental health clinicians' perceptions of the NCCADV 10-year primary prevention plan in preventing further mental illness and substance abuse of DIPV victims?

These research questions are further detailed in Section 2, which addresses the study methodology.

Review of the Literature

A review of the literature revealed prominent themes related to DIPV. Using multiple databases including SocINDEX, ERIC, Education Research Complete, Academic Search Complete, PsyINFO, and others, a wide array of articles addressing partner violence were found. The following were the search terms: *domestic violence, domestic abuse, marital aggression, intimate partner violence, outreach, education, prevention, awareness, outcomes, public awareness, public education, and partner abuse*. The articles retrieved showed the literature reflected ongoing concerns about DIPV and related mental health issues despite current intervention methods involving secondary and tertiary intervention programs.

The literature search revealed that partner violence, although prevalent in the home, extended beyond those boundaries, and with victims suffering DIPV related abuse and trauma outside the home and in the workplace. The trauma of DIPV strongly correlated with mental illness and proved indiscriminate between sex, race, and age. Therefore, to present the information found in the literature, the articles were arranged in the following categories: women, children, and teen victims; employment concerns; mental-health-related issues; race- and age-related issues; training for medical professionals; and women as perpetrators. The significance of how the information was categorized help to illustrate the far-reaching effects of DIPV on individuals and communities.

Women, Children, and Teen Victims

Studies have shown that women accounted for more cases of DIPV-related incidents than did men, and children who resided in the home were identified as secondary or unintended victims (Martin et al., 2009; Owens et al., 2009). The literature also showed that although the most common victims of domestic violence were women, knowledge of this did not equate to awareness of violence and the extent to which women were victimized. To illustrate, WHO (2005) and Brodwin and Siu (2007) reported that the most common link between a woman and violence was her spouse or intimate partner (CDC, 2010d). In addition, it was often overlooked that women are not the only victims when homes are populated with children. For instance, teens' involvement in the violence resulted from attempting to assist the parent-victim or when the teen repeated acts of violence against others (Jouriles et al., 2012).

Furthermore, intimate partner violence and its consequences are indiscriminant, with women being the most documented victims and children and teens severely affected (Simmons, Lehmann, & Collier-Tenison, 2008; Simpson & Helfrich, 2005; Sprinkle, 2006; Stinson & Robinson, 2006). Pregnant women, their fetuses, and newborn infants also faced increased risk when exposed to DIPV (Ahmed et al., 2006; Owens et al., 2009). An example of this was, Sonis and Langer (2008) found that the DIPV recurrence rate for pregnant women almost doubled if the women rated their partner high on the study's power and control scales, or if she attempted to leave the relationship. Moreover, the mortality rate of women in the Abraham et al. (2009) retrospective study of female homicides was higher than the national average for victims of abuse.

Additional studies indicated that women in violent relationships who became pregnant experienced coerced abortions and increased pregnancy-related violence (Silverman et al., 2009). Eckstein and McDonald (2010) warned of death as a consequence of DIPV, with rates as high as 70-80% for victims and abusers. Women also experienced diminished parenting skills (Bair-Merritt, Holmes, Holmes, Feinstein, & Feudtner, 2008; Barth, 2009) and faced increased levels of fear-related concerns from an intimate partner when attempting to escape (Chang et al., 2010; Sonis & Langer, 2008).

Although the literature clearly delineates women as the principal victims of DIPV and cautions of the dangers they face when exposed to partner violence, women are not the only victims (Martin et al., 2009; Owens et al., 2009; Sprinkle, 2006). Children and teens exposed to family violence are severely impacted, whether they are directly or indirectly involved in the violence (CDC, 2010c, 2010d; Foster & Brooks-Gunn, 2009; Siegfried, 2007; Sprinkle, 2006). Evidence has shown that the number of children exposed to violence is significant, resulting in large numbers of children involved in the court system (Geffner, Griffin, & Lewis, 2008; Guerrero, 2009; River, Maze, Hannah, & Lederman, 2007).

Moreover, intimate partner violence also has a negative impact on the emotional wellbeing, mental capacity, physiological functioning, social response, environmental adjustment, and educational aspects of children's lives (Cummings et al., 2009). Other DIPV-related issues affecting children include (a) emotional insecurity (Cummings et al., 2009; Dodd, 2009; Owen et al., 2009); (b) elevated levels of stress (Foster & Brooks-Gunn, 2009); (c) disrupted sleep patterns (Humphreys & Lee, 2006); (d) victimization by

technology (Price & Maholmes, 2009); and the fear of becoming perpetrators (Sprinkle, 2007). In sum, DIPV presents a clear and lasting danger to women, their unborn fetuses, children, and teens. And although Lundy and Grossman (2009) identified the home as the primary location for violence, DIPV transcends its borders.

Employment Concerns

As DIPV moves beyond the borders of the home, more acts of violence may be perpetrated in the community and in the workplace. Workplace violence is an equally important concern, and a growing body of research acknowledges that the effects of DIPV are indeed not contained to the home (Pollack, Austin, & Grisso, 2010; Rothman & Corso, 2008; Swanberg & Macke, 2006). Consequently, the negative impact of DIPV on perpetrators and victims is evident in poor work performance. For instance, Rothman and Corso (2008) disclosed that men who had a propensity for violence against their partners had higher rates of negative work- and health-related issues.

Despite this fact, the literature revealed that women who suffer from DIPV-associated problems are more likely than men, (a) to be harassed at work, (b) to be called at work, (c) to lose wages, and are (d) subjected to job loss. The literature further revealed that women who suffer DIPV-associated issues faced these issues more often than did their nonvictimized peers (Swanberg, & Macke, 2006; Swanberg, Macke, & Logan, 2006). Moreover, the literature indicated DIPV-related rape, physical assault, and stalking have caused women to lose 7, 8, and/or 10 days of work (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). Further, Arias and Corso (2005) estimated that on average, DIPV-related medical care cost women \$948.00 on a per-incident basis, in

comparison to \$387.00 for men. Therefore, as the consequences of DIPV extend beyond the home, it is necessary for prevention methods to influence the entire sphere of a victim's life.

Suggestions in the literature to address DIPV in the workplace include interventions by employee assistance programs (EAPs). Recommendations for EAPs include developing policies addressing victims, teaching management DIPV awareness, implementing victim-services programs, and addressing perpetrators of partner violence through a direct approach (Pollack et al., 2010). In short, DIPV has breached the borders of the home and is a threat in the workplace. NCCADV (2010b) recommended that primary prevention efforts address violence from a holistic perspective involving all aspects of victims' lives.

Mental Health

To adopt this holistic view, it is necessary to possess a clear understanding of how DIPV impacts mental functioning. As previously noted, mental illness is associated with present distress, increased risk of death, pain, disability, and loss of freedom. A large number of the articles I reviewed referred to the adverse effects of DIPV on victims' mental health. The effects of DIPV on victims' mental state include but are not limited to depression, threatened and attempted suicide, posttraumatic stress disorder (PTSD), mood disorders, and substance use and abuse (Afifi et al., 2008; Bair-Merritt et al., 2008). Similarly, depressions, PTSD, thoughts of suicide, eating disorders, and substance abuse have been found to result from both physical and nonphysical violence (Mascaro et al., 2007; Nicolaidis et al., 2010).

Equally important is the fact that DIPV may result in secrecy (Lott-Collins & Moore, 2006), shame (McLeod, Hays, & Chang, 2010; Shorey et al., 2011; WHO, 2005), and elevated mental health related issues in men, women, and children (Rhodes, Houry, Cerulli, Kaslow, & McNutt, 2009). Watlington and Murphy (2006) noted that as incidents of DIPV increased, so did negative mental health symptoms. In another case, Bonomi et al. (2006) reported a significant decline in the health of women exposed to continued partner violence and indicated that severe depressive symptoms were almost 3 times as likely for those recently abused.

In yet another example, Mitchell (2006) uncovered that violence affected women's spirituality and weakened social ties. To further illustrate, Straus et al. (2009) found that victims were less likely to self-advocate and demonstrated poorer physical health as instances of DIPV increased. Moreover, in their study of 122 women described as having a serious mental illness (SMI), Lewin, Abdrbo, and Burant (2010) found that the rate of depressive-recurrent episodes was 6 times higher for women exposed to DIPV (OR = 6.274, 95% CI = 1.35 – 29.17).

Consequently, mental-health-related challenges are compounded where there is *comorbidity*, which refers to the dual existence of mental and medical illnesses and other social, emotional, and/or physical limitations (Valderas, 2009). DIPV-related problems create an added barrier that compounds mental health issues by diminishing the victim's ability to end the cycle of violence and/or seek needed treatment (Straus et al., 2009).

Race- and Age-Related Issues

In addition to DIPV-related mental health concerns, race and age are compelling issues reported in the literature as risk factors for partner violence. The combination of race, mental illness, and other risk factors (education level, socioeconomic standing, etc.) contributes to adverse conditions and exacerbates the DIPV picture. According to the literature, if a woman is of low SES, is African American or a member of another minority group, or is young; her chances of experiencing DIPV are higher than those of her European American peers (Blitz & Illidge, 2006; Few, 2005). Younger women (Lundy & Grossman, 2009; Martin et al., 2009; Okenwa & Lawoko, 2010), those marginally educated (Kalaca & Dunbar, 2010), welfare mothers, and women receiving public assistance (Hetling, Saunders, & Born, 2006; Lown, Schmidt, & Wiley, 2006) all have high instances of victimization.

Other age- and race-related at-risk groups include younger mixed-race couples, whom studies have shown to have bidirectional victimization (Caetana et al., 2008). Additionally, race is a factor that may act as a barrier for women of color seeking and receiving appropriate help after victimization (Blitz & Illidge, 2006; Hampton et al., 2008). Men and women of color who have sought treatment have met with stereotypes and at times negative responses from those in the professional community (Blitz & Illidge, 2006). To summarize, the burden of DIPV is onerous to both the individual and the community in which he or she resides. DIPV-related mental distress is compounded when victims are further discriminated against because of race or age. DIPV victims suffering from depression, isolation, PTSD, and substance abuse, who were marginalized

because of race or age are more likely than not to continue in the cycle of violence (Straus et al., 2009). However, despite the aforementioned challenges, secondary and tertiary intervention methods are continually advocated in the literature as standards of practice (Strauss, 2007).

Training for Medical and Mental Health Professionals

The literature presents secondary and tertiary intervention as standards of practice to address DIPV. However, continuing education is the most thought of form of maintaining professional standards and ethics. The medical, mental health, and professional community and those who serve the needs of DIPV victims and perpetrators are expected to adhere to a standard of practice that is all encompassing.

Thus, according to the American Counseling Association (ACA, 2005), best practices support ongoing training for professionals as part of the ethical treatment of clients. As such, professionals are encouraged to maintain awareness of trends and changes in the field. However, despite the overwhelming negative impact of DIPV, training for service professionals in the form of teaching (a) health care workers (Craig, Cole, & Hayes, 2009; Davila, 2006; Dersch, Harris, & Rappleya, 2006; Guerrero, 2009; Harris et al., 2009; Holtfreter & Boyd, 2006; Josephs & Abel, 2009) and (b) physicians (Shefet et al., 2007) has been focused on secondary interventions, rather than primary prevention.

More specifically, social workers (Keats, 2010; Lindhorst, Macy, & Nurius, 2005) and victims (Chang & Decker, 2005; Macy, Giattina, Sangster, Crosby, & Montijo, 2009; Rivers et al., 2007; Stinson & Robinson, 2006) have received training and information

that has been secondarily focused and has addressed DIPV issues *after* the abuse has occurred. Bent-Goodley and Brode (2007) identified concerns with training social workers received along with several factors that placed victim and child at risk. The authors posited that training methods for social workers reflected (a) a lack of information and that, (b) social workers' knowledge and understanding of DIPV, (c) their inability to identify the violence, and (d) their missed opportunities to help, may have caused both victims and children additional exposure to harm.

Newer studies have shown, however, that victims have been speaking out and wanting professionals to know how best to serve their needs. Victims have recommended increasing the accessibility of DIPV-related information (Chang et al., 2010) and have encouraged practitioners to see the whole person and not just the battered body (Coker et al., 2007; Corvo & deLara, 2010; Lott-Collins & Moore, 2006; McLeod et al., 2010). Also found in the literature is victims' call for access to bilingual practitioners, treatment for single-sex couples, and help for those who assist with care.

Nurses have requested more training, and victims have called for respect from practitioners who work with DIPV individuals (Bent-Goodley & Brade, 2007; Nicolaidis et al., 2008; Russell, 2008; Simpson & Helfrich, 2005; Yonaka, Yoder, Darrow, & Sherick, 2007). To summarize, service providers need to pursue continued training as the literature on DIPV increases and more men, teens, bisexuals, gays, and lesbians admit to being victims and perpetrators. Additional training is also needed as the landscape and how services are delivered change.

Women as Perpetrators

Mental health, medical, and other practitioners are cautioned and must remain aware that women, who outnumber men as victims, are also perpetrators of DIPV. The female victimizer is not a role that has been traditionally accepted, but the literature has revealed that women are indeed perpetrators (Loy, Machen, Beaulieu, & Grief, 2005). Conradi and Geffner (2009a, 2009b) reported in their studies the reasons that women aggress. These reasons included aggression (a) in retaliation, (b) as a form of protection—almost 66% of the time, or (c) as a result of past trauma.

Furthermore, as uncommon as it has been to accept the female aggressor, it has been equally uncommon to recognize men as victims of DIPV (Holtzworth-Munroe, 2005). Strauss (2007) advocated abandoning long-held traditional ideologies, strategies, and treatment methods when addressing DIPV. Strauss also called for and encouraged the professional community to embrace the fact that women are not always victims. For instance, another study found that women occupied both dimensions of DIPV (Simmons, Lehmann, & Collier-Tenison, 2008).

Other research has helped to compare and contrast DIPV by gender. Afifi et al. (2009) reported results indicating that 5% more men than women were victims of DIPV. This study, along with Rhodes et al. (2009), illustrated the significant effect of DIPV on mental health functioning, with 37% of the men admitting to victimization. In addition, women more than men were found to engage in significantly higher rates of nonphysical violence against their intimate partner (Outlaw, 2009). As researchers and practitioners alike adjust to the ever-changing climate of DIPV, it is no longer acceptable to view

women as the only victims. Thus, the literature reflects that DIPV is as complex as the individuals involved in the relationships.

Therefore, I concur with Straus's (2007) recommendations to remove barriers that hinder a complete and knowledgeable understanding of the DIPV picture. To accomplish this goal NCCADV considered the following (a) its citizen base, (b) victims and perpetrators, and (c) risk factors specific to North Carolina in developing the 10-year primary prevention plan. Then NCCADV developed a proposed solution. Thus, primary prevention was chosen as the method of prevention best suited to impact the lives of all citizens and reduce instances of abuse and victimization across the state (NCCADV, 2010a).

In short, Dahlberg and Butchart (2005), and NCCADV (2010b) referred to *primary prevention* as the obstruction of violence prior to its occurrence. Other authors have expressed the need to use primary prevention awareness as a resource in combating the ongoing issues related to DIPV (Ahmed et al., 2006; Campbell & Manganello, 2006; Dahlberg & Butchart, 2005; Nelson et al., 2008; Okenway & Lawoko, 2010; Pollack et al., 2010; Stith, 2006; Whitaker et al., 2006).

Advancing primary prevention is pivotal in addressing and eventually stopping the spread of violence. In order for the implementation of primary prevention to be effective developers must recognize the change that has taken place in the DIPV culture. Both men and women are recognized as victims and perpetrators in the literature, therefore prevention efforts should be directed at both groups. As a result, ongoing primary prevention across the state could have positive implications for the future.

Implications

Possible implications for this study include developing ongoing television, radio, internet, and billboard DIPV educational awareness programs that are designed to reach the masses. Other implications include increased public awareness of the consequences of DIPV on victims, children, fetuses, infants, and the community. Information may also include how DIPV increases mental illness and substance use and abuse.

Additional implications include increased practitioner awareness that DIPV *is not* a personal problem that is contained to the home between victim and perpetrator. Implications for social change may also include dispelling myths, and fostering open communication, that may reduce the shame and stigma associated with DIPV.

Summary

To conclude, DIPV affects women, men, children, and infants. According to the literature harm from DIPV is evident in the home, workplace, and throughout the community. Instances of DIPV correlate with multiple forms of mental illness (e.g., PTSD, depression, mood disorder, and substance abuse issues), and is a burden on the legal, mental health, and medical communities. As the global milieu changes, so do the victims and perpetrators. Examples included female aggressors, male victims, and, teenage, and same-sex violence. Same-sex couples at increasing rates are experiencing violence in their relationships that presents additional challenges for mental health providers.

North Carolina is one of 14 states that were found to have multiple co-occurring risk factors leading to increased instances of DIPV. NCCADV in partnership devised a

10-year plan to address DIPV across the state and primary prevention became the focus. As the plan is implemented statewide there is a call for a shift in the agency's focus, from secondary intervention to primary prevention. To accomplish this shift, training needs and prevention awareness strategies should change as times and victims change. As a result, professionals and the community at large would be equipped to address this ongoing issue.

As I have stated, this study is designed to explore and understand the views of mental health clinicians who serve the needs of DIPV victims, their children, and the perpetrators. The study also aimed to understand the impact of DIPV awareness on those with mental health concerns. The research design, theoretical framework, participants, data collection and analysis is discussed in Section 2, the methodology. Section 2 further details the study's assumptions, limitations, and delimitations.

Section 3, describes the project with an introduction, followed by description, goals, and rationale. Outlined next are the resources and supports, barriers, implications for social change, and conclusion. In Section 4, details of the projects strengths, recommendations, and scholarships regarding this study are presented.

Section 2: The Methodology

Introduction

The DIPV situation in North Carolina reached levels that warranted support from agencies outside its borders. Therefore, to understand how prevention might impact DIPV across the state, a case study design with phenomenological constructs was used to analyze data from a sample of 10 clinicians. These professionals were based in a geographical area where they had access to active duty soldiers, retired military men, women and families, and civilians. Mental health clinicians in this study were interviewed to understand their views on how the NCCADV primary prevention plan impacted DIPV victims or perpetrators with mental illness and substance-abuse-related issues.

More specifically, phenomenological thought influenced this case study design and yielded information regarding face-to-face experiences clinicians had with victims and perpetrators (Smith, 2011). Through their lived experiences, clinicians provided insight on DIPV victims and perpetrators' behaviors, beliefs, and attitudes about primary prevention. To explore this phenomenon, I chose to conduct a case study to give voice to clinicians' views and address a void in the literature.

Clinicians who worked directly with DIPV victims, perpetrators, and family members had firsthand knowledge of the phenomenon under investigation. Through the clinicians' lenses, I identified themes to gain an understanding of how the NCCADV 10-year plan had impacted those at risk. Clinicians (mental health workers, social workers, psychiatrists, psychologists, physician assistants in mental health settings, licensed

professional counselors, etc.) had firsthand lived experience caring for the DIPV community.

These clinicians witnessed the destruction of families as children were removed from the home due to direct and indirect abuse, substance use and abuse, or severe and persistent mental illness. Sadly, clinicians were also privy to information related to when DIPV turned deadly, and one or more victims, perpetrators, or both lost their lives. Thus, this study gave voice to each clinician's view as to how she believed current primary prevention impacted DIPV victims and perpetrators (Lodico, Spaulding, and Voegtle, 2010).

Research Design

In this study, I employed a case study design influenced by phenomenology that I chose after careful consideration of the topic under investigation. Phenomenological studies provide insight into lived experiences. Whereas, "Case study research is a form of qualitative research that endeavors to discover meaning, to investigate processes, and to gain insight into an in-depth understanding of an individual, group, or situation" (Lodico et al., 2010, p. 269).

Case study research was described within a bounded system, and Creswell's (2008) definition of a bounded approach described a "study separated for research in terms of time, place, or physical boundaries" (p. 476). This study satisfied the boundaries of time, a cross-sectional design, time restrictions placed on me as the sole researcher, and additional restrictions of interviewing clinicians who worked locally.

To understand the complexities of and gain insight into clinicians' perspective on DIPV-related primary prevention, I considered the following words by Glesne (2011): "You focus on the complexity within the case, on its uniqueness, and its linkages to the social context of which it is a part" (p. 22). To that end, as I considered the dangers, fears, threats to family, and even the possibility of death that DIPV victims faced (Simmons, Lehmann, & Collier-Tenison, 2008; Simpson & Helfrich, 2005; Sprinkle, 2006; Stinson & Robinson, 2006) interviewing clinicians who worked directly with victims and perpetrators was a logical choice.

This study grew out of witnessing the impact of DIPV on families. After reviewing the literature, I surmised that giving voice to clinicians' lived experiences and internal thought patterns would provide valuable insight regarding the effectiveness, ineffectiveness, or unknown potential of primary prevention. Clinicians could also provide information on how it impacted DIPV victims and perpetrators' responses to said prevention.

To build upon the theoretical framework I employed phenomenological constructs to enhance this study. The impact of phenomenology was evident in that; (a) phenomenological studies are used both to give voice to, and (b) to describe individual experiences, (c) to allow the researcher to illuminate the individual's perspective, and (d) how she interprets what was experienced (Lodico et al., 2010). Phenomenology in its most basic form is the study of one's experiences, and phenomenologist resist evaluation and the need to understand causality (Hammersley, 2004).

Hammersley (2004) posited that, “The fundamental thesis of phenomenology is the intentionality of consciousness: that we are always conscious *of* something” (pp. 816-817). It is the ever-present consciousness of clinicians’ experiences with DIPV victims that I explored and sought to understand. A case study design influenced by phenomenological thought allowed me access to DIPV victims and perpetrators without instituting the threat of harm.

In addition, Smith’s (2011) report on phenomenology provided a current and historical view of its early beginnings. Phenomenology got its start with Husserl, Heidegger, Merleau-Ponty, and Sartre, but it is Husserl who is known as the main founder of this discipline. Phenomenology, according to Husserl, embodies conscious awareness and marks that conscious awareness known to the individual in a bracketed form (Smith, 2011).

Researchers using phenomenology are expected to put aside their own beliefs, views, and opinions—to bracket their knowledge of the phenomena under investigation—and focus on the participants’ views. Smith described Husserl’s definition of bracketing as being able to direct awareness, as in *intentionality*, toward a phenomenon. In directing awareness, the researcher is able to then become conscious of his/her surroundings and therefore study or analyze the content of the experience.

Through a case study design, I used the constructs of phenomenology to intentionally focus my awareness, thoughts, and opinions from prior exposure to DIPV-related issues; I bracketed my knowledge and focused on clinicians’ views. Thus, I chose

to understand clinicians' perspectives and expertise about current DIPV clients through a case study design influenced by phenomenology.

The constructs of intentionality and bracketing in phenomenology support the framework of a case study design. According to Hancock and Algozzine (2006), in their well-known book on case study research, they highlighted the following characteristics:

First, although case study research sometimes focuses on an individual representative of a group (e.g., a female principal), more often it addresses a phenomenon; Second, the phenomenon being researched is studied in its natural context, bounded by space and time; Third, case study is richly descriptive because it is grounded in deep and varied sources of information; Hence, information is explored and mined in the case study environment for a more thorough examination of the given phenomenon. (pp.15-16)

Therefore, exploring clinicians' lived experiences with DIPV victims and perpetrators provided an understanding of how primary prevention impacted their clients.

By exploring clinicians' conscious experience of working with DIPV victims and perpetrators and how clinicians interpreted clients' responses to primary prevention, I sought to add to the current body of knowledge and address a gap in the literature. Vivilaki and Johnson (2008) stated that "self-interpretation—the experience of the specific individual—is the source of data for the researcher and the heart of phenomenology work" (p. 86). A case design allows the benefit of focusing on data collected from individual experiences, as well as from additional sources of media, print,

and other data (Lodico et al., 2010; Vivilaki & Johnson, 2008). Therefore, a case study design provided the best framework for the research project compared to other designs.

The frameworks of qualitative research embody several methods of data collection that lend to purposive sampling. Thus, the following is a brief review of the different qualitative methods considered for this study and why they were not selected. Ethnography and grounded theory methodologies institute parameters unsuitable for giving voice to lived experiences such as clinicians' interactions with DIPV victims without extended time and resources (Lodico et al., 2010). Ethnographic researchers are immersed in a culture, listening, observing, and questioning behaviors (Oladele, Richter, Clark, & Laing, 2012).

Immersion into the DIPV culture would have involved a level of risk to me as the researcher as well as to the participants, therefore creating parameters unsuitable for ethnographic research. In addition, fixed resources prevented me from engaging in grounded theory research, which necessitates a theory derived from participants' exposure to a process, action, or interaction (Creswell, 2008, 2009). Direct involvement with DIPV victims or perpetrators presented the same level of risk already noted, which would have limited my study. Thus, for this reason, clinicians were chosen as participants for this study.

The purpose of this study was to explore and understand (a) the perceptions of clinicians as they pertained to NCCADV's ongoing DIPV primary prevention awareness efforts and (b) how clinicians believed increased awareness would impact DIPV victims with mental illness and substance-abuse-related issues.

Participants

Participants for this study were selected based on their interactions with, and knowledge of, DIPV victims and perpetrators. Clinicians in this study had face-to-face interactions with DIPV clients or worked with individuals who made up the DIPV population. Clinicians were considered key informants, or “individuals who had information or knowledge specific to the phenomena being studied” (Lodico et al., 2010, p. 59). Key informants in this study consisted of licensed clinicians (those who met criteria for state licensure and possessed an unrestricted license) and provisionally licensed clinicians (those who matriculated from a master’s-level program and were fulfilling the requirements for state licensure).

Clinicians who worked or had worked with DIPV victims, perpetrators, or family members in the 12 months preceding the study were eligible to participate. As the sole researcher, I needed to keep the number of participants small enough to manage yet large enough to ensure a wide range of responses (Lodico et al., 2010). Therefore, the sample size for this study was 10. In qualitative research, the researcher seeks to understand rather than to predict or generalize findings. Thus, the sample size in qualitative research is often smaller than sample sizes of studies in quantitative research. Additionally, qualitative researchers are interested in saturation rather than representation, and they focus on new information provided by research participants (Hodges, 2011).

Mason (2010) elucidated the impracticality, time consumption, and laborious nature of analyzing large samples of qualitative research. Mason further posited that sample sizes be large enough to uncover data pertinent to the study without excessive

repetition or superfluity. In describing guidelines for sample sizes in qualitative studies, Mason reported on studies in which sample sizes were five to 25 for phenomenological studies, 30-60 for ethnography, and 20-50 for grounded theory.

Although Mason did not specify suggested numbers for case study research, 15 participants were the number indicated for qualitative research. Guest, Bunce, and Johnson (2005) supported these figures in their investigation. The sample size, however, varied depending on the type of qualitative study. Similarly, time and financial resources are considerable factors in determining the data collection approach when using interviewing (Knox & Burkard, 2009). Another important factor in qualitative research is the principle of saturation.

Guest et al. (2005) acknowledged saturation as an important component in studies with purposive samples. The authors investigated the concept of saturation and found evidence in the literature depicting saturation as the standard for qualitative research. They reported a lack of directives governing the principles of saturation but noted its importance. Bowen (2008) supported the need for better directives governing saturation.

Alternatively, Francis et al. (2010) proposed adhering to the principle of saturation when determining sample size. In their two-part study, the authors found that data saturation was achieved after as few as 14 interviews in Study 1 and 15 interviews in Study 2, with a base number of 10 interviews in each study. The authors predicted that after the first 10 interviews, there would be no new information shared in the three consecutive interviews beyond the 10th interview.

Thus, Interviews 11, 12, and 13 would garner no additional data, at which point the authors believed that saturation would be achieved. Limitations to their study included but were not limited to further investigation into analysis of base numbers and stopping criterion (e.g., how many interviews beyond the base number would generate new data) and type of study (i.e., phenomenological, grounded theory, etc.)

In view of the aforementioned recommendations I considered, (a) data on sample sizes, (b) saturation, (c) type of study, (d) limitations of resources, and (e) being the sole researcher, prior to selecting 10 clinicians for this research. After the sample size was chosen, I developed consent forms and interview questions to submit to my department chair for approval. I used Walden's templates to construct confidentiality and informed consent letters. Then I sought full Institutional Review Board (IRB) approval to proceed with data collection. Clinicians who would participate in the study were required to sign informed consent and confidentiality forms.

Participants in this study would receive information on confidentiality and level of harm. Because of the sensitive nature of DIPV and many unreported cases, participants were questioned regarding their personal involvement with DIPV. Participants were also informed of the opportunity to withdraw from the research *prior* to initiation, and at any point throughout the study.

Clinicians were further informed of the opportunity to debrief if involvement in the study evoked unresolved issues. Although, the level of potential harm was minimal for this study I could not completely provide protection from unknown emotions that

might be provoked as a result of conversations about DIPV. Thus, I made debriefing available if the need arose.

Data Collection

To illustrate clinicians' lived experiences best, I conducted interviews to gather the data necessary to understand the phenomenon being studied. Multiple sources of data in addition to data derived from interviews with clinicians were the focus for this study (Creswell, 2009; Lodico et al., 2010; Vivilaki & Johnson, 2008). Interviews served to draw out participants' beliefs and consciousness regarding the DIPV experience on which this study was focused (Hammersley, 2004).

Role as Researcher

As a mental health clinician, I was aware of private and public mental health agencies and facilities within the local area. Having established a network of colleagues both professional and personal, I was able to spread a wide net when it came to gaining access to other clinicians. In keeping with ethical research practices, however, I received approval from agencies prior to contacting clinicians and only after I had received IRB approval (Glesne, 2011). After permission was received, a letter of introduction requesting participation in and describing the study was constructed and distributed to agencies and clinicians.

In the letter, clinicians were advised that initial and ongoing participation was completely voluntary and were made aware that no compensation was provided for participation. Letters would be sent to the Managed Care Organizations/Local Management Entities (MCO/LMEs, the overarching agencies that oversee all mental

health services in the local and surrounding counties. The MCO/LME website provides access to a number of clinicians across the state. In recruiting clinicians for the study, I requested to post a link on the MCO/LME website that advised clinicians of the study with my contact information.

Flyers were mailed to local mental health clinics and hospitals in the surrounding areas, as clinicians were located not only in mental health centers, but also throughout the community. Additional flyers were intended for distribution at annual conferences and on conference websites. All flyers contained the same IRB-approved information and did not vary based on the agency. As a licensed professional counselor, I had worked at a private mental health clinic and at the MCO/LME. In these roles, I served as a clinical case manager and a supervisor for the screening triage and referral unit, respectively.

In the role of clinical case manager, I worked with numerous government and private agency staff throughout the community and across the state. I was responsible for assisting with out-of-home placement of children in various group homes and mental health facilities. I worked with the Department of Social Services, Department of Juvenile Justice, the court systems, and the schools. As a supervisor, I was responsible for the oversight of employees who served the needs of consumers in over 18 counties throughout the state and at times out of state.

In my role as after-hours supervisor, I served as an on-call clinician in a position that required contact with hospitals, mobile crisis teams, law enforcement officials, and magistrates' offices across the state. I was a conference speaker (presenter) at the annual

Licensed Professional Counselors' conference in 2011 and had more than 35 counselors in attendance. My role as a counselor in the local community had the potential to elicit intrigue from colleagues who might become concerned about my involvement in the overarching research process. Of the individuals who volunteered to participate in the study, there was a chance that one or more would be familiar with me either from previous employment or from recognizing me as a conference speaker.

My influence in the community as a clinician differed from my role as a student researcher. Therefore, I approached agencies throughout the state as a student researcher to solicit participation from individuals interested in the phenomena under investigations. In so doing, as I solicited participants for this research I was able to maintain the integrity of the research, prior to data collection.

Data for this study were collected from clinicians' interviews, voice, print, media, and internet sources. Participants responded to open-ended questions related to how they believed their clients responded to DIPV awareness. Participants would respond to preapproved study questions. Study questions were read to all participants, in the same order, and responses were recorded using a preselected recording device. As researcher, I also took notes during the interview process and these notes became part of the data, to control for biases (Lodico et al., 2010). Prerecorded interviews were transcribed within 24 to 72 hours following the interview for future review and to ensure accuracy.

Then data was collected and transcribed. Coding is a process by which "qualitative researchers code to discern themes, patterns, processes, and to make

comparisons, and build theoretical explanations” (Glesne, 2011, p. 194). Glesne further explained how coding assists the researcher in building relationships, that lend to ease of analysis. As mentioned I took notes during the interview process, these notes helped to reflect on participants’ responses, and on my own thoughts and reflections (Creswell, 2009).

Interviews and field notes were coded to protect the identity of study participants. Data were categorized by interview date and time for ease of reference and referral. After completing of data analysis raw data were stored on a flash drive in a locked file cabinet secured by me for the time required by the state in which data were collected. In addition, data was secured to meet Walden University research guidelines. Transcribed tapes remain in a secure location in my home. All external data storage devices were subject to the same security and storage conditions.

Interview Process

The interview process consisted of three sessions. There were two 30-minute and one 45-minute to an hour-long session designated for the interviews. The initial 30 minute session were comprised of an introduction and review of my, (a) background, (b) purpose of the study, (c) confidentiality, (d) informed consent, (e) explanation of length of expected participation in the study and, (f) an opportunity to address impending questions. The initial 30-minute session was also designed to build rapport, an essential feature in field research (Glesne, 2011).

Next was a 45 minute to an hour interview followed by a final 30-minute session. Each session was initiated with consideration given to what Glesne (2011) called

“convenient, available, and appropriate locations” (p. 113). The interview session consisted of asking semistructured open-ended questions to solicit unbiased responses. The final 30 minute session were designed to provide clinicians with an opportunity to review two-page summaries of the transcribed interviews, for accuracy (Creswell, 2009).

In accordance with Glesne’s (2011) suggestions for the research being convenient, available, and appropriate; data were collected at a time and location agreed upon by clinicians and researcher. Creswell (2009) referred to the natural setting and the researcher as the “key instrument” in the data collection process (p. 125). Thus, clinicians who chose their office as the interview site were interviewed in that location. Interviews were recorded using a recording device to ensure all responses were captured.

In sum, the initial 30-minute session with each participant was designed to address any questions or concerns they had, to foster rapport and to foster a positive interview experience. Clinicians responded to open-ended questions that provided each participant the opportunity to express her thoughts without restriction or reservation about the impact of prevention. Interviews were recorded to ensure accuracy of transcription and assist with analysis.

Data Analysis

As a novice researcher I approached this stage of the research equipped with examples from the literature on best practices for data analysis. I relied on authors like Creswell, Purdy, Flick, and others to provide information on how data analysis is structured. For example, Creswell (2009) posited that qualitative data were customarily organized in such a way that the overall outcome of data collected was categorized and

described with meaning while communicating to the reader the essence of what was said during the interview or data collection phase.

Purdy (2010) observed that “phenomenology is initially descriptive and qualitative, but it doesn’t reduce the contextual data to numbers; all experience, behavioral and otherwise, is allowed its richness and diversity” (p. 35). Maintaining the richness and diversity of data, during analysis, was a goal I sought to accomplish at this stage in the research process. As such, coding data using proven methods found in the literature, helped to reach this goal.

I found additional help in *An Introduction to Qualitative Research*, where the editors described a series of steps from general to specific for coding information received from interviews. These steps included (a) open coding, (b) axial coding, and (c) selective coding (Flick, 2009). The authors also reported the use of Computer-Aided Qualitative Data Analysis Software (CAQDAS) that would afford me the ability to use computer generated coding and helped with speed of data analysis.

The decision to use CAQDAS assisted me in my goal of maintaining the integrity of data collected while benefiting from the use of technology. In my search I found several available CAQDAS to assist in the data analysis process including, MAXqda, Atlas.ti, QSR NVivo, and HyperRESEARCH. However, after careful consideration and discussion with the manufacturer, the software package QSR NVivo 10, was selected. NVivo 10 is a data collection, analysis, and organization tool that was deemed the best suited for analyzing data derived from this project. With QSR NVivo 10 software I was

able to review information from various forms of data, social media, audio and visual materials (QSR International, 2013).

Moreover, NVivo 10 is a software package with query tools that aided in organizing data, locating specific text, cataloging, performing searches, joining subtle and obvious themes, to analyze data (QSR International, 2013). As sole researcher accessing a software package that coded data and assisted in the identification of themes from interviews aided in transforming data from general to specific (Creswell, 2009). Through the use of NVivo software I was able to adhere to program specifics to ensure integrity of the data collected, and of analysis.

Another step in maintaining data and program integrity was to address personal biases. Having had personal and professional contact with victims of DIPV and their children, I had my own biases concerning the needs of this population. However, the literature (Lodico et al., 2010) provided several steps a researcher could take to reduce bias. Those steps included but were not limited to member checks, peer debriefing, and external audits. The list, though not exhaustive, provided multiple resources to assist in avoiding bias. Member checks also ensured that as a researcher I interpreted the data as it was communicated by study participants and represented the data as the participant meant for it to be understood (Lodico et al., 2010).

In addition, to achieve accuracy and credibility, I detailed the steps of the research process to include taking notes during the interview. I reviewed audio recordings and transcripts for missing or erroneous information to ensure credibility. Furthermore, I focused on the study's purpose and that helped to ensure credibility which improved

reliability (Creswell, 2009). These steps were also taken to address validity, which is unlike that of quantitative research, and is achieved in qualitative research by ensuring accuracy of information.

Validity was achieved through member checks and triangulation, as well as extracting rich, thick descriptions from information found throughout the coding process (Creswell, 2009). In addition, the process of triangulation allowed for multiple sources of information to corroborate data received from interviews. Shortly after information from interviews was transcribed, and participants had an opportunity to review a two-page summary of the transcripts. The review allowed participants to determine if the transcripts accurately depicted the content and intent of what the interviewee stated. This process was referred to as *member checking* and further bolstered validity in the qualitative process (Creswell, 2008; Glesne, 2011).

Another strategy employed was developing thick, rich descriptions from the information received during the interview and developed during coding. Based on the rich, thick descriptions I provided, the reader was allowed a glance into the world of the interviewees. Through these descriptions readers got a sense of the clinicians' surroundings and what each experienced as she recounted her experiences.

Here, I also had an opportunity to transport the reader into the world of those being interviewed and experience vicariously how a DIPV victim may or may not have responded to prevention. Creswell (2009) said it best when he wrote, "This description may transport the reader to the setting and give the discussion an element of shared experiences" (pp. 191-192). Due to the nature of DIPV, the impact on individuals and

communities, providing an objective but clear picture that would best represent the findings from this research was imperative. Each step in the data analysis process was intended to ensure the integrity of the study and the data collected. To this end, discrepant cases were coded as such and interviewees were contacted for follow up for clarification on information recorded in the transcripts. This process was well documented and the outcome detailed in the study.

Conclusion

Due to the sensitive nature of the topic a case study design with a purposive sample of 10 clinicians was chosen for this research. The case study design was influenced by phenomenological concepts. These concepts helped me to structure the research to give voice to clinicians who worked directly with the DIPV population, and to capture the essence of their experiences (Glesne, 2011). Clinicians were chosen to reflect how their clients were impacted by primary prevention as they had first-hand lived experiences with victims and perpetrators.

Interviewing clinicians reduced the potential risk to me as the researcher, the DIPV victims, and the perpetrators. Participants for this research were chosen based on preestablished and preapproved guidelines. Clinicians who work or worked with DIPV victims in the year prior to the beginning of data collection served as study participants. Clinicians were interviewed in agreed upon locations most conducive to elicit the greatest amount of feedback and input. Data for this research were derived from semistructured interviews collected during the hour-long interview sessions.

Data from print, media, and internet sources were also collected. Data was collected using a preselected recording device and notes were taken during the interview process to ensure accuracy and credibility. After IRB approval, clinicians were made aware of the study through e-mailed notifications and flyers were distributed to agencies. Participants were briefed on the voluntary nature of the study and informed there was no compensation for participation. Clinicians were further advised of their rights to confidentiality, informed consent, debriefing, and the right to withdraw from the study at any time. Questions raised during the initial and final stages of the interview process were also addressed.

Data analysis included the use of a CAQDAS specifically QSR NVivo 10, a collection, analysis, and organization tool best suited for analyzing qualitative data. Also, thick, rich descriptions of information; member's checking; and triangulation maintained the credibility and dependability of data collected. Discrepant cases were labeled as such and notated in the study along with measures taken to address each case. Following is a description of steps describing how I conducted the research; the Methods sections.

Methods

This section includes a description of the participants, steps for data collection and analysis, and the results. Also described in this section are discussions of the findings, limitations, delimitations, and direction for future research,

Participants and Procedures

The study was open to all fully and provisionally licensed clinicians in North Carolina. Clinicians who work, or had worked with members of the domestic violence population (victims, perpetrators, or family members) were eligible to participate. As sole researcher, I had to create a sample from which to recruit 10 participants for the study.

My initial intentions were to contact the MCO/LME, in addition to, hospitals, counseling organizations, and local agencies and request permission to give out fliers, or to place links on the websites informing clinicians of the research. There were 12 MCO/LMEs located throughout North Carolina. Each MCO/LME's website provided information on agencies that offered behavioral health services for clients in a number of counties governed by that MCO/LME.

I made contact with the MCO/LME closest to me, and I spoke to the chief of external operations. I explained the purpose of my call and the goals of the study and made my request. I was informed that the presence of a flier or link on the website would give clinicians the impression that the study was a requirement of the MCO/LME, thus nullifying the voluntary nature of the study (K. Salacki, personal communication, April 14, 2014).

As I made contact with other agencies I received similar responses. For example, when I contacted the hospital I was informed that the agency was unable to comply with the request (J. Conway, personal communication, April 7, 2014).and several of the larger agencies that employed numerous clinical staff indicated gave the same response. I had to find an alternative way to recruit participants for the study and, as sole researcher I did not welcome this task. One county in particular had a population of over 200,000 residents (U.S. Census Bureau, 2014) and the MCO/LME website listed clinicians in almost every county across the state.

Because all fully or provisionally licensed clinician throughout the state were eligible to participate, the task of finding 10 participants, felt daunting. However, the chief of external operations informed me that the MCO/LME website was public domain. Although they were unable to post the flier, I had access to information on the website pertaining to clinicians. Agencies and independent practitioners were listed on the website along with the agency's address, phone number, and other information for public use.

Because I had obtained this information, I tried to reduce the territory to a workable area over which I could patrol. Thus, I created a database of agencies and independent practitioners, the initial database of which covered two counties and consisted of over 350 names, phone numbers, and addresses. Agencies on the MCO/LME websites that were described as group homes or treatment facilities were excluded from the database because these facilities often housed clients whom I had no permission to contact.

Afterwards, individual practitioners and agencies were contacted by mail when I sent the IRB-approved fliers directly to the addresses, a process that took almost one month to complete. Then, Mailings were followed by phone calls, which like the mailings, produced little interest. Fliers were also e-mailed to agencies at the request of individuals I had contacted by phone. After consulting with my doctoral study chair, I explained that individuals at multiple agencies responded to follow-up calls as if I were a telemarketer (M. Castro, personal communication, August 8, 2014). When I received suggestions on successful recruiting from my chair, I decided the best course of action were to use the addresses in the database and deliver the fliers directly to the agencies.

This process, although time consuming, proved productive. Davies (2011) espoused positive outcomes from in-person recruitment in the following statement:

Door knocking turned out to be a highly successful method of recruitment, and despite the importance of not appearing to be a salesperson, this was largely due to me being there to *sell* the project in person, giving people the opportunity to meet the interviewer and ask questions. This might also help to explain the positive reaction I received. (p. 293)

As a result of in-person recruiting in a 3-month period I was able to recruit five participants and conduct interviews. There were periods of stagnation when I reached saturation of the initial counties. As this occurred, I repeated the process of gathering more names and moving my recruiting efforts to other counties. I continued this process after receiving an extension from the IRB until I had recruited all 10 study participants.

With the exception of two participants who responded to e-mailed fliers, all other participants were recruited as a result of going to agencies and handing out fliers. Thus, data for this research were collected over the period of one year from July 2014 to July 2015 with IRB approval # 03-25-14-0141860. Initial approval expired March 24, 2015, and renewed IRB approval expired April 8, 2016 (Appendices B & C).

Participants

All of the participants in this study were women, which is consistent with the U.S. Bureau of Labor Statistic's (2014), review that reported a higher number of women than men in the behavioral health professions. A male participant was removed from the study to maintain his anonymity and confidentiality. During recruitment, there were other male clinicians whom I encountered; however, some expressed no interest in the study while others did not work with the domestic violence population.

Participant demographics included six individuals who identified as Caucasian, three who identified as African American, and one who identified as Hispanic. Only one participant was provisionally licensed, and the other nine participants were fully licensed and held current unrestricted licenses. Two clinicians were doctoral level graduates, and eight were master's level graduates. Of the 10 participants, the years of experience were as follows: two clinicians had less than 5 years experience; five clinicians had less than 20 years experience; and three, clinicians had more than 20 years experience in counseling.

As fliers were handed out, there was a clinician who requested to be interviewed on the same day. The other nine clinicians went through the 30 minute initial interview,

either face-to-face or by phone, after receiving or seeing the flier at their respective agencies. Then each scheduled the interview for a later time. The initial 1/2 hour interview did not always last the allotted 30 minutes.

Nevertheless, I met with potential participants, answered their questions, and explained the nature of the study. I explained confidentiality, consent, and remained with each participant until she was comfortable enough to proceed to the next phase of the research, the semistructured interview. With one exception, each participant preferred to have the interview in her office, and I accommodated each request and returned at the scheduled time.

There was a study participant who fell ill and had to reschedule her interview. During that time, I reminded the participant of the voluntary nature of the study, yet, she continued to express interest. The interview was rescheduled twice, but the participant still followed through with the interview. During the interview process it was found that three participants worked with victims and perpetrators, one worked specifically with children of victims, and the remaining six participants worked mostly with victims.

Nine of the participants wanted the interview held at their offices, while the remaining clinician requested I meet her at a home she had on the market for sale. With the exception of the latter participant, at the start of each interview I was escorted to the participant's office and offered a seat where, ordinarily, clients would sit during counseling.

Data Collection

Counselors' offices consisted of a desk, a chair where the counselor sat, and one or two couches where clients would sit during sessions. Other than the sound of a fish tank gurgling in the background and an air conditioner or heating units, the offices were quiet and conducive to counseling. Upon entering the office, I sat down, thanked the participant, and briefly informed her that our interview would be recorded.

Then I positioned the recorder for the best reception and began the interview. All interviews were completed during the 45 minute to an hour meeting. Taping was stopped during several interviews as participants requested to answer their cell phones, and one interview was interrupted by a clinician's officer manager. Despite those interruptions, interviews were continued and all the research questions were answered. There were no problems during the interview process and being recognized did not impede the process.

For example, I stated there was a chance that one or more of the clinicians who volunteered to participate in the study would recognize me. Although three participants were familiar with me, their familiarity did not impact the interview process. All three clinicians were focused on the questions being asked during the interviews. Each demonstrated passion and commitment to her work with domestic violence clients and her responses reflected that dedication. A participant with whom I was familiar stated at the end of her interview, "Well that was very interesting, very detailed, very detailed." The participant's comment demonstrated surprise about the structure of the questions and the professionalism that I demonstrated during the interview process (field notes, November 11, 2014).

Following this, only two participants required debriefing after the interview was over. Each participant waited until the interview was over to reveal to me her involvement with domestic violence. Participant A required a brief debriefing, less than 10 minutes, after disclosing a history of domestic abuse. Participant A was no longer involved in the violent relationship and stated there had been a 12-year period of recovery. On the other hand, participant B required more time, approximately 20 minutes, after she recounted a history of witnessing her mother as a victim of abuse. Participant B stated it was difficult for her siblings and her, but through forgiveness she was able to move on. She continued to try to help her siblings address their issues in hopes they too would find forgiveness.

In each case, I used active listening, offered support and encouragement, and remained with each participant to ensure there were no negative effects as a result of the interview. At the end of each interview, I thanked participants and reminded each of the two-page summaries they would receive for review. All requested the summary via e-mail, at which time I secured an e-mail address for participants if I did not have her address.

The interviews were then transcribed verbatim using Sony Sound Organizer recording software that allowed for slowing down of the recording. Once transcribed, the recording was played at normal speed, and the transcripts reread to ensure accuracy of transcription. There were no discrepant cases; however, two participants were contacted via e-mail to confirm their responses to questions I thought I missed during the interviews.

As transcripts were read and reread, it became clear that the questions were not missed but that responses were intertwined. Responses to the questions were recorded in the previous or following questions. Contact was made with each participant to verify her responses matched the questions. In each case, the clinician verified there were no additional comments, and the responses were indeed correct. After I verified the accuracy of the information, responses were aligned with the correlating questions and the two-page summary completed.

Member Checks

Following this, member checks were achieved when a two-page summary was compiled from each transcript and e-mailed to participants for review following the recommendations of Lodico et al. (2010). Two participants did not respond to the e-mails; however, I did request a response if changes were needed. The lack of a response from the two participants could mean each participant was in agreement with the summary and that no changes were required. Of the eight participants who did respond, one responded with changes and a correction, and seven stated that there were no changes.

Data Analysis

At this point, I began data analysis which was a multi-stage process. Transcripts and field notes were uploaded into NVivo 10 software and several queries run. Nodes were created from each of the subquestions, and NVivo listed each participant's response to the subquestions under the designated node. Nodes are described by NVivo as "a collection of references about a specific theme, place, person or other area of interest"

(QSR International, 2015). In creating nodes, I isolated responses to each subquestion, which allowed for coding. To ensure accuracy, each node was cross-referenced with the original transcript to make sure the responses were placed with the corresponding question. Finally, each node was then printed and manually compared to the original transcript.

As each node containing all ten responses were read and reread, categories and patterns were identified and grouped into common themes. NVivo 10 was used to run word searches, word frequencies, and text searches based on the categories identified. After coding began, I also listened to the recorded interviews because this process allowed me to recall idioms expressed during the interviews as I reread the transcripts. Baskarada (2014) cautioned that despite the use of automated software for the origination of data, “any meaningful patterns and categories in qualitative data as well as any explanatory/descriptive theories need to be identified and interpreted by the analyst” (p. 15).

Lastly, rigor was established based on Houghton, Casey, Shaw, and Murphy’s (2013) explanation of Lincoln and Guba’s design for qualitative research. All four approaches that included credibility, dependability, conformability, and transferability were applied. Through triangulation of data, member checks, participants’ descriptions, use of NVivo 10 software, and reflectivity rigor was achieved. By addressing all four approaches suggested by these authors I decided that rigor was established and prepared to draft the results.

Results

Analysis of the data revealed themes related to clinicians' perception of the 10-year primary prevention plan on victims' lives. Two themes evident from the data were the following: *Clients and clinicians lacked awareness, knowledge, and/or understanding of the 10-year primary prevention plan, its impact, and benefits.* In addition, *clinicians were more confident in their knowledge of how secondary and tertiary intervention would impact further instances of violence than they were in the plan's potential to impact victims' lives.*

These themes were woven throughout the data and applied to study participants, the domestic violence population, and stakeholders. As I sought to understand clinicians' perceptions of the plan, it was evident, as the data revealed, individuals must have knowledge of a phenomenon for it to be understood, and awareness was insufficient. Assay (2011) emphasized this point in her research when she recalled, "Listening to the voices of the participants, it was obvious that there was a general lack of awareness and accurate information about domestic violence" (p. 133).

The words knowledge, awareness, and understanding may be used interchangeably; however, when relating to domestic violence and victims, a distinction is needed. This distinction is necessary because as the data will show a working knowledge of primary prevention is needed to impact the violence. To illustrate verbatim quotes were used to report a participant's response to interview questions and italics indicated themes.

Research Question 1. *Clients and clinicians lacked awareness, knowledge, and/or understanding of the 10-year primary prevention plan, its impact, and benefits.*

Research question one considered what was clinicians' perceptions of positive influences from the 10-year primary prevention plan on DIPV victims with mental illness or substance abuse issues. Of the clinicians who participated in the study, eight did not believe their clients were aware of the plan, did not know what the nature of the plan was, or were unaware of its impact.

When asked directly how the 10-year plan impacted their clients, responses included the following: "I don't think I even know what that is. I'll be very honest, I don't know what that is;" "Actually it hasn't changed anything. It doesn't appear it has changed anything in the last 5 years that I've worked in North Carolina;" "I have no idea;" "I am not familiar with their 10-year plan;" "Slim to none;" and, "I really don't know how to answer that one."

Two of the study's participants indicated an awareness of the plan. However, of these two participants, only one clinician reported a direct knowledge of the plan. Despite her knowledge of the plan she could not state its impact on the clients in question. The other clinician's awareness of the plan stemmed from an e-mail with information she had received about the plan. This clinician stated she was motivated to take part in the study because of the coincidence between when she received the e-mail and when she received the research flier. In spite of these two exceptions, participants demonstrated limited awareness, knowledge, and/or understanding of the NCCADV 10-year primary prevention plan.

Moreover, the data revealed that clinicians had no knowledge of the impact of primary prevention on the number of DIPV cases as demonstrated by the following passages; “I don’t know if it’s had any impact;” “Statistically, I wouldn’t know, but I’m getting more people;” “I don’t think I can speak intelligently about that;” “I don’t know the statistics;” “I have no idea;” “Well that’s hard to gauge. I don’t know. I would hope it’s brought it down, but it’s hard to pull that variable out.”

The participant continued, “Reporting goes up because people are more aware of it but not because more incidents are happening;” and yet another stated “That’s hard to answer because I feel like so many people don’t report and so I honestly don’t know what those numbers are out there.” Two participants had programs on ongoing primary prevention and reported past instances of increases in their caseloads, but stated that no recent increases were evident.

In addition, of the ten clinicians who participated in the study, data indicated that *none* felt her fellow clinicians were knowledgeable about the 10-year plan. Responses included, “I never heard them talk about it.” “I can’t say we ever have.” “I really don’t know what that is. I’ve never heard of it or heard anyone say anything or talk about it,” “Not very;” “I don’t think we’re aware at all. I don’t think there is any awareness at all;”and “I’ve never heard anybody mention the plan.”

Clinicians responded similarly to questions directly related to primary prevention. Six participants were unaware of the influence of primary prevention on victims. A participant reported, “I don’t know if they have been influenced by it [primary prevention]. I don’t think any of them have been aware of the signs of a potential abuser.”

Another stated, “I don’t know that it has. I don’t have any direct stories or evidence to give that it has had an effect.” Still, this participant also indicated, “I can’t assume that it hasn’t either,” in follow up to that question.

More importantly, eight participants reported no specific mention of primary prevention when asked to what their client’s most referred. Furthermore, clinicians expressed mixed thoughts concerning how primary prevention had/had not impacted DIPV clients. For example, this clinician stated “I generally don’t know if my clients have had any primary prevention. I don’t know if they have had it. I haven’t seen them be aware of signs to look for in an abuser.” On the other hand, another participant claimed, “I think simply the fact that because they have the plan and everything that is making people talk about it more and having people be more concerned with it.”

Despite the lack of direct knowledge of the plan, clinicians expressed positive though mixed thoughts about how they perceived primary prevention *would* impact the lives of victims. Impact responses included the following: “I mean I think it’s worth doing even if it just helps one person.” Another responded, “I think it does in that it empowers victims to take steps, or to have steps taken for them.” Yet another participant said, “I think it does impact domestic violence clients, just in the way we were talking about knowing where they can reach out.” Another clinician stated, “I believe that primary prevention would impact them greatly because most people do not even know what domestic violence is. They do not understand that there is a continuum.”

Clinicians also expressed positive thoughts about the influence *of* exposure to primary prevention. And as it related to exposure, one participant stated, “I’m hoping

stigma will decrease just in mental health in general. Probably you know just as well as I know that [there is] stigma even with them walking in the door for counseling.”

Clinicians also thought exposure to prevention strategies would lead to positive outcomes. In spite of the fact that clinicians had limited knowledge of the plan, each expressed the impact and influence of the plan had positive implications.

Respondents also expressed primary prevention had not reached their clients, and they believed stakeholders lacked knowledge of domestic violence based on how stakeholders designed primary prevention materials. Participants wanted stakeholders to “target young people; host discussion groups; and generate discussion around social mores.” In addition, clinicians wanted stakeholders to provide, “Better, more, additional education, and widespread education for clinicians;” “That it should be in a language people understood;” and to “Put the information where women congregate.” Others wanted stakeholders to, “understand the dynamics of it, just simply understanding the different dimensions of it. It’s not so black and white, always;” “Get people who have been through it on the team, that have learned to navigate the system through assistance from people in the prevention program;” “Create transparency;” “Find some way to reach people who really need it a little better.”

This particular clinician, who stated she had not heard of the 10-year plan insisted, “We do not have primary prevention in this area” and recommended to stakeholders, “That they come here and work. They come here and get a front line experience in impoverished areas like H, NH, and W counties. They come here and get a firsthand experience and do not allow the text book to dictate how they design that

program because they will mess it up every time.” In short, clinicians did not perceive stakeholders possessed a full knowledge of what domestic violence was, or as a clinician stated that they understood the “insidious nature of it.”

Finally, each clinician was asked at the end of the first research question if there were any questions or comments. Eight clinicians had no questions, one wanted to know if the Violence against Women Act was part of the Coalition’s 10-year plan, and the other participant who had a question wanted to know if results of this study would, as she put it, “be relayed to someone that is wanting to see true changes in North Carolina”. She continued “I really do [hope so] because all we’ve gotten so far is lip service.”

Additional comments came from two participants. One who stated, “It’s hard for me because like I said I don’t know a whole lot about the North Carolina primary prevention act stuff,” and the other indicated, “If we could create a perfect world, and we could screen little kids at the elementary school level for family dynamics, and start intervention, then, that would be a dream I have.”

This participant stated she worked directly with soldiers and their families and revealed, “That’s the majority of mental health disorders I see coming in once they hit the 5th grade. How fantastic would that be?” As this quotation indicated, the mental health future of citizens was not only on my mind but also on the mind of this participant. Recorded verbatim are responses to question two, how effective clinicians perceived the 10-year plan would be in preventing further mental illness and substance abuse of DIPV victims.

Research Question 2. *Clinicians were more confident in their knowledge of how secondary and tertiary interventions would impact further instances of violence than they were in the plan's potential to impact victims' lives.* When asked what specific prevention strategies helped their clients, three participants referred to prevention, which are primary measures, whereas the other seven gave responses related to interventions that are secondary, tertiary, or recovery measures.

Evidence of responses to secondary and tertiary measures included the following: "Like I said, those practical needs, so getting those basic things taken care of, so like anything that will support that is what helps the most;" "Safety first, making sure they have a safe place or understand that there is a safe place that they can go to;" "One thing is trying to know what some of the triggers are for their partner;" and, "Usually when I see them they have come out of the domestic violence, so it's not even like tertiary at that point it's kind of recovery." Comments similar to the aforementioned were repeated when clinicians were asked what prevention strategies their clients reported were most helpful.

Afterwards, when participants were asked if they had evidence of their clients reporting violence that resulted from exposure to primary prevention, eight clinicians responded "no," they had no evidence, and two responded with answers that related to secondary interventions not primary prevention. As a clinician I recognized the difference between violence and harm. I wanted to establish this distinction as I queried study participants. As a result, the data revealed clinicians' responses were mixed concerning

evidence of harm resulting from exposure to primary prevention with seven of the 10, believing primary prevention was beneficial.

A respondent did report on a client who was triggered after viewing a poster related to primary prevention. The clinician stated that her client said “every time I see that [referring to the poster] I get triggered.” This clinician perceived that the client was harmed by viewing the poster but later indicated the client was motivated to work through the triggering event. Although this client experienced a triggering event as a result of viewing the poster she was, with the help of her therapist, able to move beyond in incident. Primary prevention is a tool for prevention and not intended to institute harm; it is an instrument for awareness.

As participants responded to questions related to an increase in awareness, six participants believed DIPV awareness had increased and two were unsure if there were an increase. A participant who worked at the shelter believed that, “an increase of awareness was more visible based on an individual’s proximity to programs that promoted awareness.” The final participant stated, “I’d say there was a decrease. Every year there is a piece in the newspaper that runs for one day and that’s pretty much it.”

Of the clinicians who reported an increase in awareness they attributed that increase to (a) outreach programs on the military base, (b) primary prevention campaigns on college campuses, and (c) sensationalized events in the media. Despite clinicians’ beliefs, however, that awareness had increased; only three of the participants interviewed made reference to specifics that their clients reported. Overall, clinicians agreed prevention was not mentioned during a session.

Following that series of questions each clinician was asked if she understood what primary prevention was, and all but two gave responses detailing a correct understanding. One clinician who did not correctly identify primary prevention, framed her response towards teaching clients, she stated:

To be able to put resources and information out there for people who are in domestic violence situations, we are trying to promote, you know, people living in healthy environments, less violence. Giving people access to resources that they are unaware of and trying to get that education and information out there to save lives.

The other clinician referred to secondary interventions, not primary prevention when she stated, “My understanding of primary prevention it is to support individuals in transitioning out of their unhealthy situation into a situation that is going to be more beneficial to themselves, their children, their family, and the community.”

Although eight participants defined primary prevention correctly, responses to other questions reflected that, experientially, clinicians possessed a greater understanding of secondary and/or tertiary interventions than they did of primary prevention. For example, when reporting on prevention strategies clients found most helpful, one clinician stated, “Usually just the stuff like department of social services, DSS, support because once they get into the system they figure out DSS could help me find a place to stay with my kids.” Another participant discussed, “help locating a safe place.” These responses were evident of *interventions* that are secondary in nature because the clients

were already in a violent situation. On the other hand, *prevention*, which has a primary focus, would have an impact prior to involvement in abuse.

Another illustration and a surprising find was that six clinicians identified secondary intervention when asked of their agency's primary prevention programs. The other four clinicians, however, had previously engaged in primary prevention campaigns or were actively engaged with such campaigns. These four participants were employed by agencies that mandated primary prevention efforts. Still, participants did point out that, when events of domestic violence happened in the media, there was more talk of awareness among their clients than what normally occurred.

For instance, an event mentioned during several interviews concerned a video that went viral of NFL football player R. R. who punched his then fiancé in an elevator and later dragged her out. Shortly thereafter, several other prominent sports figures were accused of domestic violence against their partners or former partners which were also topics of discussion among clients. The clinician stated, with it being in the news that seems to be what I hear people talk about more often than pamphlets. It's just commercials and all that that's coming out. I hear a lot more people talk about those kinds of [situations]. It seems like news and media."

Although the majority of research questions were focused on prevention, one question did refer to clients' responses to interventions. Responses to this question raised another surprising find where clinicians were divided on how they perceived clients responded to interventions. Five clinicians believed clients' responses were "hit or miss" or "positively in session" but did not translate to the clients' lives beyond the counseling

session. The other five clinicians thought clients' responses reflected the client's level of progress. Clinicians stated clients took "baby steps," or were confident in where they received counseling. "They [the clients] trusted the center."

It is evident from responses to Questions 1 and 2 that none of the clinicians were confident in the state's 10-year primary prevention plan. They also did not think that the plan had a current or that it would have a future impact on the lives of their clients. Throughout the interviews the state's plan was not mentioned as a resource, and there were no voluntary references made to the plan.

Similar to Research Question 1, at the end of Question 2 participants were asked for questions and comments. Eight had no questions, and one was concerned about treatment of domestic violence clients. She stated, "Regarding treatment for patients of domestic violence, victims are not always *diagnosable*, but truly need help." As a clinician in the role of researcher, I asked the participant to explain what was meant by *diagnosable*. In my role as researcher, I understood that the participant and I spoke the same language as clinicians. However, I was not there as a clinician but as an instrument to collect data. Therefore, I was responsible for ensuring that participants spoke to the study and not to me as a colleague.

The participant went on to explain, "For us to be able to clinically provide treatment they have to have a diagnosis." When I asked why clients did not have diagnoses, the participant stated, "They are not mentally ill." This response indicated an abused victim was not mentally ill; however, research indicated prolonged engagement in violence placed a strain on the emotional and mental well-being of the individual (CDC,

2011). The participant stated the exception; however, was for those who as a result of prolonged engagement, were diagnosed as clinically depressed, substance abusers, as having PTSD, or some other form of mental illness.

The other clinician with a question asked, “Is this area being looked upon to get this 10-year domestic violence program?” *A strange question*, I thought to myself, considering I was there inquiring about her beliefs about the plan (field notes, July 03, 2015). At the end of Q2, six participants had comments ranging from interest in finding out more about (a) the 10-year plan, (b) their client’s and their awareness or lack thereof of, domestic violence, (c) questions about survivors, (d) designing primary prevention, and (e) the accused. At the end of each interview I took the time to address participants’ questions and ensured debriefing was provided if needed.

Discussion

The results of this case study provided valuable insight into clinicians’ perceived impact of the state’s 10-year primary prevention plan on their domestic violence clients with mental health and substance abuse issues. Results indicated that clinicians’ perception of primary prevention, specifically the 10-year plan, had yet to impact their clients’ lives, mental health, or future as it related to violence. Clinicians believed that primary prevention had not impacted their clients, for it had yet to impact their practices.

Data also revealed clients lacked knowledge and even awareness of primary prevention programs generally and, specifically, the 10-year plan. Few clients were exposed to any form of primary prevention, and the clients identified as having had exposure to prevention failed to incorporate information into their current situation.

Clients also did not refer to prevention strategies by which they were impacted and only discussed prevention when it was sensationalized in the media.

Although this study was aimed at clinicians' perceptions of how the 10-year plan impacted their clients, there were several surprising results. Results included clinicians' lack of knowledge of the plan. The clinicians indicated in their responses their clients' lack of exposure to the plan; therefore, they believed the plan failed to impact the lives of their clients. But clinicians were also forthcoming about their own limited knowledge of the plan including the benefits and drawbacks. Another surprising result was, of the 10 clinicians interviewed, none felt her colleagues were knowledgeable of the plan, and there were no discussions related to the plan or about its impact.

Equally surprising were the data illustrated that less than half, only four of the clinicians interviewed, had identified primary prevention strategies in their agencies. In this situation the four clinicians who were identified as participating in regular prevention efforts worked in institutions where prevention were mandated.

In addition, study results indicated that primary prevention had not impacted the lives of the clients with whom the research participants worked. Clinicians, though confident in their work with and assistance of DIPV victims, failed to understand the very nature of counseling was a secondary rather than a primary prevention measure. For instance, the clinician stated that, "vicariously through providing education for me" clients are reached. Although there were occasions where clinicians are the source of primary prevention, one clinician's reach is limited. If primary prevention is to be

effective it must reach those for whom it is intended. The goal of primary prevention is to target those at risk of becoming victims, and prevent and/or avert victimization.

For example, Spivak et al. (2014) said it best when they stated, “The problem of IPV can only be addressed if the focus is shifted from responding to acts of violence to preventing violence before it starts” (p. 40). Primary prevention must take precedence over secondary and tertiary intervention because in the year it took to collect data for this study, 55 people across the state of North Carolina lost their lives to domestic violence (NCCADV, 2015). In corroborating these statistics a clinician stated, “But I also know murder by a mate and domestic violence. I don’t think those numbers are really coming down in our area.”

And in a recent study of North Carolina’s cost for domestic violence, it was calculated the state spent over \$307 million annually, with domestic violence related mental health costs of over \$57 million (Billings & Troyer, 2014). Although these figures indicated the need for primary prevention existed, study participants indicated prevention had not reached their clients. In sum, study participants believed their clients were unaware of primary prevention and available resources, and clinicians indicated that the need for education was great.

However, clinicians’ lack of awareness of what impact primary prevention had on the number of DIPV cases locally or statewide, may have limited their own prevention efforts Knowledge of this information, an outcome measure was important because it informs practice (Duarte, 2014). A key point of this research that was previously stated was ongoing DIPV primary prevention awareness would serve to (a) teach the public

against its negative consequences, (b) challenge erroneous beliefs, (c) dispel long held myths, and (d) alert the public to resources available within the local community.

Clinicians hold an important position in the community and could reach the domestic violence population and the community at large.

Moreover, clinicians' responses to interview questions further corroborated findings in the literature. Research participants recommended that stakeholders develop materials in a language people could understand and host discussion groups (Gonzalez-Guarda, Lipman-Diaz, Cummings, 2012). This reference to language highlighted one of the known risk factors in North Carolina, home to a large Latino population.

Another risk factor was the presence of member of the military. Although only one clinician in the study stated that she worked with the military men, women, and children, North Carolina, is home to multiple military bases. Finally, clinicians suggested that stakeholders target the young (Jakobsson, Borgstede, Krantz, Spak, & Hensing, 2013), many of whom had parents returning home from war with PTSD and war related injuries. Also evident were the need to provide resources for practitioners, teach stakeholders (Duarte, 2014); and clearly define the dynamics of DIPV in the literature.

Limitations and Implications for Future Research

The study's findings would contribute to the existing scholarship; however, limitations were present within this study. First, the small number of participants limits generalization of findings. In spite of this fact, qualitative case study research does not seek to generalize findings but aims to understand phenomena through rich themes and thick descriptions. Though not generalizable, the findings indicated the need to expand

primary prevention efforts across the state.

Practitioners who worked directly with the DIPV population could benefit from a direct method of accessing primary prevention information, education, training, and outcome measures. Primary prevention materials that explain what domestic violence is and teaches clients as well as stakeholders would serve to bolster prevention efforts. Second, study participants did not include all practitioners who worked with DIPV clients. Third, participants for this research were selected from the websites of the MCO/LMEs, and not all clinicians across the state were registered with the MCO/LME. These factors could indicate a bias in the selection process, another limitation of this research.

Finally, clinicians who responded to the research flier may have had available time to participate in the research when the study was being conducted. Both agency and private practitioners' work is based on billable hours. Therefore, clinicians who took part in this study were not impacted financially by their decision to participate. Despite these limitations, future studies could examine the beliefs of a wider range of providers who treat members of the DIPV community. Finally incorporate qualitative and quantitative studies that would provide further insight into the effects of primary prevention on the DIPV situation.

Conclusion

To my knowledge, this study is of a select few designed to understand from the clinician if, and how, their clients were impacted by primary prevention. The following two research questions framed this study: (a) What are mental health clinicians'

perceptions of positive influences from the NCCADV 10-year primary prevention plan on DIPV victims diagnosed with mental illness or substance abuse issues? and b) What are mental health clinicians' perceptions of the NCCADV 10-year primary prevention plan in preventing further mental illness and substance abuse of DIPV victims?

Findings from this research indicated clinicians were unable to identify, specific or general, positive influences from the coalition's plan. In addition, there were no indications that clinicians believed the coalition's plan had the potential for future influence on the mental health of, and substance use by, their DIPV clients. Findings from this study could inform stakeholders who design primary prevention as well as clinicians and practitioners who work with DIPV clients, and bridge the literature gaps.

As a researcher, I concluded that dissemination of primary prevention information and materials to those who directly affect individuals in the DIPV community would inform practice. Primary prevention information could equip clinicians and providers with the tools necessary to design and/or promote primary prevention in their agencies.

To illustrate, in their research on prevention of sexual violence, Van den Ameele, Keygnaert, Rachidi, Roelens, and Temmerman (2013) concluded, "Before developing and setting up secondary and tertiary prevention initiatives, the feasibility of primary prevention initiatives should be considered, as they are the basic conditions for sustainable and effective change." Ongoing primary prevention that reaches the masses, would help to reduce this public health crisis greatly. As such, the next step would be to implement the NCCADV 10-year or similar plan to address the lack of primary prevention locally and across the state.

Section 2 contained data analysis, and findings of this research the methodology section. Included in Section 3 are the project, and a justification for the choice of a position paper.

Section 3: The Project

Introduction

This project resulted from supporting literature and data analyzed from this research. Research results indicated that NCCADV had failed to catalyze primary prevention across North Carolina to address the DIPV need of its citizens. Although equipped with the training, resources, and recommendations for promoting primary prevention statewide, the research indicated that the state spent \$307 million for DIPV care annually. Moreover, eighty percent of the clinicians in this study had not heard of the NCCADV 10-year plan. A plan designed to promote DIPV awareness across the state.

Furthermore, results from this study indicated evidence that there was a need to understand primary prevention. To illustrate, clinicians demonstrated an inability to correctly distinguish between prevention and intervention. In view of these findings, I determined a position paper was the tool best suited to effectively communicate the following; (a) the purpose of primary prevention, (b) the need for statewide implementation, and (c) the vehicle through which implementation could take place.

In this section I define prevention, highlight its importance, and present recommendations on how to promote primary prevention in the public square. In addition, the merits of a position paper are detailed, along with an explanation of how mass media could benefit coalitions as they move forward with efforts to promote prevention.

Review of the Literature

The need to understand primary prevention is evident as the data from this research indicated clinicians failed to correctly identify the difference between prevention and intervention. The CDC (2013) described *primary prevention* as “designed to prevent a disease or condition (such as arthritis) from occurring in the first place” (p. 1). As previously noted, Van den Ameele et al. (2013) called primary prevention, “the basic condition for sustainable and effective change” (p. 11). The need for stakeholders, academia, and practitioners to ascribe to primary prevention as it relates to DIPV is evident in the literature as it was found that DIPV touches every sphere of every community (Asay, 2011; de Carvalho, 2014).

According to Rosen’s (1975) groundbreaking research, the history of primary prevention dates to the 1950s, with research on the etiology and discovery of communicable and transmissible diseases and in response to the need for control. Rosen reported that primary prevention took on three distinct approaches to address contagion: (a) to learn through constant repetition how individuals in communities addressed hygiene; (b) to interrupt, through isolation and cleaning, the communicability of diseases; and (c) to discover the etiologies to determine control of infectious and deficiency diseases. While it may seem that prevention efforts have advanced, modern-day prevention adheres closely to this paradigm. However, despite the existence of a prevention model, DIPV and related issues continue to negatively impact communities.

For example, the literature contains information on the dangers of domestic violence to individuals, families, and communities (Roberto, Brossoie, McPherson,

Pulsifer, & Brown, 2013). Scholars have learned through repetition how violence is perpetrated (Kottenstette & Stulberg, 2013), and programs exist specifically to interrupt violence. There are also programs to isolate perpetrators (Juodis, Starzomski, Porter, & Woodworth, 2014; Stewart, Gabora, Kropp, & Lee, 2014) and assist victims (Asay, 2011; Gonzalez-Guarda et al., 2012).

Programs are also in place to identify those at risk (Davidov & Jack, 2014) and to control for violence (Bola & Mankowski, 2014). These systems, however, are mainly secondary, tertiary, and recovery focused (Freire et al., 2015). Primary prevention efforts are often minimized, however, as the fight against DIPV continues and agencies build collaborations to address this public health issue.

To illustrate, the U.S. Department of Health and Human Services (DHHS) tasked CDC with many preventative-care-related activities in response to cancer, heart disease, stroke, obesity, and tobacco cessation (HHS, 2015). Prevention is also used to address social ills and was implemented in programs to address substance use, teenage sexual activity, and aggression (Prevention Science, 2014). Prevention programs were employed in Rhode Island to address the rise in opioid addictions and deaths, and to inform the public of this preventable issue (Bowman et al., 2014). DIPV, like opioid abuse, is a preventable public-health-related issue, an issue that the CDC and its partners sought to address.

The CDC was responsible for the partnership between the DELTA PREP projects to integrate primary prevention into various states' domestic violence coalition programs. It was through this partnership that North Carolina's coalition developed its primary

prevention program. The CDC had long recognized DIPV as a public health issue that threatened the physical and mental health of victims (Freire et al., 2015).

On reporting on the purpose of DELTA PREP, Freire et al. (2015) stated the goal of DELTA PREP as, “The *innovation* was a public health approach to preventing IPV focused on preventing first-time perpetration or victimization of IPV, and the *desired change* was DV coalitions’ integration of prevention with their traditional response work” (p. 437).

In other words, through collaboration, states would implement primary prevention into its existing domestic violence programs. Until implementation of DELTA PREP, most coalitions focused on secondary or tertiary intervention. In its evaluation of the DELTA PREP program, the Robert Wood Johnson Foundation (RWJF; 2015) interviewed one coalition staff member who rightly described her agency’s level of prevention when she stated, “Our program has been taking care of victims of domestic violence for the past 20 years. We’ve always been reactive. We’ve never really made an effort to end it. Prevention is that effort to end it. It’s time to be proactive” (p. 5).

Primary prevention required a shift not only in program structure, but also in organizational culture and language (RWJF, 2015). As this staff member indicated and the CDC recognized, it was time to get in front of the problem as with primary prevention. Despite this evidence, however, the culture of current programs supported from behind with secondary and tertiary intervention methods.

To further illustrate, the DELTA PREP project evaluation presented rather interesting results. Results indicated that upon initiation of the project (baseline), states’

coalitions showed only three areas in which prevention existed. At the end of the project (completion), the number had increased to four. These prevention activities, however, were mostly internal, and external events had a greater representation with other agencies via training and meetings (Freire et al., 2015). These findings were also corroborated by the RWJF (2015), citing another evaluator of the DELTA PREP project.

In addition to the aforementioned, and another alarming finding, was that, as Freire et al. (2015) stated, “Our findings support most coalitions had some (albeit limited) experience with IPV prevention in their organizations, but most coalitions had not moved outside their organizations to catalyze prevention within their state” (p. 445). These results not only validated the findings of my research, but also spoke to the need to, as previously indicated, take a proactive rather than a reactive approach to prevention. Agencies with the staff, resources, and support to conduct prevention efforts must move its primary prevention efforts beyond the walls of the agency if change is expected to occur. Primary prevention saves lives, as is evident with seat belt use (CDC, 2015) and the cessation of smoking (CDC, 2014).

As researchers have found (Freire et al., 2015; RWJF, 2015), it is also imperative to recognize that the culture of prevention is one that must be learned. Most professionals, though aware of primary prevention and the need to advance this cause, ascribe to secondary and tertiary interventions. This was evidenced by clinicians’ responses to study questions.

The task at hand is great; however, the evidence exists throughout the literature and has been recognized by organizations such as the CDC, WHO, and the vice president

of the United States (White House, n.d.) that primary prevention is needed. Scholarship and relevant research are critical to developing evidence-based prevention strategies, and evaluation (Matjasko, Niolon, & Valle, 2013) is a necessary component of any prevention program. As the components of collaboration, scholarship and design converge; what is necessary, however, is to understand that effective action on the part of all citizens is equally important.

Summary

As I have said, primary prevention addresses an issue before onset. The history of prevention laid the framework by which many programs are designed today.

Collaboration among the CDC, DELTA PREP, and states' coalitions to address DIPV indicated that primary prevention efforts had lacked widespread implementation and had not reached North Carolina's citizen base.

Although primary prevention had been proven effective, stakeholders, advocates, practitioners, and the community lacked education on this critical issue. Research reflected that to move forward with primary prevention and actively engage the community, stakeholders and other decision makers must be willing to educate the general public and embrace new ways of addressing this issue.

It is to that end I advocate for DIPV-related primary prevention for the masses through the use of new and old technologies. New technologies exist that would serve to expedite the dissemination of information. Old technologies are also a viable option for the distribution of information to those in disadvantaged areas who lack advanced technology, as well as those identified as at highest risk for DIPV (Bureau of Labor and

Statistics, 2014; Chen, Funk, Straubhaar, & Spence, 2013). By implementing the use of New and Old technologies stakeholders could potentially impact countless lives.

Therefore, I chose a position paper as an effective way to communicate information on the benefits of using mass media as a source of primary prevention with stakeholders, service providers, and agencies that develop DIPV prevention materials.

Implementation

As the sole researcher, I was responsible for development and implementation of the project resulting from this study. Project development emerged from integrated results of data analysis, current literature, and study objectives. Further considerations included financial and human resources with specific attention to time requirements. Guidance from my doctoral study chair and committee members proved crucial in the success of project development, and their input was solicited.

Position Paper

A position paper was the best tool to communicate findings to stakeholders and professionals who worked with DIPV populations and might lack the time and resources to explore current literature. A *position paper* is described as a tool used for communicating a position on a particular issue, gives the rationale for said position, and garners support from those to whom the paper is presented. Composed of an introduction, body, and conclusion, a position paper succinctly presents the argument, along with solutions (Xavier University Library, 2014). The Young Adult Library Services Association (2006), a division of the American Library Association, described a position

paper as a powerful advocacy tool, an aid to assist with decision making, a means to transfer knowledge and understanding, and a way to present a professional perspective.

Through the use of this position paper (the project), findings from this study and current literature can be compiled and communicated to stakeholders, clinicians, service providers, and agencies that design primary prevention materials. In addition, stakeholders and agencies that design prevention information could, use this paper, to examine how mass media is a viable tool for educating not only the general public, but also victims and those in the advocacy community. Therefore, in the following position paper I will develop and support my position on the use of mass media to promote DIPV primary prevention.

Introduction

Mass media as a resource will deliver information to larger groups of individuals in shorter amounts of time, and through the use of media constructs, stakeholders could direct not only how, but also what information is delivered to the masses (Brown, 2014; Park & Calamaro, 2013).

To illustrate, below is an example of how mass media reports impacted the lives of victims as reported by clinicians during several interviews. As I interviewed clinicians several respondents indicated that despite their clients' lack of knowledge of primary prevention, prevention was referenced as it related to a sensationalized video. The video involved a famous football player in a domestic violence-related incident. An online search indicated that the YouTube video in question had been viewed more than 11 and a

half million times in 2014 (TMZSports, 2014) during the period when data for this study were collected.

In another example of the impact of mass media, on February 1, 2015, CNN reported that 114.4 million viewers watched Super Bowl 49, with a viewership that peaked at 120.8 million at the height of the game. The halftime show had 118.5 million viewers, the most in Super Bowl history, and there were 28.4 million game-related tweets. The previous year, Super Bowl 48 had a viewership of 112.2 million viewers who watched the game (Pallotta, n.d.).

In yet another example, on October 8-9, 2015, WHO (2015) hosted the mhGAP Forum and posted the following on its website:

Forum participants heard moving testimonies from two invited speakers about their lived experience of mental illness, the challenges they experienced, and the central role that dignity played in their recovery. The theme of dignity in mental health also touched many people worldwide, reflected in the fact that @WHO's tweet on this subject was retweeted over 9,600 times which made it the most retweeted tweet in WHO history, and the second most retweeted message from a UN agency.

In the aforementioned examples, the first two examples reflected the use of new and old media, and the final example demonstrated a convergence of media. The organizations and individuals illustrated in these examples show how using mass media in various forms reached the general public for advocacy, entertainment, and education.

Argument: Mass Media as an Impetus for Change

It is for this purpose, widespread dissemination and immediate access of primary prevention that I propose the use of mass media to reach North Carolinians with the message of prevention. Results from this research indicated that despite information on the plan available by e-mail, nine clinicians had not received the e-mailed communication. Therefore, clinicians recommended stakeholders improve how DIPV information was distributed to the public in the following examples.

Clinician's recommendations for stakeholders included (a) targeting the young, (b) establishing better reach in services and languages, (c) generating discussions, (d) outreach to disenfranchised areas, (e) educating clinicians and stakeholders, and (f) providing a clear picture of domestic violence.

Another recommendation implied but not directly stated was the need to educate the general public. In other words, clinicians believed that current efforts to address DIPV failed to reach those in need. Therefore, in considering the above recommendations I argue that the use of mass media (Spivak et al., 2014) would satisfy each of these recommendations once appropriately governed.

Definitions

For the purpose of this paper, *mass media* encompass print, audio, phone, and Internet use. A debate currently exists in the literature on the use of *new* and *old* media, termed *convergence* (Choa-Chen, 2013). Although this paper does not address the merits of this discourse, it is important to highlight existing literature as it applies to current research. Mass media, social media, and new media are responsible for the current flow

of information readily available in society. Participating in this media convergence would benefit not only stakeholders, but also the public at large, in response to the DIPV crisis.

Merriam-Webster's Online Dictionary (n.d.) defines *mass medium* as “a medium of communication (as newspapers, radio, or television) that is designed to reach the mass of people.” Another media form popular in today’s culture, is *social media*. *Social media* can be defined as including “a range of tools and services that all enable direct user interaction on computer mediated environments” (Lampe, LaRose, Steinfield, & DeMaagd, 2011, p. 2), as well as “forms of electronic communication (as websites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (as video)” (Merriam-Webster, n.d.). Finally, there is *new media*, defined as “the forms of communicating in the digital world, which includes publishing on CDs, DVDs, and most significantly over the Internet. It implies that the user obtains the material via desktop and laptop computers, smartphones, and tablets” (*PC Magazine Encyclopedia*, n.d.).

Individuals have access to data in all forms through select media channels at their discretion without restrictions on time, place, or content (Boyd, 2014). In Boyd’s (2014), well-referenced book on teens’ use of social media, captured were the essence of today’s young adults’ use of technology. She also noted its impact on society when she referred to the “geographically unbounded settings” into which media extend their activities (p. 8). The unbounded nature of social media allows for information to be accessed and broadcasted in various formats. The access to social media, however, presents both benefits and challenges to the user as demonstrated in the following examples.

Media's Reach

Pennington and Birthisel (2015) reported that the Steubenville rape case was documented on smartphones by the victim's assailants and witnesses and posted on social media. Reports of the case indicated that "technology served as a witness and helped galvanize attention and activism" (p. 8.). They further posited that social media cast this case into the national spotlight, bringing attention to a crime that otherwise might have gone unnoticed (Pennington & Birthisel, 2015).

In another case, during the government shutdown of 2013, when major government and health agencies lost the ability to communicate with the public, social media became the intermediary through which information was shared (Merchant et al., 2014). Then in the midst of the flu pandemic and Hurricane Sandy, social media was recognized as a vital asset during a crisis (UPMC, Center for Health Security, 2014).

Moreover, in national news, social media was used to showcase police brutality, spurred riots, and how to advocate for help. Richards, Gillespie, and Givens (2014) posited, "The media have the unique power to harness the attention of news consumers and shape public opinion concerning important social problems, such as crime and violence, as well as society's role in prevention and intervention efforts" (p. 453). It is with this framework in mind that I recognized how the use of *Mass Media* would serve as an impetus for change to address the DIPV crisis (Jakobsson et al., 2013).

Implementations

As a public health issue, DIPV prevention should be promoted in all areas. Victims and members of the general public should receive warnings of the deleterious

nature of DIPV. In examining her state's expectation of due diligence towards the treatment of violence against women, Qureshi (2013) emphasized the following:

Prevention should be focused on transforming discriminatory attitudes that position women as sub humans. Under this approach prevention extends to education and awareness-raising, gender mainstreaming in all the government policies and plans, eradication of gender stereotyping, nationwide media campaigns targeting change in attitudes and gender trainings for law enforcers, judiciary, policy makers and other key personnel. These initiatives must have as an ultimate goal the positive transformation of perspectives, social values and approaches which have been perpetrating violence against women. (pp. 62-63)

In the text above, Qureshi included nationwide media campaigns as an area in which prevention should focus.

In conjunction with the DELTA program, Spivak et al. (2014) described a community's approach to primary prevention with teens involved "using creative social marketing and social media efforts focused on youths and parents" (p. 40). Considering this, elements of social media are common place in every institution across the nation and have the potential to impact countless lives (McNab, 2009).

In Social Media Use in the United States: Implications for Health

Communication, Chou, et al. (2009) proposed that programs using social media to communicate health messages should consider the following guidelines. The information must first be (a) age-specific in its focus, (b) understand race and ethnicity are not

limitations *on* social media, and (c) that social media have changed the landscape in American communication.

For example, in a 2012 survey the Pew Research Center (2013) found that health information was searched for by 72% of internet users. Though not considered a *health problem*, factual DIPV information on the internet would benefit those who search and use the internet for, health-related information. A study participant indicated that domestic violence clients might not know they were involved in a domestic violence situation until they are told. She stated:

And sometimes relatives talk to them about things and try to help them in the process. You know the person may not feel like they are a victim of domestic violence and then until someone names it for them and says this is what this is. Sometimes it's a family member, especially because if that person is very young, family members are still very much involved with them. Mother and grandmother especially and they try to tell them you can go here and you can do this and you don't have to be in this.

In an example such as described above, family members and/or victims searching the Internet could have access to factual information on DIPV. With factual information an individual could make an informed decision regarding the safest approach to his or her situation.

To illustrate, McNab (2009) asserted, "Increased access to the internet and mobile communication combined with strategic uses of social media can bring public health information to many more people, more quickly and directly than at any time in history"

(p. 566). Thus, stakeholders and advocacy groups have the ability, through mass media, to provide the public with information pertaining to DIPV more rapidly than ever before. It is therefore recommended that stakeholders should take advantage of all facets of mass media to implement prevention.

Convergence

In referring to social media as “a great information equalizer” McNab (2009) addressed this convergence of health information across socioeconomic and language barriers. Through the use of *new* and *old* media, stakeholders would have additional opportunities to engage every aspect of society. Combining new (social media) technologies and old (television, radio, and print) media, stakeholders could address their concerns for underserved populations. For instance, studies including the use of (old) media indicated 80% of Americans spent almost three hours of their leisure time watching television (Bureau of Labor and Statistics, 2014). Therefore, television (old media) is also a viable tool for the dissemination of DIPV information.

In related information, Chen, Funk, Straubhaar, and Spence (2013) researched the once popular public and government access channels (PEG), and found that these stations continued to have a relevant impact on public communication consumption. The authors reported Asian Americans, Hispanics, Native Americans, and African Americans were more likely to watch PEG stations more often than European Americans. They posited, “Public access television remains relevant for underprivileged populations” (p. 278). Furthermore, the Bureau of Labor and Statistics (2011) found that men tended to view an additional 20 minutes more of television than did women.

When this study was conducted, there were 18 television stations that offered various forms of PEG programming across North Carolina. Locally, there is a television station that specifically targets the Hispanic populace. And, as previously reported, Asian Americans, Hispanics, Native Americans, and African Americans were at higher risk for DIPV, and North Carolina has a growing Hispanic population. Chen et al. (2013) further posited public access television remains a viable option for public expression and community information, and includes programming for individuals of all ages.

Underserved Populations

Age, gender, and race. In previously cited information, the NCCADV 10-year plan intends to address children as young as 3 years of age and adults beyond age 61. This is an indication that the plan would target all segments of the population for primary prevention outreach. In support, the Pew Research Center (2015) reported that in 2005 only 2% of adults 65 years and older used social media. However, in 2015 those figures increased to 35% for adults in the same age range. Furthermore, women tended to use social networking sites at a higher rate than did men.

Also, the disparities between racial and ethnic users of social media have decreased, and the growth of social media use was present in individuals of lower socioeconomic standing. In addition, research shows that young adults ages 18-29 are high consumers of all forms of social media (Boyd, 2014; Pew Research Center, 2015). Therefore, as the demographics of consumers of social media change, change should also take place among those who provide information via social media. Young adults, individuals over 65, women, and other ethnic groups have increased access to

information on social media. With this in mind, designers of prevention information could reach subsets of the population at risk for DIPV.

Male victims and perpetrators. A subset of the DIPV population addressed less often is the male victim. Because of this, it is important that stakeholders and practitioners who work with victims do not overlook this group as services are not readily available for male victims (Tsui, 2014). In addition, men are less forthcoming about abuse than are women (McCarrick, 2015). McCarrick advocated, “More media coverage addressing the IPV experiences of both men and women is needed in order to educate people about this issue” (p. 378).

In related information, Tsui (2014) reported, “The male victim may perceive online media as being less threatening to their masculine self-image and ego while still maintaining their autonomy” (p. 128). Tsui also advocated for further education and training for those with immediate access to victims and perpetrators and commented “In addition, the service provider can use the technology as an effective and efficient means to disseminate knowledge about IPA and adopt a user-friendly approach to involve abused men in internet services such as anonymous open forums and online support groups” (p. 129). These authors spoke directly to the practitioner and presented media as a valuable resource to address DIPV in underserved populations.

Additionally, to impact the DIPV picture, attention should focus on perpetrators. As a research participant highlighted about working with the accused, she stated;

Yeah, I think it's narrow of us to only work with the survivor. I think we need to take a step back and much like thinking about how much do a woman get paid

and that idea of subjugating anyone and making them less than, is the cornerstone of all the next pieces of that violence piece. If we are really going to stop it, we have to go to the accused and say, how do we stop you from behaving this way. As I have stated, it is uncommon to recognize men as victims of DIPV. Despite this fact, however, the literature has indentified women as aggressors. Knowing this, the success of primary prevention would be contingent on addressing both victims and perpetrators.

The media, as an impetus for change, is a viable option to address the DIPV crisis locally, nationally and internationally. Although it is true that the use of media presented many opportunities for advancing prevention, challenges should be considered. The use of media presented challenges and the literature indicated scholars were concerned with the freedom users are afforded when engaging in online discourse (Turner, 2010; Vance, Howe, & Dellavalle, 2009).

Potential Barriers

Social media, citizen journalism, missed opportunities. As stakeholders move forward with prevention outreach on social media there are several challenges that should be considered. However, I chose to focus on the issues raised most often in the literature, when media presented on DIPV related issues. For instance, *Citizen Journalism* is the participation of public views in the shaping of contemporary media. Citizen journalist demonstrates the power and ability to transform current discourse (Turner, 2010). Bou-Franch (2013) researched public participation in the domestic violence discourse, and found citizen journalist could, or have the potential to direct the conversation on DIPV if stakeholders continued to miss the opportunity to lead in the discussion.

Consequently, participants in Bou-Franch's research were found to minimize the severity of DIPV, promote victim-blaming, and advocated for privatizing the violence. Bou-Franch's research demonstrated the potential that information on social media had to compound the DIPV problem, she reported, "Incidentally while there was much debate about the reasons why women did not leave their abusive partners to the point of incriminating victims in their own battering, nothing was said of abuse perpetrators throughout the discussion" (p. 295). In the previous example citizen journalist promoted fear, and encouraged stereotypes, all of which are areas primary prevention could address.

Another challenge presented by the use of social media is the plethora of information available on websites housing unverified or incorrect sources (Brown, Nasiruddin, Dao, & Halabi, 2015). To address these issues, recommendations in the literature included the use of professionals knowledgeable of the DIPV situation to provide factual information. Additionally, stakeholders should be selective in their choice of DIPV terminology used on social media or in other context. The literature advises against the use of terminology that could have multiple meanings to the lay person unfamiliar with DIPV related terms even if those terms are familiar to academia (Merchant et al., 2014).

For example, during the Ebola outbreak and in the midst of a media frenzy, the WHO and CDC used social media to update the public with information that was both accurate and timely (CDC, 2014; WHO, 2014). As the literature has shown, on social media voices are silenced in many ways, and heard in many others. Therefore, it is

recommended that the online discussion on DIPV should not take place without educated professionals. Bou-Franch (2013) also reported that citizen journalists who were involved in the DIPV discourse and advocated victim-blaming were challenged and changed their views when presented with factual information. By challenging individuals who promote myths, and stereotypes, knowledgeable professionals could change erroneous beliefs.

Framing. Another potential barrier for stakeholders involves *framing*; media framing influences the reader's, viewers' or media participants' attitudes on what is disclosed in the media content (Patterson, Semple, Wood, Duffy, & Hilton, 2015). Media framing directs or defines problems, causes, moral judgments, and remedies; and it is used to report crimes, and in the shaping of public opinion (Meyer & Post, 2013).

In fact, Meyer and Post (2013) reported in their quantitative analysis of newspaper articles that framing of DIPV incidences in the media swayed public opinion into believing DIPV was “the result of a triggering incident rooted in the intimate dyad” (p. 8). Letourneau et al. (2014) reported media framing of child sexual abuse as inciting fear and/or victim blaming. Still, Richards et al. (2014) found that DIPV and other violence related stories in the media lacked consultation with professionals who were able to provide facts rather than interpretations.

In fact, when presenting a domestic or violence related incident in the media, scholars (Baluta, 2015; Meyer & Post, 2013; Pennington & Birthisel, 2015) reported due to a lack of knowledge on the part of the reporter, the incident was presented in a way that steered the reader from understanding the depth to which DIPV is a public issue (Richards et al., 2014). As mentioned, professionals knowledgeable of the DIPV situation

are needed to guide conversations that would take place in the media, and on social media platforms. If professionals are absent from this dialogue issues such as victim-blaming (Bou-Franch, 2013), incorrect information (Meyer & Post, 2013), and inciting fear (Letourneau et al., 2014) are likely to continue. Despite the challenges with social media, the literature provides guidelines on how to address those challenges.

Proposal for Implementation and Timetable

Addressing Social Media

Although there are negative connotations framing holds positive elements for stakeholders who are willing to construct factual frames to disseminate information to the public. Bou-Franch (2013) posited, “Identifying, resisting and contesting abuse-sustaining ideologies will contribute to dismantling the discourses and ideologies in the larger social context that currently naturalize violence against women” (p. 297). In fact, in their study of femicide-suicide Richards et al. (2014) stated “Recommendations to cite experts, provide statistics, and include contact information are crucial to spreading awareness and combating violence” (p. 461).

Following the recommendations of these authors, stakeholders would capture opportunities, leverage social media, educate the public, and potentially save lives. In another study on media coverage, Baluta (2015) advised, “The role of media is highly important in regards to violence against women, both in terms of how media cover the issue, and how media may become a tool used by activist and decision makers to raise awareness, mobilize people and implement programs on the issue” (p. 53).

As previously noted by the RWJF, (2015) in their evaluation of the DELTA PREP program implementation of social media into prevention requires a change in stakeholder and agency culture. Thus, it is important that the culture within the advocating agencies change if the agency expects to impact the larger culture. The literature provides strategies on how to report DIPV in the media.

Guidelines for Reporting in the Media

As stakeholders consider mass media as a resource to promote DIPV awareness consideration should include the aforementioned constructs (media's reach, addressing underserved populations and potential barriers). Framing is a construct that has the potential to greatly impact how DIPV information is presented. Well framed DIPV information could also address incorrect myths and beliefs in the public arena. Therefore, how stakeholders approach framing is essential to the success of any media campaign. Baluta (2015) gave his recommendations on framing. He stated,

the 'paradigm' of journalistic practices can be slowly adjusted so that media products framing violence reveal responsibility, understanding the phenomenon, an authentic intention to inform the public/citizens and to urge them to raise questions on the topic and the involvement of the institutions and that of the larger community. (p. 64)

Also, in constructing programs geared at child sexual abuse prevention, Letourneau et al. (2014), outlined guidelines for media reporting. The authors advocated for the use of the public health approach to child sexual assault (CSA) prevention. They further stated that CSA may be a tool used to formulate prevention strategies for DIPV

related media prevention. The author's posited prevention of CSA was achievable through the public health prevention model and attainable through its use.

Additional resources on reporting in the media included those supported by Richards et al. (2014). These authors specifically recommended guidelines used for reporting on femicide-suicide, which the authors defined as suicide directly following the homicide of an intimate partner. Although these guidelines were initially designed to address suicide, the authors advocated for its use in approach to DIPV in the media. Eight recommendations were summarized from the authors' research and highlighted below:

1. Report information that is concise, factual, and not overly simplistic.
2. Terminology is important label the act as a domestic violence related incident.
3. Avoid titles or article headings that could promote sensationalism.
4. Direct focus away from the perpetrator and acknowledge the dynamics of IPV.
5. Avoid using photos that lead to the sensationalism of the incident and encourage attention-getting from others who may seek to do the same.
6. Use the media to promote knowledge and awareness.
7. Use quotes from professionals with knowledge of the DIPV picture, also provide a journalist with factual educational statistics and information on reporting DIPV.
8. Provide local and national resources, phone numbers, websites, shelters, and coalition information.

By using these eight recommendations practitioners could frame DIPV information in factual ways that provide the viewer/reader with information on how DIPV affects the community. Gillespie, Richards, and Givens (2013) in a separate research advocated for an alliance between journalist and local coalitions to enhance reporting on DIPV related issue. In sum, these guidelines are resources that could frame the foundation for stakeholders as they move forward with DIPV prevention in the media.

Timeline for implementation. Once guidelines are adopted agencies are equipped to begin promoting primary prevention. The time between adoption of a set of guidelines or recommendations is program specific; however, considering the current need for prevention, agencies should attempt to expedite the process. For instance, the RWJF reported its findings of the DELTA PREP program in 2013, then, Freire et al. reported on their discovery 2 years later in 2015. It is safe to conclude that *now* is the time for NCCADV to catalyze primary prevention information to the public. Coalitions can no longer afford to wait until the decision is made to change the culture inside the agency before programs are implemented.

To illustrate, NCCADV reported on its website evidence of why the need for prevention is great. In the final year of implementation of the DELTA PREP program (2012), 63 DIPV-related deaths were reported. In the years following there were; 64 deaths in 2013, 64 in 2014, and 69 in 2015. RWJF (2013) reported coalitions were prepared to present the information to the public when they stated, “CDC staff and consultants delivered training and technical assistance to grantee coalitions to plan and

implement changes that would expand their capacity for primary prevention of intimate partner violence” (p.1).

In this situation, although coalitions had not catalyzed prevention beyond its walls, they were best prepared to deliver information on prevention to the public. Therefore, if coalitions, professionals, and stakeholders do not take the lead in determining what and how information is presented to the public, erroneous information and common myths will continue to add to the perpetuation of the cycle of violence.

Roles and Responsibility of Students and Others

Although it is true that organizations are responsible for promotion of prevention statewide, it is equally true that individual citizens are responsibility to ensure a safe personal environment. As a researcher, student, and clinician, I have firsthand knowledge of the DIPV problem within the state. Working with military families, meeting with colleagues, attending conferences, and exploring the literature provided a complete picture of the impact of DIPV. These experiences afforded me an advantage not had by most clinicians.

Understanding the effect of DIPV equipped me with the knowledge to address erroneous discourse. When presented, I have taken the opportunity to instruct others with whom I interacted on the facts surrounding DIPV in an attempt to dispel myths. As an educator, I encouraged others to take information that they have learned and to pass on accurate information. When possible, I have provided resources to the individual or groups extending knowledge and suggested that they share the resources with others. As a host or speaker at conferences I was offered opportunities to engage other professionals

in the discourse on prevention and other DIPV-related issues. In short, I have accepted each opportunity to inform and instruct others on the harmful effects of DIPV, and encouraged and supported others to do the same.

Project Evaluation

As I have done with this research, it is necessary to examine the merits of programs designed to assist members of the public. In their evaluation of the DELTA PREP program of coalitions' ability to integrate prevention, Freire et al. (2015) listed six types of preventive activities, two of which were unique to this project, (a) to work with media outlets, and (b) to work with social media campaigns.

The authors also listed communication channels (i.e., newsletters, listserv, blog, website, Twitter, and Facebook) as areas of capacity where an agency had potential in which to expand its prevention efforts. Also, the authors defined two specific areas in their evaluation for agencies that work with media outlets. The two areas were to focus on prevention, and on framing of DIPV information in the media. Examples of prevention activities provided by the authors included; working with public television, the journalists' role in framing, and distribution of press kits.

At the end of their evaluation, Freire et al. (2015) found, "Only three coalitions were implementing program activities with partners and no coalitions had initiated policy activities or work with media outlets" (p. 444). Despite these findings, the authors gave coalition specifics on prevention capacity and prevention activities in the area of media relations. Having identified both prevention capacity – communication channels, and prevention activities – works with media, coalitions were equipped to implement and

evaluate these areas, despite not having done so in the past. Thus, the failure of the agency to adopt recommendations on how to bring about prevention in no way diminishes the need.

To summarize, in this position paper, I presented on the merits of prevention in the media and the challenges of navigating mass media. In addition, I provided guidelines on how to frame DIPV related issues in the media. Both areas were cited by DELTA PREP as focus areas for working with the media. Information from DELTA PREP provided coalitions with guidelines on how to frame information in the media, and in what areas to evaluate its effectiveness (i.e., prevention catalyst statewide; Freire et al., 2015). Staffs within coalitions and specifically the staff of NCCADV were trained and educated on program evaluation.

In order to move forward, implementation of sound and existing strategies, and the use of current resources would best help the citizens of North Carolina far better than attempting to create an evaluation tool or rubric by which to assess an ongoing program. The citizens of North Carolina both military and civilian are in need of the prevention resources available to NCCADV. Therefore, prevention is imperative and 1day, could mean a life saved. As a result, I concluded that prevention is unto life, and it warrants promoting.

Implications Including Social Change

Stakeholders with access to the information in this research are equipped to move forward with outreach. DELTA PREP approached coalitions in high-risk states and

provided the training necessary for the implementation of prevention into its current domestic violence programs.

DELTA PREP also made coalitions aware of its potential for *new* media to disseminate information and this research showed how *old* media could reach underserved populations. *New* and *old* media constructs such as framing, and collaborations with journalist could potentially impact this population not only in North Carolina but also nationally and internationally.

Conclusion

To summarize, this position paper was intended to provide stakeholders, advocates, and designers of primary prevention with information on the efficacy of prevention in mass media. Presented were examples of how individuals responded to information in the media. How the media was used as resource for information, education and advocacy, and how new and old technologies were effective in reaching large audiences. Addressed were the challenges of developing and maintaining dialogue on social media and how to address those challenges.

Furthermore, I presented media's current and potential impact on underserved populations, introduced terms used and the definitions, and guidelines for reporting DIPV and related violent incidents in the media. As a researcher and scholar I believe that DIPV as a public health problem has in large part, and for the moment, received predominantly sensationalized coverage in the media. After reviewing the literature, I also believe that citizen journalists could be the catalyst that forces coalitions and other experts to address DIPV through the media, and in the public square. As time passes,

each day holds the potential for another child, woman, or man to become a victim of DIPV.

Professionals guiding the discourse surrounding DIPV could; (a) positively impact change, (b) minimize violence, and (c) potentially save countless men, women, and children the mental, emotional, and physical distress caused by DIPV. Moreover, stakeholders are in a prime position and have an opportunity through this medium to determine the local, national and possibly international direction of DIPV.

In the next section, Section 4, I address several areas of self-analysis, self-development, recommendations and strengths of the project, implications and other factors for future consideration, and the conclusion.

Section 4: Reflections and Conclusions

Introduction

In the previous section I introduced a position paper that contained information on, and recommendations for, disseminating DIPV information resources to; individuals at risk, underserved populations, and members of the general public. I proposed to stakeholders a means by which they could distribute information on prevention. I also suggested that they should use mass media, which includes new and old technologies, to distribute this information. I chose a position paper as the best resource by which to communicate this information, and there are guidelines and recommendations in the paper on implementation. Also found in the paper are the barriers to using mass media and how to address those barriers.

In this section, I will address the strengths of and limitations of this paper. I will also address scholarship and reflect on my role as a researcher and practitioner. Finally, I will follow with recommendations for future research and the project's impact on social change.

Project Strengths

The strength of this position paper was grounded in the foundation on which it was proposed, primary prevention. Primary prevention is the vehicle through which information, strategies, and resources are presented to the public when it is determined that a threat exists to public health. Federal, state and local government agencies such as the CDC, WHO, and DHHS are all advocates for, and promoters of, primary prevention. Recognizing DIPV as a public health problem and the need to implement primary

prevention on a state and local level, the CDC partnered with states' coalitions to bring this to pass. Once coalitions received materials and trained on the merits of prevention, each coalition was responsible for statewide implementation.

A position paper presented to stakeholders, practitioners, and creators of DIPV primary prevention materials was an avenue least explored to promote primary prevention to those in need. Through mass media (new and old technologies), primary prevention would teach members of the DIPV population, and the general public. By working with the members of the media coalitions could use framing, educate journalists, and take hold of opportunities to provide immediate access to accurate information, phone numbers, addresses, and available resources.

Professionals who work directly with the domestic violence population could use the information in this position paper to determine how best to implement primary prevention into their practices. Identified resources and references are provided in this position paper for scholars and nonscholars alike who are interested in further research. This paper also introduces to the clinician expanded information on coalitions' abilities to provide primary prevention. Individuals unfamiliar with their states' prevention efforts could use this paper as a resource with which to start the dialogue.

An additional strength of this position paper is its design. The position paper is easy to read and lends to portability. Professionals and nonprofessionals alike could use the information found in this position paper to communicate with those in management and inform them on the threats of DIPV. A final strength of this position paper is the recommended collaboration between journalist in mass media and promoters of primary

prevention. This collaboration is needed for promoters of primary prevention to influence how DIPV and other forms of violence are portrayed in the media.

Recommendations for Remediation of Limitations

Limitations

The greatest challenge this project poses is the implementation of primary prevention. Moving coalitions, practitioners, and stakeholders from a secondary intervention framework to a primary prevention framework, goes against years of history in the field of DIPV (RWJF, 2013). Coalitions' prior work consisted of addressing the needs of the victim and to some extent prosecuting the perpetrator, as evidenced by their "strong community support" (RWJF, 2013, p. 4).

In other word, as coalitions collaborated with state and community agencies the needs of victim, and at times the perpetrator, were addressed. An additional limitation is the coupling of mass media with primary prevention. Coalitions have failed to demonstrate proficiency in establishing the connection between these two areas (Freire, 2015). Because of this failure, intervention rather than prevention is the framework from which practitioners work.

Remediation of Limitations

Despite the limitations coalitions are trained in how to promote primary prevention, to recognize agency capacity and activities, and in implementation (see previously cited material). Each coalition has capacity in its agency to promote awareness on a large scale. The Pew Research Center (2015) reported that 85% of adults were Internet users and another 67% were smartphone users. According to the Pew Research

Center, coalitions within its agencies have individuals who are familiar with Internet and smartphone use. It is, therefore, safe to suggest that the unfamiliarity coalitions may experience with implementation of mass media into its prevention programs could be addressed through the use of internal resources (i.e., those familiar with social media).

Although this paper posits the use of old and new technologies, when considering implementation, new technologies come to mind due to the ubiquitous nature of such technologies (Van Niekerk & Maharaj, 2013). Coalitions could use staff members who hold communication degrees or those most skilled in navigating mass media to assist with implementation. In leveraging internal resources, coalitions could place the agency at an advantage to quickly distribute primary prevention.

Another advantage coalitions possess is that the agency holds the key to change. Coalitions are in a prime position to enlist from across the state practitioners who are interested in implementing primary prevention in their practices. Coalitions are also equipped to educate professionals in communities where primary prevention is nonexistent, provide resources where there are none, and connect with those who work directly with the DIPV population. As one study participant stated, there are communities whose members feel ignored and forgotten by the state's coalition. To summarize, coalitions were equipped to recognize internal and external capacity, and to promote and implement prevention.

Scholarship

Throughout the process of selecting a research topic, reviewing the literature, data collection, analysis, and project development, I have completed; (a) hours of course

work, (b) interacted with cohorts, (c) thoroughly searched and become immersed in the literature, (d) corroborated with professors and chairs, and (e) spent hundreds of hours writing. Walden University's search engines such as Academic Search Complete and ERIC are among the resources to which I attribute the success of this project.

In addition, I have also been a conference speaker and conference host on domestic-violence-related topics. Stuhlmiller and Tolchard (2015) referred to immersion in academic, civic, and outreach activities as engaged scholarship. Engaged scholarship is: "Scholarship that puts the academic resources of the university to work in solving public problems" (p. 3). Engaged scholarship is a two-part system that "joins academic service learning with community action research. Academic service learning is about developing and translating academic knowledge while community based action research responds to community-identified needs through civic engagement" (p. 3).

The concepts of engaged scholarship also demanded that I was knowledgeable on the topic of investigation, as was required of me before becoming a conference speaker. As a conference speaker (Annual Licensed Professional Counselor's Conference, October 2011), I presented on the topic of domestic violence and mental health before 35 of my colleagues. Afterwards I was expected to respond to questions and guide discussions. I believed that an additional requirement of engaged scholarship was the ability to collaborate with conference hosts and service organizations throughout the community and those that worked with DIPV survivors, family members, and perpetrators.

Later, I was also expected to develop leadership and organizational skills when I made the decision to host a conference on my own. The conference I hosted was geared

toward community awareness and participation (Tell the Truth Women's Conference, 2014, 2015). The first Tell the Truth Women's Conference was attended by almost two dozen individuals, half of whom were professionals in the community; and the second conference had almost 20 attendees.

Also contributing to the building of scholarship was the interview process. The discourse with professionals who worked directly with DIPV victims, perpetrators, and family members added significantly to my understanding as a scholar. As I engaged in the interview process, I was afforded trust and confidence as participants exposed information kept within the confines of the counseling relationship. I was challenged to consider diverse and contrasting angles of the DIPV picture and encouraged to take the prevention message beyond the bounds of the research. The experience and exposure informed the project and inspired and encouraged me to continue to advocate for change and the implementation of primary prevention.

Project Development and Evaluation

In 2006, after 6 years in the classroom, I was on the verge of completing my master's degree in counseling, an area of study in which I became interested after witnessing student behaviors I did not understand and could not describe. As I progressed in my master's program, I learned that many of my students had some form of mental illness and took medication when they came to school. After leaving education, my initial position in the mental health field was that of a clinical counselor at a private mental health agency.

Less than 3 years later, I transitioned as a supervisor to the Local Management Entity, which later became the Managed Care Organization, hence MCO/LME. During my tenure as a supervisor, I began studies to obtain this degree. I became one of the members of the charter class in my specialization, Higher Education and Adult Learning, which permitted the use of my current field of employment as a resource for developing a project. As a former educator and mental health clinician, I wanted to find a way to impact both mental health and education.

As I thought of my early days as an undergraduate student and the directives of my former professor, who suggested I pick a topic with which I was both familiar with and interested in, I decided on domestic violence. I realized that throughout my academic career, I had researched and written on the topic of domestic violence numerous times.

Domestic violence was a topic not talked about despite its prevalence, and as an educator, my thoughts were that I could educate others on an issue that needed to be addressed. Domestic violence as a topic, however, was too broad, and I needed to narrow my focus. I started to search the literature in an attempt to decide on how this should be done when I came across the coalition's 10-year primary prevention plan.

After downloading the document and reading it, I remembered thinking that it could make a big difference, and I became very excited about what the plan promised to deliver. As I continued my search, I found the executive summary, an abbreviated version of the document, and read that information. As I continued reading about and researching the topic, I began to wonder why I had not heard of the plan.

There I was, in my seventh or eighth semester; by then, I had worked in the mental health field for 5 years and was completely unaware of the document or related programs. As a supervisor, I was responsible for coordination with hospitals in over a dozen counties, magistrates' offices, local law enforcement, private clinicians and mental health agencies, mobile crisis and critical response teams, residential treatment facilities, and a host of other community and government agencies, clients, and family members.

Yet despite the breadth of services I provided and services in which I were involved, I did not remember anyone having mentioned the 10-year plan. A brief and informal survey of my colleagues resulted in the same feedback; they also had not heard of the plan. My interest was stirred, and I wondered if I was alone. Were there clinicians or practitioners who had heard of the 10-year primary prevention plan? And, if so, were they implementing the elements of the program, and what were the outcomes?

This plan had the potential through primary prevention to impact the lives of the state's citizen base from newborn infants through the elderly. Moreover, as a mental health clinician, I believed that I had a responsibility to get the information into the hands of those for whom it would do the most good. Building on this idea, I began to research the 10-year plan, domestic violence, and primary prevention.

Now that I have completed the project I believe a logical progression would be towards evaluation. Project evaluation would be outcome based in the form of its impact on the professionals throughout the community and citizens across the state. An outcome based evaluation of this project would provide immediate feedback at professional

trainings, conferences, and seminars. Opportunities also exist for evaluation of the project through feedback from clinicians who work with members of the DIPV community.

The position paper advocates for primary prevention through mass media, and just as sensationalized cases of domestic violence were mentioned during the interviews, widespread media prevention campaigns are likely to generate discussions. Increased discussion of DIPV prevention could influence victims and family members to seek information from clinicians. As clinicians provide information to their clients based on the client's inquiry about the 10-year plan, awareness should increase.

Additional opportunities for evaluation after implementation of primary prevention might include increased traffic on coalition websites, calls to hotlines, and requests for help—statistics that the coalitions currently maintain. Turning to existing resources within the coalition for implementation and evaluation would decrease the burden of additional programs and reduce cost.

Another way to evaluate the effectiveness of coalitions' implementation of primary prevention would be to survey the counties with increased areas of interest and/or need. For example, in collecting data for this research study, I traveled a distance of approximately 160 miles across six counties to conduct interviews. Coalitions' reach across the state would measure program effectiveness.

Leadership and Change

When I consider the impacts that pursuing this degree and developing this project have had on my life, *change* is a most fitting term. Through immersion in the literature, participant interviews, and professional encounters, I have come to understand that the

issue of domestic violence is a most sensitive and often uncomfortable topic. This discovery proved true regardless of who was on the other end when I engaged in conversation.

Survivors, advocates, and professionals, in my experience, exist in a silent world enshrouded by the cloak of domestic violence. Those who lacked understanding of the dynamics of domestic violence would make crude and hurtful jokes or dismiss the significance of the problem as unrelated to their daily lives. Now that I have completed the project, I understand even more how, through silence, this issue still holds so much negative power over this population and its advocates.

When I consider change, what comes to mind is the need to approach the topic of DIPV differently from what was done historically. Primary prevention has the potential to change the landscape of how this issue is perceived, approached, discussed, and managed. Change is a process that is never without resistance; however, for any cause worth pursuing, resistance is expected.

Although I no longer have the same level of enthusiasm as when the plan was discovered, I am still excited about the possibilities that primary prevention holds for the citizens of North Carolina. My focus has changed, and I am now concentrating on educating the immediate and surrounding communities on the benefits of primary prevention. With help, I hope to start locally and saturate each county with information on primary prevention until the entire state is blanketed with information on prevention.

In pursuit of the goal of saturating the counties with prevention, I expect resistance. However, after organizing and hosting two conferences on domestic violence,

I understand as a leader I must engage those with whom I work. I also understand the need to engage leaders who are gatekeepers. These gatekeepers are often responsible for determining whether or not programs are implemented.

Furthermore, the determination, discipline, and commitment I have had to demonstrate as I pursued my degree have equipped me with the leadership skills and tools necessary to engage today's leader and yesterday's gatekeeper. I have learned the cost to businesses when they employ victims and perpetrators of abuse, as well as how abuse affects the entire community. Educating leaders requires that, as a leader, I lead by example, and I have journeyed along that path through the hosting of two conferences.

Helping the leaders of this community and surrounding communities understand the importance of primary prevention is a challenge I have yet to overcome. The years spent working on this degree has on occasion been extremely challenging, both personally and professionally. However, I have been guided by the thought of how prevention could save a life, prevent a perpetrator from being incarcerated, or prevent a child from entering the system. This awareness, to me, is more important than any potential or expected resistance or challenge. To that end, I have decided I am a leader who is ready to help implement change!

Analysis of Self as Scholar

As a child growing up I was always very studious. With the exception of a few of my teen years when academics were of little importance, I loved learning and I am an avid reader. I attributed my academic slips as a teen to navigating the teen years more than to the inability to learn. My first attempt at junior college was halted due to personal

reasons. However, when I decided to return, I did so with focus and determination. I was on the Dean's list and had my name published in the Honor Society book.

Throughout my undergraduate years, I had one *C* and maintained above a 3.0 grade point average despite being a nontraditional student. Academics came easy for me, and when I decided to pursue this degree I approached it with the same focus and determination.

I completed my course work at Walden University in the required 3-year time frame with a grade point average above 3.8 and I expected graduation would be at the end of that milestone. As I embarked on the journey of writing the doctoral capstone, I was faced with multiple challenges. The greatest of these challenges were the internal struggle of not knowing. As an individual, studious, knowledgeable, educated, and skilled, I chose projects with the knowledge of when my obligations would end. I had accepted many challenges and embarking on this journey was no different than before; after all, I knew my proven skills as a student and success was imminent.

Although I was confident in my academic abilities another challenge I faced was working with others with whom I did not have direct contact. The lack of face-to-face contact was a struggle for me and this program was my first program that was completely online. At times I felt most challenged when I had more questions than I had answers.

Also, because I had exceeded my expected goal of graduating in 3 years this knowledge caused mounting stress and at times, frustration. Over the years, the stress and frustration caused me to have writer's block and I often felt I had not made progress.

During these times, however, I reminded myself that I had already finished the program; I just needed to demonstrate what I had learned.

Faced with the above challenges I had to adjust to the structure of an online program. I had to work at the pace of professors I did not see face-to-face. I had to learn to engage in feedback loop that was predetermined, and I had to adjust to the subjective nature of the iterative process of writing the doctoral capstone. Although much of what I described went against everything I knew as a student and a professional, I knew I had to figure a way to turn the challenges into successes.

In order to overcome the challenges I faced I drew on my strongest character traits, determination. I knew that when I set my mind on a task and determined to complete that task, I would finish it. As a scholar I drew on that determination to move myself forward from semester to semester despite what goals I had not completed. I was committed to seeing what I started through to the end and bringing my focus on my goal of attaining my degree.

I determined that working with others was necessary to accomplish the goal of completion, and I further determined that I would work according to how I was trained. I understood my role in the progression of the work and did my part and trusted the process. I learned that time was going to work with or against me depending on how it was used, so I determined to use it to my advantage.

Throughout the process of writing the doctoral capstone, I have grown to appreciate many things, some of which are the remembered words of my mother. I have learned valuable lessons about working with others and being goal oriented. As a scholar

I learned that being studious, determined, and committed are not the only qualities required when collaboration is needed to achieve the goal at hand. I now acknowledge that collaboration is an integral part of any structurally sound foundation on which to build the scholarship from which scholars eventually draw.

Analysis of Self as Practitioner

The American Counseling Association Code of Ethics (2014), “Section A: The Counseling Relationship” mandates that a counselor do no harm. Prior to pursuing this degree, teaching, training, and education were always of high priority. As an educator and counselor, I espouse to do no harm by educating individuals so they are best equipped to make informed decisions. I extend education by making myself available to the individuals or group in the event there are questions. I also provide supporting and/or supplemental information useful to guide and foster understanding.

I am a lifelong learner and I engage in personal and professional development even when not required. I seek out opportunities to learn, and I am always reading. I freely share information I learned if and when I see a need, or if I am presented with an opportunity to enhance the lives of others. I facilitate conversations if I think sharing information would benefit the hearer.

I also share written information that has enhanced my life with those with whom I come in contact. When I started the journey of completing my degree, a goal I set was to bring together counseling and education. Through hosting three conferences, I accomplished that goal, and I have expectations for hosting other conferences in the

future. Another goal for the future is to develop training materials for educators and counselors, and those who work in both professions.

Analysis of Self as Project Developer

In considering how best to communicate the findings of this research I focused on developing a tool that would reach the greatest number of individuals. I considered the project option and a position paper held the greatest potential to reach the largest number of people in various disciplines, professions, and industries.

As an educator and a clinician, I considered the other options of designing professional development/training, or curriculum and materials offered in this course. However, I decided against those options because I believed an essential component of the project I developed was time. I believed the need for primary prevention could not wait for the development and approval of curriculum and/or training materials. I believed that primary prevention implementation could not wait because of the ongoing rise in deaths across the state (previously cited), and the fact that clinicians in this study had not heard of the 10-year plan.

After I made the decision I needed to find a way to present the information in a format that was least threatening and required the least amount of time for approval when presented to agencies and stakeholders. I concluded that a position paper was the format that would allow for ease of access and would meet with the least amount of resistance from stakeholders. Therefore, I developed a project that provides stakeholders with an option to address the unmet needs of the DIPV clients in their communities. As a

developer, I wanted a project that would be a resource *for* stakeholders, and that could be used *by* stakeholders, in advancing primary prevention.

The Project's Potential Impact on Social Change

The potential impact of the project on the larger social issue is of great consequence. Many of the factors to consider when measuring the potential impact of the project are; (a) the number of deaths listed on the coalition's website, (b) the cost to the state in DIPV dollars, (c) the burden on the medical, mental health, and legal communities, and (d) the personal toll on the lives of members in the DIPV community.

The project provides a plan for stakeholders to establish local and statewide prevention efforts. The NCCADV is identified in the project as a resource for those interested in implementing prevention on a smaller scale and are in need of assistance. Stakeholders in every industry; medical, academia, sports, and the media could draw from the information found in the position paper. The only limitations to implementation would come from self imposed restrictions within an agency. The position paper has far reaching effects and could help to save individual lives and improve communities.

Implications, Applications, and Directions for Future Research

Findings from this research indicated clinicians lacked confidence in the 10-year plan, and previously cited literature indicated that the coalition failed to implement prevention across North Carolina. In response, the position paper advocated the use of mass media as a tool to disseminate prevention. The CDC worked with and trained coalition members on DIPV prevention and its uses. To illustrate, the CDC (2015b) engages in prevention on social media where its audiences have access to Facebook and

Twitter pages. Through Facebook and Twitter, CDC followers have access to current research, experts, forums, chats rooms, and prevention resources (CDC, 2015b). In short, coalition members received training from the CDC an agency that has implemented mass media into its prevention efforts, and provided effective examples for coalitions.

Implications of this research are introducing stakeholders and practitioners to prevention efforts, implementation strategies, and current literature. Furthermore, in the project are the tools to assist stakeholders who are knowledgeable of prevention on ways to implement prevention to have the greatest impact. Also provided were guidelines and recommendations for implementation, for agencies and providers, who deliver direct care services. Another implication was the recommendations for stakeholder/practitioner collaboration. Stakeholders should recognize that clinicians are centrally positioned to report on the effectiveness or ineffectiveness, of programs and who could also provide feedback on future studies.

Future research could include qualitative and quantitative studies on how prevention through social media is received. Additional research is also needed on prevention efforts after programs are initiated by coalitions and agencies. Finally, future research could focus on individual and community discourse, surrounding DIPV related issues, and how expert advice impacts the hearers.

Conclusion

In summary, DIPV is a known public health crisis and states' coalitions are responsible for shouldering the responsibility of intervention and prevention. Results from this research pointed to an increased need for prevention statewide. Studies showed

that for coalitions, prevention was a new idea, an idea that required a paradigm shift within the agencies. The project, a position paper, which resulted from the finding of this research, recommended stakeholders use mass media to increase prevention efforts locally, and statewide. Mass media's reach holds great potential for the distribution of DIPV information to the public.

Therefore, to assist stakeholders with implementation of prevention through mass media, constructs were presented such as; (a) framing DIPV information prior to release, (b) working with journalists, (c) providing current research, and (c) provide opportunities for continued discourse. These recommendations could change how the public view and respond to domestic violence.

Moreover, it was advised that Stakeholders take a leading role in determining how the discussion on DIPV was structured and provide support to practitioners who were in need of reforming their practices to reflect prevention. Clinicians, during the interviews demonstrated passion about helping the DIPV community, and interest in information about the state's prevention efforts.

In the final analysis, I believe that well informed and well equipped clinicians are valuable assets to the citizens of North Carolina. Stakeholders who recognize the potential of clinicians statewide would add to the value of prevention efforts by using all available resources. Also, as prevention is promoted through mass media, the shift from secondary and tertiary interventions would take place. As a result, NCCADV could potentially experience increased traffic on its website as individuals across the state learn

of available resources. There may be an increased need for trainings for professionals from various disciplines to assist victims and family members, and educate perpetrators.

Finally, the potential impact to the state in cost of DIPV dollars could be reduced and monetary resources reallocated for training and prevention efforts. More importantly the cycle of violence in North Carolina could be broken and the goal of healthy North Carolinians would be realized.

References

- Abrahams, N., Jewkes, R., Martin, L. J., Matthew, S., Vetten, L., & Lombard, C. (2009). Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence & Victims*, 24, 546-556. doi:10.1891/0886-6708.24.4.546
- Afifi, T. O., MacMillan, H., Cox, B. J., Asmundson, G. J. G., Stein, M. B., & Sareen, J. (2008). Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females. *Journal of Interpersonal Violence*, 24, 1398-1417. doi:10.1177/0886260508322192
- Ahmed, S., Koenig, M. A., & Stephenson, R. (2006). Effects of domestic violence on perinatal and early-childhood mortality: Evidence from North India. *American Journal of Public Health*, 96, 1423-1628.
- American Counseling Association. (2005). ACA code of ethics. Retrieved from <http://www.counseling.org>
- American Counseling Association. (2014). 2014 ACA code of ethics. Retrieved from <http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Arias, I., & Corso, P. (2005). Average cost per person victimized by an intimate partner of the opposite gender: A comparison of men and women. *Violence and Victims*, 20(40), 379-391. doi:10.1891/vivi.2005.20.4.379

- Awareness. (2015). In *Merriam-Webster's online dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/awareness>
- Bair-Merritt, M. H., Holmes, W. C., Holmes, J. H., Feinstein, J., & Feudtner, C. (2008). Does intimate partner violence epidemiology differ between homes with and without children? A population-based study of annual prevalence and associated risk factors. *Journal of Family Violence*, 23, 325-332. doi:10.1007/s10896-008-9154-y
- Barth, R. P. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *Future of Children*, 19(2), 95-118.
- Baskarada, S. (2014). Qualitative case study guidelines. *Qualitative Report*, 19, 1-25. Retrieved from <http://www.nova.edu/ssss/QR/QR19baskarada24.pdf>
- Bent-Goodley, T. B., & Brade, K. (2007). Domestic violence and kinship care: Connecting policy with practice. *Journal of Health & Social Policy*, 22(3/4), 65-83. doi:10.1300/J045v22n03_05
- Billings, S., & Troyer, J. (2014). UNCC economic study: Domestic violence in North Carolina. Retrieved from <http://inside.uncc.edu/news-features/2014-10-24/economics-professors-reveal-costs-domestic-violence-north-carolina>
- Blitz, L. V., & Illidge, L. C. (2006). Not so Black and White: Shades of gray and brown in antiracist multicultural team building in a domestic violence shelter. *Journal of Emotional Abuse*, 6(2/3), 113-134. doi:10.1300/J135v06n02-08
- Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2009). Health care utilization and cost associated with physical and nonphysical-only intimate

- partner violence. *Health Services Research*, 44, 1052-1067. doi:10.1111/j.1475-6773.2009.00955.x
- Bonomi, A. E., Thompson, R. S., Anderson, M., Reid, R. J., Carrell, D., Dimer, J. A., & Rivara, F. P. (2006). Intimate partner violence and women's physical, mental, and social functioning. *American Journal of Preventive Medicine*, 30, 458-466. doi:10.1016/j.amepre.2006.01.015
- Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research*, 8(1), 137-152. doi:10.1177/1468794107085301
- Brodwin, M. G., & Siu, F. (2007). Domestic violence against women who have disabilities: What educators need to know. *Education*, 127, 548-551. Retrieved from: <http://www.projectinnovation.biz/>
- Buila, S. M. D. (2009). Using the media to enhance well-being and mental health. *Rural Society*, 19, 363-367. Retrieved from <http://www.e-contentmanagement.com/>
- Caetana, R., Vaeth, P. A. C., & Ramisetty-Miller, S. (2008). Intimate partner violence victim and perpetrator characteristics among couples in the United States. *Journal of Family Violence*, 23, 507-518. doi:10.1007/s10896-008-9178-3
- Campbell, J. C., & Manganello, J. (2006). Changing public attitudes as a prevention strategy to reduce intimate partner violence. *Journal of Aggression, Maltreatment, & Trauma*, 13(3/4), 13-39. doi:10.1300/J146v13n0302
- Centers for Disease Control and Prevention. (2005). Adverse health conditions and health risk behavior associated with intimate partner violence: United States. *Morbidity & Mortality Weekly Report*, 57(05), 113-117. Retrieved from

www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm

Centers for Disease Control and Prevention. (2008). Violence prevention: A timeline of violence as a public health issue. Retrieved from

<http://www.cdc.gov/ViolencePrevention/overview/timeline.html>

Centers for Disease Control and Prevention. (2009). Understanding intimate partner violence, fact sheet. Retrieved from <http://www.cdc.gov/violenceprevention>

Centers for Disease Control and Prevention. (2010a). Break the silence: Stop the violence. Retrieved from

[http://www.cdc.gov/cdctv/breakthesilence/transcript/break the silence pdf](http://www.cdc.gov/cdctv/breakthesilence/transcript/break%20the%20silence.pdf)

Centers for Disease Control and Prevention. (2010b). Preventing intimate partner & sexual violence, program activities guide. Retrieved from http://www.cdc.gov/violenceprevention/pub/ipv_sv_guide.html

Centers for Disease Control and Prevention. (2010c). Understanding teen dating violence, factsheet. Retrieved from <http://www.cdc.gov/violenceprevention>

Centers for Disease Control and Prevention. (2010d). Violence by intimate partners, World Report on Violence and Health. Retrieved from http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap4.pdf

Centers for Disease Control and Prevention (2011). National Center for Injury Prevention and Control Division of Violence Prevention: *Understanding intimate partner violence*. Retrieved from

http://www.cdc.gov/ViolencePrevention/pdf/IPV_factsheet-a.pdf

Chang, J. C., Dado, D., Hawker, L., Cluss, P. A., Buranoshi, R., Slagel, L., & Scholle, S.

- H. (2010). Understanding turning points in intimate partner violence: Factors and circumstances leading women victims toward change. *Journal of Women's Health, 19*, 251-259. doi:10.1089/jwh.2009.1568
- Chang, J. C., Decker, M. R., Moracco, K. E., Martin, S. L., Petersen, R., & Frasier, P. Y. (2005). Asking about intimate partner violence: Advice from female survivors to health care providers. *Patient Education and Counseling, 59*, 141-147. doi:10.1016/j.pec.2004.10.008
- Coker, A. L., Flerx, V. C., Smith, P. H., Whitaker, D. J. Fadden, M., & Williams, M. (2007). Partner violence screening in rural health care clinics, *American Journal of Public Health, 97*, 1319-1325. doi:10.2105./AJPH.2005.085357
- Community Hospital Emergency Departments Admissions for Persons with a Mental Illness, Developmental Disability or Substance Abuse Disorder. Retrieved from <http://www.ncdhhs.gov/mhddsas/statpublications/reports/ed-admissions/sfy10q4edadmissionsrptapr-jun10data.pdf>
- Conduct Problems Prevention Research Group. (2014). Trajectories of risk for early sexual activity and early substance use in the Fast Track prevention program. *Prevention Science, 15*(1), S33-S46. doi:10.1007/s11121-012-0328-8
- Conradi, L., & Geffner, R. (2009a). Introduction to part I of the special issue on female offenders of intimate partner violence. *Journal of Aggression, Maltreatment & Trauma, 18*, 547-551. doi:10.1080/10926770903120143
- Conradi, L., & Geffner, R. (2009b). Introduction to part II of the special issue on female offenders of intimate partner violence. *Journal of Aggression, Maltreatment &*

Trauma, 18, 667-671. doi:10.1080/10926770903260295

Corvo, K., & deLara, E. (2009). Towards an integrated theory of relational violence: Is bullying a risk factor for domestic violence? *Aggression and Violent Behavior*, 15, 181-190. doi:10.1016/j.avb.2009.12.001

Craigien, L. M., Cole, R. F., & Hays, D. G. (2009). Promoting healthy relationships: A seminar for human service professionals. *Human Service Education*, 29(1), 76-83.

Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Los Angeles, CA: Sage Publications.

Cummings, E. M., El-Sheikh, M., Douros, C. D., & Buckhalt, J. A. (2009). Children and violence: The role of children's regulation in the marital aggression-child adjustment link. *Clinical Child & Family Psychology Review*, 12(1), 3-15. doi:10.1007/s10567.009-0042-7

Dahlberg, L., & Butchart, A. (2005). State of science: Violence prevention efforts in developing and developed countries. *International Journal of Injury Control & Safety Promotion*, 12(2), 93-104. doi:10.1080/15660970500086239

Davila, Y. R. (2006). Increasing nurses' knowledge and skills for enhanced responses to intimate partner violence. *Journal of Continuing Education in Nursing*, 37(4), 171-177.

Dersch, C. A., Harris, S. M., & Rappleyea, D. L. (2006). Recognizing and responding to

- partner violence: An analogy study. *American Journal of Family Therapy*, 34, 317-331. doi:10.1080/01926180600553878
- Dodd, L. W. (2009). Therapeutic groupwork with young children and mothers who have experienced domestic abuse. *Educational Psychology in Practice*, 25(1), 21-36. doi:10.1080/02667360802697571
- Domestic Violence Prevention Enhancement and Leadership Through Alliances. (n.d.) Information Retrieved from <http://www.cdc.gov/violenceprevention/DELTA/>
- Duarte, D. (2014). Successful implementation of a federally funded violence prevention elementary school counseling program: Results brings sustainability. *Professional School Counselor*, 18(1), 71-81.
- Duke, J. C., Vallone, D. M., Allen, J. A., Cullen, J., Xiao, H., Dorrier, N., Heaton, C. (2009). Increasing youths' exposure to a tobacco prevention media campaign in rural and low-population-density communities. *American Journal of Public Health*, 99, 2210-2216. Retrieved from: <http://ajph.aphapublications.org/>
- Eckstein, D., & McDonald, L. (2010). The battered woman syndrome: Counseling implications. *Journal of Education and Sociology*, 1, 4-14.
- Eisen, S. V., Schultz, M. R., Vogt, D., Glickman, M. E., Elwy, A. R., Drainoni, M., Martin, J. (2012). Mental and physical health status and alcohol and drug use following return from deployment to Iraq or Afghanistan. *American Journal of Public Health*, 102(S1), S66-S73. doi:10.2105/AJPH.2011.300609
- Few, A. L. (2005). The voices of Black and White rural battered women in domestic violence shelters. *Family Relations*, 54, 488-500. doi:10.1111/j.1741-

3729.2005.00335.x

- Flick, U. (2009). *An introduction to qualitative research* (4th ed.). London, UK: Sage Publications.
- Foster, H., & Brooks-Gunn, J. (2009). Toward a stress process model of children's exposure to physical family and community violence. *Clinical Child & Family Psychology Review*, 12, 71-94. doi:10.1007/s10567-009-0049-0
- Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, 25, 1229-1245. doi:10.1080/08870440903194015
- Geffner, R., Griffin, D. A., & Lewis, J., III (2008). Children exposed to violence: An often neglected social, mental health and public health problem. *Journal of Emotional Abuse*, 8(1/2), 3-28.
- Gerlock, A. A., Grimesey, J., & Sayre, G. (2014). Military-related posttraumatic stress disorder and intimate relationship behaviors: A developing dyadic relationship model. *Journal of Marital and Family Therapy*, 40(3), 344-356. doi: 10.1111/jmft.12017
- Glesne, C. (2011). *Becoming qualitative researchers: An introduction*. Boston, MA: Pearson.
- Guerrero, D. A. V. (2009). Hypermasculinity, intimate partner violence, sexual aggression, social support, and child maltreatment risk in urban, heterosexual fathers taking parenting classes. *Child Welfare*, 88(4), 135-155.
- Guest, G., Bunce, A., & Johnson, L. (2005). How many interviews are enough? An

experiment with data saturation and variability, *Field Methods*, 18(59), 58-82.

doi:10.1177/1525822X05279903

Hammersley, M. (2004). Phenomenology. In M. Lewis-Beck, A. Bryman, & T. Liao (Eds.), *Encyclopedia of social science research methods* (pp. 816-817). Thousand Oaks, CA: Sage. doi:10.4135/9781412950589.n708

Hampton, R. L., LaTaillade, J. J., Darcy, A., & Marghi, J. R. (2008). Evaluating domestic violence interventions for Black women. *Journal of Aggression, Maltreatment, & Trauma*, 16, 300-353. Retrieved from <http://www.tandfonline.com/toc/wamt20/current>

Hancock, D. R., & Algozzine, B. (2006). *Doing case study research: A practical guide for beginning researchers*. New York: Teachers College Press.

Hancock, T. (2006). Addressing wife abuse in Mexican immigrant couples: Challenges for family social workers. *Journal of Family Social Work*, 10(3), 31-50.
doi:10.1300/J039v10n03_03

Harris, J. M., Novalis-Marine, C., Ameno, R. W., & Surprenant, Z. J. (2009). Promoting free online CME for intimate partner violence: What works at what cost? *Journal of Continuing Education in the Health Professions*, 29(3), 135-141.
doi:10.1002/chp.20025

Hetling, A., Saunders, C., & Born, C. E. (2006). "Missing" domestic violence victims in welfare caseloads: The discrepancy between administrative and survey disclosure rates. *Journal of Health & Social Policy*, 22(2), 79-95.
doi:10.1300/J045v22n02_05

- Hodges, N. (2011). Qualitative research. A discussion of frequently articulated qualms (FAQs). *Family & Consumer Sciences Research Journal*, 40(1), 90-92.
doi:10.1111/j.1552-3934.2011.02091.x
- Holtfreter, K., & Boyd, J. (2006). A coordinated community response to intimate partner violence on the college campus. *Victims and Offenders*, 1(2), 141-157.
doi:10.1080/15564880600626031
- Holtzworth-Munroe, A. (2005). Male versus female intimate partner violence: Putting controversial findings into context. *Journal of Marriage and Family*, 67, 1120-1125.
- Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher*, 20(4), 12-17.
- Humphreys, J. C., & Lee, K. A. (2006). Sleep of children of abused women in transitional housing. *Pediatric Nursing*, 32, 311-316.
- Josephs, L. L., & Abel, E. M. (2009). Investigating the relationship between intimate partner violence and HIV risk-propensity in Black/African American women. *Journal of Family Violence*, 24(4), 221-229. doi:10.1007/s10896-009-9223-x
- Jouriles, E. N., Mueller, V., Rosenfield, D., McDonald, R., & Dodson, M. C. (2012). Teens' experiences of harsh parenting and exposure to severe intimate partner violence: Adding insult to injury in predicting teen dating violence. *Psychology of Violence*, 2(2), 125-138. doi:10.1037/a0027264
- Kalaca, S., & Dunder, P. (2010). Violence against women: The perspective of academic women. *BMC Public Health*, 1-7. doi:10.1186/1471-2458-10-490

- Keats, P. A. (2010). Reflecting on "Issues supervising family violence cases." *Canadian Journal of Counseling*, 44, 329-333.
- Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research Methods*, 19(4-5), 566-575. doi:10.1080/10503300802702105
- Lewin, L. C., Abdrbo, A., & Burant, C. J. (2010). Domestic violence in women with serious mental illness involved with child protective services. *Issues in Mental Health Nursing*, 31(2), 128-136. doi:10.3109/01612840903383984
- Lindhorst, T., Macy, R. J., & Nurius, P. (2005). Special section: Domestic violence and social work education contextualized assessment with battered women: Strategic safety planning to cope with multiple harms. *Journal of Social Work Education*, 41(2), 331-352.
- Lindsay-Brisbin, J., DePrince, A. P., & Welton-Mitchell, C. (2014). Missed opportunities: Newspaper reports of domestic violence. *Journal of Aggression, Maltreatment & Trauma*, 23, 383-399. doi:10.1080/10926771.2014.896839
- Lipsky, S., & Caetano, R. (2007). The role of race/ethnicity in the relationship between emergency department use and intimate partner violence: Findings from the 2002 national survey on drug use and health. *Research and Practice*, 97, 2246-2252.
- Lodico, M. G., Spaulding, D. T., & Voegtle, K. H. (2010). *Methods in educational research: From theory to practice*. San Francisco, CA: Jossey-Bass.
- Lott-Collins, W., & Moore, S. E. (2006). Theological and practice issues regarding domestic violence: How can the Black church help victims? *Social Work & Christianity*, 33(3), 252-267.

- Lown, A. E., Schmidt, L. A., & Wiley, J. (2006). Interpersonal violence among women seeking welfare: Unraveling lives. *American Journal of Public Health, 96*, 1409-1415.
- Loy, E., Machen, L., Beaulieu, M., & Greif, G. L. (2005). Common themes in clinical work with women who are domestically violent. *American Journal of Family Therapy, 33*, 33-44. doi:10.1080/01926180590889248
- Lundy, M., & Grossman, S. F. (2009). Domestic violence service users: A comparison of older and younger women victims. *Journal of Family Violence, 24*, 297-309. doi:10.1007/s10896-009-9230-y
- Macy, R. J., Giattina, M., Sangster, T. H., Crosby, C., & Montijo, N. J. (2009). Domestic violence and sexual assault services: Inside the black box. *Aggression and Violent Behavior, 14*, 359-373. doi:10.1016/j.avb.2009.06.002
- Martin, S. L., Gibbs, D. A., Johnson, R. E., Rentz, E. D., Clinton-Sherrod, M., Walters, J. L. H., & Sullivan, K. (2009). Male soldier family violence offenders: Spouse and child offenders compared to child offenders. *Violence & Victims, 24*, 458-468. doi:10.1891/0886-6708.24.4.458
- Mascaro, N., Arnette, N. C., Santana, M. C., & Kaslow, N. J. (2007). Longitudinal relations between employment and depressive symptoms in low-income, suicidal African American women. *Journal of Clinical Psychology, 63*, 541-553. doi:10.1002/jclp.20365
- Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research Sozialforschung, 11*(3). Retrieved

from <http://nbn-resolving.de/urn:nbn:de:0114-fqs100387>

- Max, W., Rice, D. P., Finkestein, E., Bardwell, R. A., & Leadbetter, S. (2004). The economic toll of intimate partner violence against women in the United States. *Violence and Victims, 19*, 259-272.
- McCarroll, J. E., Ursano, R. J., Liu, X., Thayer, L. E., Newby, J. H., Norwood, A. E., & Fullerton, C. S. (2010). Deployment and the probability of spousal aggression by U.S. Army soldiers. *Military Medicine, 175*, 352-356. doi:10.1037/t02125-000
- McFarlane J. M., Groff, J. Y., & O'Brien, J. A. (2006). Secondary prevention of intimate partner violence: A randomized controlled trial. *Nursing Research, 55*(1), 52-61.
- McLeod, A. L., Hays, D. G., & Chang, C. Y. (2010). Female intimate partner violence survivors' experiences with assessing resources. *Journal of Counseling & Development, 88*, 303-310.
- Meyer, E. M., & Post, L. (2013). Collateral intimate partner homicide. *Sage Open, 1*- 11. doi:10.1177/2158244013484235
- Mitchell, M. D., Hargrove, G. L., Collins, M. H., Thompson, M. P., Reddick, T. L., & Kaslow, N. J. (2006). Coping variables that mediate the relation between intimate partner violence and mental health outcomes among low-income, African American women. *Journal of Clinical Psychology, 62*, 1503-1520. doi:10.1002/jclp.20305
- National Center for Injury Prevention and Control. (2003). *Cost of intimate partner violence against women in the United States*. Atlanta, GA: Centers for Disease Control and Prevention.

Nelson, E. E., Gallogly, M., Pederson, L. L., Barry, M., McGoldrick, D., & Malbach, E.

W. (2008). Use of consumer survey data to target cessation messages to smokers through mass media. *American Journal of Public Health*, 98, 536-542.

Nicolaidis, C., Gregg, J., Gallan, H., McFarland, B., Curry, M., & Gerrity, M. (2008).

“You always end up feeling like you’re some hypochondriac”: Intimate partner violence survivors’ experiences addressing depression and pain. *Journal of General Internal Medicine*, 23, 1157-1163. doi:10.1007/s11606-008-0606-0

Nicolaidis, C., Timmons, V., Thomas, M. J., Waters, A. S., Wahab, S., Mejia, A., &

Mitchell, S. R. (2010). “You don’t go tell White people nothing”: African American women’s perspectives on the influence of violence and race on depression and depression care. *American Journal of Public Health*, 100, 1470-1476.

North Carolina Coalition Against Domestic Violence. (2010a). State legislative summary.

Retrieved from <http://nccadv.org/pdf/2010/2010StateLegislativeSummary.pdf>

North Carolina Coalition Against Domestic Violence. (2010b). North Carolina 10-year

plan to prevent intimate partner violence. Retrieved from

http://nccadv.org/in_the_news.htm

North Carolina Coalition Against Domestic Violence. (2010c). Comprehensive homicide

report. Retrieved from <http://www.nccadv.org/pdf/2012/>

[NCCADVComprehensiveHomicideReport2002-2010.pdf](http://www.nccadv.org/pdf/2012/NCCADVComprehensiveHomicideReport2002-2010.pdf)

North Carolina Coalition Against Domestic Violence. (2011). Homicide report. Retrieved

from <http://www.nccadv.org/pdf/2012/2011HomicideReport.pdf>

North Carolina Coalition Against Domestic Violence. (2015). Homicides. Retrieved from <http://www.nccadv.org/resources/homicides>

North Carolina Department of Administration: Coalition for Women. (n.d.). Retrieved from <http://www.nccfwdvc.com/stats.aspx>

Okenwa, L., & Lawoko, S. (2010). Social indicators and physical abuse of women by intimate partners: A study of women in Zambia. *Violence & Victims*, 25, 278-288. doi:10.1891/0886-6708.25.2.278

Oladele, D., Richter, S., Clark, A., & Laing, L. (2012). Critical ethnography: A useful methodology in conducting health research in different resource settings. *Qualitative Report*, 17(77), 1-21. Retrieved from <http://www.nova.edu/ssss/QR/QR17/oladele.pdf>

Outlaw, M. (2009). No one type of intimate partner abuse: Exploring physical and non-physical abuse among intimate partners. *Journal of Family Violence*, 24(4), 263-272. doi:10.1007/s10896-009-9228-5

Owens, A. E., Thompson, M. P., Shaffer, A., Jackson, E. B., & Kaslow, N. J. (2009). Family variables that mediate the relation between intimate partner violence (IPV) and child adjustment. *Journal of Family Violence*, 24, 433-445. doi:10.1007/s10896-009-9239-2

Phenomenology. In M. Lewis-Beck, A., Bryman, & T. Liao (Eds.), *Encyclopedia of Social Science Research Methods* (pp. 816-817). Thousand Oaks, CA: Sage Publications. doi:10.4135/9781412950589.n708

- Pollack, K. M., Austin, W., & Grisso, J. A. (2010). Employee assistance programs: A workplace resource to address intimate partner violence. *Journal of Women's Health, 19*, 729-733. doi:10.1089/jwh.2009.1495
- Potter, S. J., Stapleton, J. G., & Moynihan, M. M. (2008). Designing, implementing, and evaluating a media campaign: Illustrating the bystander role. *Journal of Prevention & Intervention, 36*(1/2), 39-55. doi:10.1080/10852350802022308
- Price, L. N., & Maholmes, V. (2009). Understanding the nature and consequences of children's exposure to violence: Research perspectives. *Clinical Child & Family Psychology Review, 12*, 65-70. doi:10.1007/s10567-009-0057-0
- QSR International. (2013). QSR NVivo 10, Retrieved from <http://www.qsrinternational.com/default.aspx>
- QSR International. (2015). NVivo Help. Retrieved from http://help-nv10.qsrinternational.com/desktop/concepts/about_nodes.htm#MiniTOCBookMark2
- Research Methods Knowledge Base: Web Center for Social Research Methods. (2011). Retrieved from <http://www.nccadv.org/pdf/2012/2011HomicideReport.pdf>
- Rhodes, K. V., Houry, D., Cerulli, C., Kaslow, N. J., & McNutt, L. (2009). Intimate partner violence and comorbid mental health conditions among urban male patients. *Annals of Family Medicine, 7*(1), 47-55.
- Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Healthcare utilization and cost for women with a history of intimate partner violence. *American Journal of Preventive Medicine, 32*(2), 89-

96. doi:10.1016/j.amepre.2006.10.001

Rivers, J. E., Maze, C. L., Hannah, S. A., & Lederman, C. S. (2007). Domestic violence screening and service acceptance among adult victims in a dependency court setting. *Child Welfare*, 86(1), 123-144.

Rothman, E. F., & Corso, P. S. (2008). Propensity for intimate partner abuse and workplace productivity: Why employers should care. *Violence Against Women*, 14, 1054-1064. doi:10.1177/10778012083211985

Russell, M. (2008). Violence across the lifespan: An interprofessional WebCT course. *Social Work Education*, 27, 797-810. doi:10.1080/02615470701708685

Shefet, D., Dascal-Weichhendler, H., Rubin, O., Pessach, N., Itzik, D., Benita, S., & Ziv, A. (2007). Domestic violence: A national simulation-based educational program to improve physicians' knowledge, skills and detection rates. *Medical Teacher*, 29(5), 133-138. doi:10.1080/01421590701452780

Shorey, R. C., Sherman, A. E., Kivisto, A. J., Elkins, S. R., Rhatigan, D. L., & Moore, T. M. (2011). Gender differences in depression and anxiety among victims of intimate partner violence: The moderating effect of shame proneness. *Journal of Interpersonal Violence*, 26, 1834-1850. doi:10.1177/0886260510372949

Siegfried, C. (2007). Victimization and youth violence. *Prevention Researcher*, 14(1), 14-16.

Sliverman, J. G., Decker, M. R., McCauley, H. L., Gupta, J., Miller, E., Raj, A., & Goldberg, A. B. (2010). Male perpetration of intimate partner violence and involvement in abortions and abortion-related conflict. *American Journal of*

Public Health, 100, 1415-1417. doi:10.2105/AJPH.2009.173393

Simmons, C. A., Lehmann, P., & Collier-Tenison, S. (2008). From victim to offender:

The effects of male initiated violence on women arrested for using intimate partner violence. *Journal of Family Violence*, 23, 463-472. doi:1007/s10896-008-9173-8

Simpson, E. K., & Helfrich, C. A. (2005). Lesbian survivors of intimate partner violence:

Provider perspectives on barriers to accessing services. *Journal of Gay & Lesbian Social Services*, 18(2), 39-59. doi:10.1300/J041v18n02_03

Smith, D. W. (2011). Phenomenology: *The Sanford encyclopedia of philosophy* (Fall

ed.). E. N. Zalta (Ed.). Retrieved from <http://plato.sanford.edu/archives/fall2011/entries/phenomenology/>

Sonis, J., & Langer, M. (2008). Risk and protective factors for recurrent intimate partner

violence in a cohort of low-income inner-city women. *Journal of Family Violence*, 23, 529-538. doi:10.1007/s10896-008-9158-7

Sprinkle, J. E. (2006). Domestic violence, gun ownership, and parental educational

attainment: How do they affect the aggressive beliefs and behaviors of children? *Child and Adolescent Social Work Journal*, 24(2), 133-151. doi:10.1007/s10560-006-0071-8

Spivak, H. R., Jenkins, E. L., VanAudenhowe, K., Lee, D., Kelly, M., & Iskander, J.

(2014). CDC grand rounds: A public health approach to prevention of intimate partner violence. *Morbidity and Morbidity Weekly Report*, 63(2), 38-41.

Stinson, C. K., & Robinson, R. (2006). Intimate partner violence: Continuing education

- for registered nurses. *Journal of Counseling Education in Nursing*, 37(2), 58-62.
- Stith, S. M. (2006). Future direction in intimate partner violence prevention research. *Journal of Aggression, Maltreatment & Trauma*, 13(3/4), 229-234.
doi:10.1300/J146v13n0309
- Strauss, M. A. (2007). Processes explaining the concealment and distortion of evidence on gender symmetry in partner violence. *European Journal on Criminal Policy and Research*, 13(3/4), 227-232. doi:10.1007/s10610-007-9060-5
- Straus, H., Cerulli, C., McNutt, L.A., Rhodes, K. V., Conner, K. R., Kemball, R. S., ... Houry, D. (2009). Intimate partner violence and functional health status: Associated with severity, danger, and self-advocacy behaviors. *Journal of Women's Health*, 18, 625-631. doi:10.1089/jwh.2007.0521
- Stuhlmiller, C. M., & Tolchard, B. (2015). Developing a student-led health and wellbeing clinic in an underserved community: Collaborative learning, health outcomes and cost savings. *BMC Nursing*, 14(1), 1-8. doi:10.1186/s12912-015-0083-9
- Swanberg, J. E., & Macke, C. (2006). Intimate partner violence and the workplace: Consequences and disclosure, *Journal of Women and Social Work*, 21, 391-406.
doi:10.1177/0886109906292133
- Swanberg, J. E., Macke, C., & Logan, T. K. (2006). Intimate partner violence, women, and work: Coping on the job. *Violence and Victims*, 21, 561-578. Retrieved from <http://www.springerpub.com/>
- Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., & Monson, C. M. (2011). Posttraumatic stress disorder and intimate relationship problems: A meta-analysis.

Journal of Consulting and Clinical Psychology, 79, 22-33. doi: 10.1037/a0022196

U.S. Census Bureau. (2014). QuickFacts Beta. Retrieved from

<http://quickfacts.census.gov/qfd/states/37/3722920.html>

Valderas, J. M., Starfield, B., Sibbald, B., Salisbury, C., & Roland, M. (2009). Defining comorbidity: Understanding health implications for and health services. *Annals of Family Medicine*, 7, 357-363. doi:10.1370/afm.983

Vallone, D. M., Niederdeppe, J., Richardson, A. K., Patwardhan, P., Niaura, R., & Cullen, J. (2011). A national mass media smoking cessation campaign: Effect by race/ethnicity and education. *American Journal of Health Promotion*, 25(5), 38-50. doi:10.4278/ajhp.100617-QUAN-201

Van Niekerk, B., & Maharaj, M. (2013). Social media and information conflict.

International Journal of Communication, 7, 1162-1184. 1932-8036/20130005

Vivilaki, V., & Johnson, M. (2008). Research philosophy and Socrates: Rediscovering the birth of phenomenology. *Nurse Researcher*, 16(1), 84-91. Retrieved from <http://rcnpublishing.com/journal/nr>

Watlington, C. G., & Murphy, C. G. (2006). The roles of religion and spirituality among African American survivors of domestic violence. *Journal of Clinical Psychology*, 62, 837-857. doi:10.1002/jclp.20268

Whitaker, D. J., Morrison, S., Lindquist, C. A., Hawkins, S. R., O'Neil, J. A., Nesius A. M., & Reese, L. (2006) A critical review of interventions for the primary prevention of perpetration of partner violence. *Aggression and Violent Behavior*, 11, 151-166.

- World Health Organization. (2005). WHO multi-county study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses. Retrieved from http://www.who.int/gender/violence/who_multicounty_study/summary_report/en/index/html
- World Health Organization. (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence. Retrieved from http://www.who.int/violence_injury_prevention/violence/activities/child_maltreatment/en/index.html
- Yonaka, L., Yoder, M. K., Darrow, J. B., & Sherck, J. P. (2007). Barriers to screening for domestic violence in the emergency department. *Journal of Continuing Education in Nursing*, 38(1), 37-45.

Appendix A: The Project

Mass Media: A Catalyst
For Moving Primary Prevention
Into the Public Square
A Position Paper

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July 2016

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Introduction

Mass media as a resource for primary prevention will deliver information to larger groups of individuals in shorter amounts of time and through the use of media constructs, stakeholders could direct not only how, but also what, information is delivered to the masses (Brown, 2014; Park & Calamaro, 2013).

To illustrate, below are examples of how mass media reports impacted the lives of victims, as recounted by clinicians during several interviews. As I interviewed clinicians, several respondents indicated that despite their clients' lack of knowledge of primary prevention, prevention was referenced as it related to a sensationalized video. The video involved a famous football player in a domestic violence-related incident. An online search indicated that the YouTube video in question had been viewed more than 11 and a half million times in 2014 (TMZSports, 2014) during the period when data for this study were collected.

In another example of the impact of mass media, on February 1, 2015, CNN reported that 114.4 million viewers watched Super Bowl #49, with a viewership that peaked at 120.8 million at the height of the game. The halftime show had 118.5 million viewers, the most in Super Bowl history, and there were 28.4 million game-related tweets. The previous year Super Bowl #48 had a viewership of 112.2 million viewers who watched the game (Pallotta, n.d.).

In yet another example, on October 8-9, 2015, WHO (2015) hosted the mhGAP Forum and posted the following on its website;

Forum participants heard moving testimonies from two invited speakers about their lived experience of mental illness, the challenges they experienced, and the central role that dignity played in their recovery. The theme of dignity in mental health also touched many people worldwide, reflected in the fact that @WHO's tweet on this subject was retweeted over 9,600 times which made it the most retweeted tweet in WHO history, and the second most retweeted message from a UN agency.

In the aforementioned examples, the first two examples reflected the use of new and old media, and the final example demonstrated a convergence of media. The organizations and individuals illustrated how using mass media in various forms reached the general public, for advocacy, entertainment, and education.

Argument – Mass Media as an Impetus for Change

It is for this purpose, widespread dissemination and immediate access of primary prevention that I propose the use of mass media to reach North Carolinians with the message of prevention. Results from this research indicated that despite information on the plan available by e-mail, nine clinicians had not received the e-mailed communication. Therefore, clinicians recommended stakeholders improve how DIPV information was distributed to the public in the following examples.

Clinician's recommendations for stakeholders included, (a) targeting the young, (b) establishing better reach in services and languages, (c) generating discussions, (d) outreach to disenfranchised areas, (e) educating clinicians and stakeholders, and (f) providing a clear picture of domestic violence.

Another recommendation implied but not directly stated was the need to educate the general public. In other words, clinicians believed that current efforts to address DIPV failed to reach those in need. Therefore, in considering the above recommendations I argued that the use of mass media (Spivak et al., 2014) would satisfy each of these recommendations once appropriately governed.

Definitions

For the purpose of this paper, *mass media* encompass print, audio, phone, and internet use. A debate currently exists in the literature on the use of *new* and *old* media, termed *convergence* (Choa-Chen, 2013). Although this paper does not address the merits of this discourse, it is important to highlight existing literature as it applies to current research. Mass media, social media, and new media are responsible for the current flow of information readily available in our society. Participating in this media convergence would benefit not only stakeholders but also the public at large, in response to the DIPV crisis.

Merriam-Webster's online dictionary (n.d.) defines *mass medium* as “a medium of communication (as newspapers, radio, or television) that is designed to reach the mass of people.” Another media form popular in today’s culture is *social media*. *Social Media* can be defined as including, “a range of tools and services that all enable direct user interaction on computer mediated environments” (Lampe, LaRose, Steinfield, & DeMaagd, 2011, p. 2), as well as “forms of electronic communication (as websites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content (as video)” (Merriam-

Webster, n.d.). Finally, there is *New Media*, defined as “the forms of communicating in the digital world, which includes publishing on CDs, DVDs, and most significantly over the internet. It implies that the user obtains the material via desktop and laptop computers, smartphones, and tablets (*PC Magazine Encyclopedia*, n.d.).

Individuals have access to data in all forms through select media channels at their discretion without restrictions on time, place, or content (Boyd, 2014). In Boyd’s (2014) well-referenced book on teens’ use of social media captured were the essence of today’s young adults’ use of technology.” She also noted “its impact on society when she referred to the “geographically unbounded settings” into which media extends their activities (p. 8). The unbounded nature of social media allows for information to be accessed and broadcasted in various formats. This access to social media, however, presents both benefits and challenges to the user as demonstrated in the following examples.

Media’s Reach

Pennington & Birthisel (2015) reported that the Steubenville rape case was documented on smartphones by the victim’s assailants and witnesses and posted on social media. Reports of the case indicated that “technology served as a witness and helped galvanize attention and activism” (p. 8.). They further posited that social media cast this case into the national spotlight bringing attention to a crime that otherwise might have gone unnoticed (Pennington & Birthisel, 2015).

In another case, during the government shutdown of 2013 when major government and health agencies lost the ability to communicate with the public, social media became the intermediary through which information was shared (Merchant et al.

2014). Then, in the midst of the flu pandemic and Hurricane Sandy social media was recognized as a vital asset during a crisis (UPMC, Center for Health Security, 2014).

Moreover, in national news social media was used to showcase police brutality, spurred riots, and how to advocate for help. Richards, Gillespie, and Givens (2014) posited “The media have the unique power to harness the attention of news consumers and shape public opinion concerning important social problems, such as crime and violence, as well as society’s role in prevention and intervention efforts” (p. 453). It is with this framework in mind that I recognized how the use of *Mass Media* would serve as an impetus for change to address the DIPV crisis (Jakobsson et al., 2013).

Implementations

Media, Government Agencies, and Public Health. As a public health issue, DIPV prevention should be promoted in all areas. Victims and members of the general public should receive warnings of the deleterious nature of DIPV. In examining her state’s expectation of due diligence towards the treatment of violence against women, Qureshi (2013) emphasized the following:

Prevention should be focused on transforming discriminatory attitudes that position women as sub humans. Under this approach prevention extends to education and awareness-raising, gender mainstreaming in all the government policies and plans, eradication of gender stereotyping, nationwide media campaigns targeting change in attitudes and gender trainings for law enforcers, judiciary, policy makers and other key personnel. These initiatives must have as

an ultimate goal the positive transformation of perspectives, social values and approaches which have been perpetrating violence against women. (pp. 62-63)

In the text above, Qureshi included nationwide media campaigns as an area in which prevention should focus. In conjunction with the DELTA program, Spivak et al. (2014) described a community's approach to primary prevention with teens involved "using creative social marketing and social media efforts focused on youths and parents" (p. 40). Considering this, elements of social media are common place in every institution across the nation and have the potential to impact countless lives (McNab, 2009).

In Social Media Use in the United States: Implications for Health

Communication, Chou, et al. (2009) proposed that programs using social media to communicate health messages should consider the following guidelines. The information must first be (a) age-specific in its focus, (b) understand race and ethnicity are not limitations *on* social media, and (c) that social media have changed the landscape in American communication.

For example, in a 2012 survey the Pew Research Center (2013) found that health information was searched for by 72% of internet users. Though not considered a *health problem*, factual DIPV information on the internet would benefit those who search and use the internet for, health-related information. A study participant indicated that domestic violence clients might not know they were involved in a domestic violence situation until they are told. She stated:

And sometimes relatives talk to them about things and try to help them in the process. You know the person may not feel like they are a victim of domestic

violence and then until someone names it for them and says this is what this is.

Sometimes it's a family member, especially because if that person is very young, family members are still very much involved with them. Mother and grandmother especially and they try to tell them you can go here and you can do this and you don't have to be in this.

In an example such as described above, family members and/or victims searching the internet could have access to factual information on DIPV. With factual information an individual could make an informed decision regarding the safest approach to his or her situation.

To illustrate, McNab (2009) asserted "Increased access to the internet and mobile communication combined with strategic uses of social media can bring public health information to many more people, more quickly and directly than at any time in history" (p. 566). Thus, stakeholders and advocacy groups have the ability, through mass media, to provide the public with information pertaining to DIPV more rapidly than ever before. It is therefore recommended that stakeholders take advantage of all facets of mass media to implement prevention.

Convergence

In referring to social media as "a great information equalizer" McNab (2009, p. 566) addressed this convergence of health information across socioeconomic and language barriers. Through the use of *new* and *old* media stakeholders would have additional opportunities to engage every aspect of society. Combining new (social media) technologies and old (television, radio, print) media stakeholders could address their

concerns for underserved populations. For instance, studies including the use of (old) media indicated 80% of Americans spent almost three hours of their leisure time watching television (U.S. Bureau of Labor and Statistics, 2014). Therefore, television (old media) is also a viable tool for the dissemination of DIPV information

In related information, Chen, Funk, Straubhaar, and Spence (2013) researched the once popular public and government access channels (PEG), and found that these stations continued to have a relevant impact on public communication consumption. The authors reported Asian Americans, Hispanics, Native Americans, and African Americans were more likely to watch, and watched these stations more often than European Americans. They posited “public access television remains relevant for underprivileged populations” (p. 278). Furthermore, the Bureau of Labor and Statistics (2011) found that men tended to view an additional 20 minutes more of television than did women.

When this study was conducted, there were 18 television stations that offered various forms of PEG programming across North Carolina. Locally, there is a television station that specifically targets the Hispanic populace. And, as previously reported, Asian Americans, Hispanics, Native Americans, and African Americans were at higher risk for DIPV, and North Carolina has a growing Hispanic population. Chen et al. (2013) further posited public access television remains a viable option for public expression and community information, and includes programming for individuals of all ages.

Underserved Populations.

Age, Gender, and Race. In previously cited information, the NCCADV 10-year plan intends to address children as young as 3 years of age and adults beyond age 61.

This is an indication that the plan would target all segments of the population for primary prevention outreach. In support, the Pew Research Center (2015) reported that in 2005 only 2% of adults 65 years and older used social media. However, in 2015 those figures increased to 35% for adults in the same age range. Furthermore, women tended to use social networking sites at a higher rate than did men.

Also, the disparities between racial and ethnic users of social media have decreased, and the growth of social media use is present in individuals of lower socioeconomic standing. In addition, research showed that young adults ages 18-29 are high consumers of all forms of social media (Boyd, 2014; Pew Research Center, 2015). Therefore, as the demographics of consumers of social media change, change should also take place among those who provide information via social media. Young adults, individuals over 65, women, and other ethnic groups have increased access to information on social media. With this in mind, designers of prevention information could reach subsets of the population at risk for DIPV.

Male Victims and Perpetrators. A subset of the DIPV population addressed less often is the male victim. Because of this, it is equally important that stakeholders and practitioners who work with victims do not overlook this group as services are not readily available (Tsui, 2014). In addition, men are less forthcoming about abuse than women (McCarrick, 2015). McCarrick advocated “More media coverage addressing the IPV experiences of both men and women is needed in order to educate people about this issue” (p. 378).

In related information, Tsui, (2014) reported, “The male victim may perceive online media as being less threatening to their masculine self-image and ego while still maintaining their autonomy” (p. 128). Tsui, also advocated for further education and training for those with immediate access to victims and perpetrators and recommended “In addition, the service provider can use the technology as an effective and efficient means to disseminate knowledge about IPA and adopt a user-friendly approach to involve abused men in internet services such as anonymous open forums and online support groups” (p. 129). These authors spoke directly to the practitioner and presented media as a valuable resource to address DIPV in underserved populations.

Additionally, to impact the DIPV picture, attention should focus on perpetrators. As a research participant highlighted about working with the accused, she stated;

Yeah, I think it’s narrow of us to only work with the survivor. I think we need to take a step back and much like thinking about how much do a woman get paid and that idea of subjugating anyone and making them less than, is the cornerstone of all the next pieces of that violence piece. If we are really going to stop it, we have to go to the accused and say, how do we stop you from behaving this way.

As I have stated, it is uncommon to recognize men as victims of DIPV. Despite this fact, however, the literature has identified women as aggressors. Knowing this, the success of primary prevention would be contingent on addressing both victims and perpetrators.

The media as an impetus for change is a viable option to address the DIPV crisis locally, nationally and internationally. Although it is true that the use of media presented many opportunities for advancing prevention, there are challenges that should be

considered. The use of media presented challenges and the literature indicated scholars were concerned with the freedom users are afforded when engaging in online discourse (Vance, Howe, & Dellavalle, 2009; Turner, 2010).

Potential Barriers

Social Media, Citizen Journalism, Missed Opportunities. As stakeholders move forward with prevention outreach on social media there are several challenges that should be considered. However, I chose to focus on the issues raised most often in the literature, when media presented on DIPV related issues. For instance, *Citizen Journalism* is the participation of public views in the shaping of contemporary media. Citizen journalist demonstrates the power and ability to transform current discourse (Turner, 2010). Bou-Franch (2013) researched public participation in the domestic violence discourse, and found citizen journalist could, or have the potential to, direct the conversation on DIPV if stakeholders continue to miss the opportunity to lead in the discussion.

Consequently, participants in Bou-Franch's research were found to, minimize the severity of DIPV, promote victim-blaming, and advocated for privatizing the violence. Bou-Franch's research demonstrated the potential information on social media had to compound the DIPV problem, she reported, "Incidentally while there was much debate about the reasons why women did not leave their abusive partners to the point of incriminating victims in their own battering, nothing was said of abuse perpetrators throughout the discussion" (2013, p. 295). In the previous example, citizen journalist promoted fear, and encouraged stereotypes, all of which are areas primary prevention could address.

Another challenge presented by the use of social media is the plethora of information available on websites housing unverified and or incorrect sources (Brown, Nasiruddin, Dao, & Halabi, 2015). To address these issues, recommendations in the literature included the use of professionals knowledgeable of the DIPV situation to provide factual information. Additionally, stakeholders should be selective in their choice of DIPV terminology used on social media or in other context. The literature advised against the use of terminology that could have multiple meanings to the lay person unfamiliar with DIPV related terms even if those terms are familiar to practitioners and academia (Merchant, et al, 2014).

For example, during the Ebola outbreak and in the midst of a media frenzy, the WHO and CDC used social media to update the public with information that was both accurate and timely (CDC, 2014; WHO, 2014). As the literature has shown, on social media voices are silenced in many ways, and heard in many others. Therefore, it is recommended that the online discussion on DIPV should not take place without educated professionals.

Bou-Franch (2013) also reported that citizen journalists who were involved in the DIPV discourse and advocated victim-blaming were challenged and changed their views when presented with factual information. By challenging individuals who promote myths, and stereotypes, knowledgeable professionals could change erroneous beliefs.

Framing. Another potential barrier for stakeholders involves *framing*; media framing influences the reader's, viewers' or media participants' attitudes on what is disclosed in the media content (Patterson, Semple, Wood, Duffy, & Hilton, 2015). Media framing directs or defines problems, causes, moral judgments, and remedies; and it is used to report crimes, and the media in the shaping of public opinion (Meyer & Post, 2013).

In fact, Meyer and Post reported in their quantitative analysis of newspaper articles that framing of DIPV incidences in the media swayed public opinion into believing DIPV was “the result of a triggering incident rooted in the intimate dyad” (2013, p. 8). Letourneau et al. (2014) reported media framing of child sexual abuse as inciting fear and/or victim blaming. Still, Richards et al. (2014) found that DIPV and other violence related stories in the media lacked consultation with professionals who were able to provide facts rather than interpretations.

Thus, when presenting a domestic or violence related incident in the media, scholars (Baluta, 2015; Meyer & Post, 2013; Pennington & Birthisel, 2015) reported due to a lack of knowledge on the part of the reporter, the incident was presented in a way that steered the reader from understanding the depth to which DIPV is a public issue (Richards et al., 2014). As mentioned, professionals knowledgeable of the DIPV situation are needed to guide conversations that would take place in the media, and on social media platforms. If professionals are absent from this dialogue issues such as victim-blaming (Bou-Franch, 2013), incorrect information (Meyer & Post, 2013), and inciting fear

(Letourneau et al., 2014) could continue. Despite the challenges with social media, the literature provides guidelines on how to address these challenges.

Proposal for Implementation and Timetable

Addressing Social Media

Although there are negative connotations, framing holds positive elements for stakeholders who are willing to construct factual frames to disseminate information to the public. Bou-Franch (2013) posited, “Identifying, resisting and contesting abuse-sustaining ideologies will contribute to dismantling the discourses and ideologies in the larger social context that currently naturalize violence against women” (p. 297). In fact, in their study of femicide-suicide Richards et al. (2014) stated, “Recommendations to cite experts, provide statistics, and include contact information are crucial to spreading awareness and combating violence” (p. 461).

Following the recommendations of these authors, stakeholders would capture opportunities, leverage social media, educate the public, and potentially save lives. In another study on media coverage, Baluta (2015) advised, “The role of media is highly important in regards to violence against women, both in terms of how media cover the issue, and how media may become a tool used by activist and decision makers to raise awareness, mobilize people and implement programs on the issue” (p. 53). As previously noted by the RWJF, (2015) in their evaluation of the DELTA PREP program, implementation of social media into prevention requires a change in stakeholder and agency culture. Thus, it is important that the culture within the advocating agencies

change if these agencies expect to impact the larger communities. The literature provides strategies on how to report DIPV in the media.

Guidelines for Reporting in the Media

As stakeholders consider mass media as a resource to promote DIPV awareness consideration should include the aforementioned constructs (media's reach, addressing underserved populations and potential barriers). Framing is a construct that has the potential to greatly impact how DIPV information is presented. Well framed DIPV information could also address incorrect myths and beliefs that members of the public hold. Therefore, how stakeholders approach framing is essential to the success of any media campaign. Baluta (2015) gives his recommendations on framing. He stated

the 'paradigm' of journalistic practices can be slowly adjusted so that media products framing violence reveal responsibility, understanding the phenomenon, an authentic intention to inform the public/citizens and to urge them to raise questions on the topic and the involvement of the institutions and that of the larger community. (p. 64)

Also, in constructing programs geared at child sexual abuse prevention, Letourneau et al. (2014), outlined guidelines for media reporting. The authors advocated for the use of the public health approach to child sexual assault (CSA) prevention. They further stated that CSA may be a tool used to formulate prevention strategies for DIPV related media prevention. The author's posited prevention of CSA was achievable through the public health prevention model and attainable through its use.

Additional resources on reporting in the media included those supported by Richards et al. (2014). These authors specifically recommended guidelines used for reporting on femicide-suicide, which the authors define as suicide directly following the homicide of an intimate partner. Although these guidelines were initially designed to address suicide, the authors advocated for its use in approach to DIPV in the media. Eight recommendations were summarized from the authors' research and highlighted below:

1. Report information that is concise, factual, and not overly simplistic.
2. Terminology is important; label the act as a domestic violence related incident.
3. Avoid titles or article headings that could promote sensationalism.
4. Direct focus away from the perpetrator and acknowledge the dynamics of IPV.
5. Avoid using photos that lead to the sensationalism of the incident and encourage attention-getting from others who may seek to do the same.
6. Use the media to promote knowledge and awareness.
7. Use quotes from professionals with knowledge of the DIPV picture, also provide journalist with factual educational statistics and information on reporting DIPV.
8. Provide local and national resources, phone numbers, websites, shelters, and coalition information.

By using these eight recommendations practitioners could frame DIPV information in factual ways that provide the viewer/reader with information on how DIPV affects the community. Gillespie, Richards, and Givens (2013) in a separate research, advocated for an alliance between journalist and local coalitions to enhance

reporting on DIPV related issue. In sum, these guidelines are resources that could frame the foundation for stakeholders as they move forward with DIPV prevention in the media.

Timeline for Implementation. Once guidelines are adopted agencies are equipped to begin promoting primary prevention. The time between adoption of a set of guidelines or recommendations is program specific; however, considering the current need for prevention, agencies should attempt to expedite the process. For instance, the RWJF reported its findings of the DELTA PREP program in 2013, then, Freire et al. (2015) reported on their discovery two years later in 2015. It is safe to conclude that *now* is the time for NCCADV to catalyze primary prevention information to the public. Coalitions can no longer afford to wait until the decision is made to change the culture inside the agency before programs are implemented.

To illustrate, NCCADV reported on its website evidence of why the need for prevention was great. In the final year of implementation of the DELTA PREP program (2012), 63 DIPV-related deaths were reported. In the years following, there were 64 deaths in 2013, 64 in 2014, and 69 in 2015. RWJF (2013) reported coalitions were prepared to present the information to the public, when they stated, “CDC staff and consultants delivered training and technical assistance to grantee coalitions to plan and implement changes that would expand their capacity for primary prevention of intimate partner violence” (p.1).

In this situation, although coalitions had not catalyzed prevention beyond its walls, they were best prepared to deliver information on prevention to the public. Therefore, if coalitions, professionals, and stakeholders do not take the lead in

determining what and how information is presented to the public, erroneous information and common myths will continue to add to the perpetuation of the cycle of violence.

Roles and Responsibility of Students and Others

Although it is true that organizations are responsible for promotion prevention statewide, it is equally true that each citizen is responsibility to ensure a safe personal environment. As a researcher, student, and clinician I have firsthand knowledge of the DIPV problem within the state. Working with military families, meeting with colleagues, attending conferences, and exploring the literature provided a complete picture of the impact of DIPV. These experiences afforded me an advantage not had by most clinicians.

Understanding the effects of DIPV equipped me with the knowledge to address erroneous discourse. When presented, I have taken the opportunity to instruct others with whom I interacted on the facts surrounding DIPV in an attempt to dispel myths. As an educator, I encouraged others to take information that they have learned and to pass on accurate information.

When possible I have provided resources to the individual or groups extending knowledge and suggested that they share the resources with others. As a host or speaker at conferences I was offered opportunities to engage other professionals in the discourse on prevention and other DIPV related issues. In short, I accepted each opportunity to inform and instruct others on the harmful effects of DIPV, and encouraged and supported others to do the same.

As I have done with this research, it is necessary to examine the merits of programs designed to assist members of the public. In their evaluation of the DELTA

PREP program of coalitions' ability to integrate prevention, Freire et al. (2015) listed six types of prevention activities two of which are unique to this project a) to work with media outlets, and b) to work with social media campaigns.

The authors also listed communication channels (i.e., newsletters, listserv, blog, website, Twitter, and Facebook) as areas of capacity where an agency had potential in which to expand its prevention efforts. Also, the authors defined two specific areas in their evaluation for agencies that work with media outlets. The two areas were to focus on prevention and framing of DIPV information in the media. Examples of prevention activities provided by the authors included working with public television, journalists' role in framing, and distribution of press kits.

At the end of the evaluation, Freire et al. found "Only three coalitions were implementing program activities with partners and no coalitions had initiated policy activities or work with media outlets" (2015, p.444). Despite these findings, the authors gave coalitions specifics on prevention capacity, and prevention activities in the area of media relations. Having identified both prevention capacity - communication channels; and prevention activities - works with media, coalitions were equipped to implement and evaluate these areas despite not having done so in the past. Thus, the failure of the agency to adopt recommendations on how to bring about prevention in no way diminishes the need.

To summarize, in this position paper, I presented on the merits of prevention in the media and the challenges of navigating mass media. In addition, I further provided guidelines on how to frame DIPV related issues in the media. Both areas cited by

DELTA PREP as focus areas for working with the media. Information from DELTA PREP provided coalitions with recommendations on how to frame information and in what areas to evaluate the effectiveness (i.e. prevention catalyst statewide, Freire et al., 2015). Staffs within coalitions and specifically the staff of NCCADV were trained and educate on program evaluation.

In order to Move forward, implementation of sound and existing strategies, and the use of current resources would best help the citizens of North Carolina far better than attempting to create an evaluation tool or rubric by which to assess an ongoing program. The citizens of North Carolina both military and civilian are in need of the prevention resources available to NCCADV. Therefore, prevention is imperative and, 1 day, could mean a life saved. As a result, I concluded that prevention is unto life, and it warrants promoting.

Implications Including Social Change

Stakeholders with access to the information in this research are equipped to with outreach. DELTA PREP approached coalitions in high-risk states and provided the training necessary for the implementation of prevention into its current domestic violence programs.

DELTA PREP also made coalitions aware of its potential for *new* media to disseminate information, and this research showed how *old* media could reach underserved populations. *New* and *old* media constructs such as framing, and collaborations with journalist could potentially impact this population not only in North Carolina but also nationally and internationally.

Conclusion

To summarize, this position paper was intended to provide stakeholders, advocates, and designers of primary prevention with information on the efficacy of prevention in mass media. Presented were examples of how individuals responded to information in the media. How the media was used as resource for information, education and advocacy, and how new and old technologies were effective in reaching large audiences.

Addressed were the challenges of developing and maintaining dialogue on social media and how to address those challenges. Further I presented on media's current and potential impact on underserved populations, introduced terms used and the definitions, and guidelines for reporting DIPV and related violent incidents in the media.

As a researcher and a scholar I believe that DIPV as a public health problem has in large part, and for the moment, received predominantly sensationalized coverage in the media. After reviewing the literature, I also believe that citizen journalist could be the catalyst that forces coalitions and other experts to address DIPV through the media, and in the public square. As time passes, each day holds the potential for another child, woman, or man to become a victim of DIPV.

Professionals guiding the discourse surrounding DIPV could (a) positively impact change, (b) minimize violence, and (c) potentially save countless men, women, and children the mental, emotional, and physical distress caused by DIPV. Moreover, stakeholders are in a prime position and have an opportunity through this medium to determine the local, national, and possibly international direction of DIPV.

References

- Assay, S. (2011). Awareness of domestic violence within the evangelical community: Romania and Moldova. *Journal of Family Violence*, 26, 131-138.
doi:10.1007/s10896-010-9350-4
- Baluta, O. (2015). Representing and consuming women. Paradoxes in media covering violence against women. *Journal of Media Research*, 8(2[22]), 52-67.
- Boal, A. L., & Mankowski, E. S. (2014). The impact of legislative standards on batterer intervention program practices and characteristics. *American Journal of Community Psychology*, 53, 218-230. doi:10.1007/s10464-014-9637-3
- Bou-Franch, P. (2013). Domestic violence and public participation in the media: The case of citizen journalism. *Gender and Language*, 7(3), 275-302.
doi:10.1558/genl.v7i3.275
- Bouri, N., Minton, K., Jolani, N., & Rubin, S. (2014). Riding the mobile wave: What local health departments need in order to adopt social media and mobile health technologies for emergency preparedness. UPMC Center for Health Security and the National Association of County and City Health Officials (NACCHO).
Retrieved from http://www.naccho.org/topics/emergency/upload/Report-Riding-the-Mobile-Wave_UPMCHHealthSecurity-and-NACCHO_Feb2014.pdf
- Bowman, S., Engleman, A., Koziol, J., Mahoney, L., Maxwell, C., & McKenzie, M. (2014). The Rhode Island community responds to opioid overdose deaths. *Rhode Island Medical Journal*, 97(10), 34-37

Boyd, D. (2014). *It's complicated: The social lives of networked teens*. New Haven, CT:

Yale University Press.

Brown, B. (2014). Public health education using pop culture and media. *Frontiers in*

Public Health, 2, 1-3. doi:10.3389/fpubh.2014.00231

Brown, B., Nasiruddin, M., Dao, A., & Halabi, M. (2015). Responsible use of pop culture

and communication in the face of Ebola virus. *PLoS Neglected Tropical Diseases*,

9(8). doi:10.1371/journal.pntd.0003890

CDC.gov. (2014). “#EbolaFact: Here’s what you need to know about when a person can

spread the disease to others.” 29 Oct 2014, 12:33 p.m. Twitter post.

<https://twitter.com/CDCgov/status/527543653489987584>.

Centers for Disease Control and Prevention. (2013). Arthritis: The arthritis challenge.

Retrieved from [http://www.cdc.gov/arthritis/temp/pilots-](http://www.cdc.gov/arthritis/temp/pilots-201208/pilot1/online/arthritis-challenge/03-Prevention/concept.htm)

201208/pilot1/online/arthritis-challenge/03-Prevention/concept.htm

Centers for Disease Control and Prevention (2014). Smoking and tobacco use. What you

need to know about smoking. Retrieved from [http://www.cdc.gov/tobacco/](http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm#fact-sheets)

[data_statistics/sgr/50th-anniversary/index.htm#fact-sheets](http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm#fact-sheets)

Centers for Disease Control and Prevention. (2015c). Injury prevention and control:

Motor vehicle safety. Distracted driver. Retrieved from

http://www.cdc.gov/Motorvehiclesafety/Distracted_Driving/index.html

Centers for Disease Control and Prevention (2015a). Injury prevention and control:

Motor vehicle safety. Seat belts: Get the facts. Retrieved from

<http://www.cdc.gov/motorvehiclesafety/seatbelts/facts.html>

Centers for Disease Control and Prevention (2015b). Violence prevention and social media. Retrieved from <http://www.cdc.gov/ViolencePrevention/socialmedia/index.html>

Chao-Chen, L. (2013). Convergence of new and old media: New media representation in traditional news. *Chinese Journal of Communication*, 6(2), 183-201.
doi:10.1080/17544750.2013.785667

Chen, W., Funk, M., Straubhaar, J. D., & Spence, J. (2013). Still relevant? An audience analysis of public and government access channels. *Journal of Broadcasting and Electronic Media*, 57(3), 263-281. doi:10.1080/08838151.2013.816707

Chou, W. S., Hunt, Y. M., Beckjord, E. B., Moser, R. P., & Hesse, B. W. (2009). Social media use in the United States: Implications for health communication. *Journal of Medical Internet Research*, 11(4), e48. doi:10.2196/jmir.1249

Davidov, D. M., & Jack, S. M. (2014). Nurse home visitors' perceived awareness of mandatory reporting requirements: Pregnant women's and children's exposure to intimate partner violence. *Journal of Advanced Nursing*, 70, 1770-1779.
doi:10.1111/jan.12334

de Carvalho, I. M. (2014). An exploratory study of social workers' perceptions of violence against older people in Portugal. *Indian Journal of Gerontology*, 28, 414-430.

Freire, K. E., Zaocs, R., Le, R., Hill, J. A., Brown, P., & Wheaton J. (2015). Evaluation of DELTA PREP: A project aimed at integrating primary prevention of intimate

- partner violence within state domestic violence coalitions. *Health Education & Behavior*, 42, 436-448. doi:10.1177/1090198115579413
- Gillespie, L. K., Richards, T. N., & Givens, E. M. (2013). Framing intimate partner victimization: Why the media's spin matters in newspaper coverage of femicide. *Violence Against Women*, 19(2), 222-244.
- Gonzalez-Guarda, R. M., Diaz Lipman, E. G., & Cummings, A. M. (2012). A community forum to assess the needs and preferences for domestic violence prevention targeting Hispanics. *Hispanic Health Care International*, 10(1), 18-27. doi:10.1891/1540-4153.10.1.18
- Jakobsson, A., Von Borgstede, C., Krantz, G., Spak, F., & Hensing, G. (2013). Possibilities and hindrances for prevention of intimate partner violence: Perceptions among professionals and decision makers in a Swedish medium-sized town. *International Journal of Behavioral Medicine*, 20, 337-343. doi:10.1007/s12529-012-9238-1
- Juodis, M., Starzomski, A., Porter, S., & Woodworth, M., (2014). What can be done about high-risk perpetrators of domestic violence? *Journal of Family Violence*, 29, 381-390. doi:10.1007/s10896-014-9597-2
- Kottenstette, J. B., & Stulberg, D. (2013). Time to routinely screen for intimate partner violence. *Journal of Family Practice*, 62(2), 90-92.
- Lampe, C., LaRose, R., Steinfield, C., & DeMaagd, K. (2011). Inherent barriers to the use of social media for public policy informatics. *Innovation Journal: The Public Sector Innovative Journal*, 16(1), 222-228.

- Letourneau, E. J., Eaton, W. W., Bass, J., Berlin, F. S., & Moore, S. G. (2014). The need for a comprehensive public health approach to preventing child sexual abuse. *Public Health Reports, 129*, 222-228.
- Matjasko, J. L., Niolon, P. H., & Valle, L. A. (2013). What does research suggest are the primary risk and protective factors for intimate partner violence (IPV) and what is the role of economic factors? *Journal of Policy Analysis and Management, 32*(1), 122-141. doi:10.1002/pam.21666
- McCarrick, J. (2015). New voices: The 'minority' man? *Psychologist, 28*, 376-379.
- McNab, C. (2009). What social media offers to health professionals and citizens. *Bulletin of the World Health Organization, 87*, 566-566. doi:10.2471/BLT.09.066712
- Merchant, R. M., Ha, Y. P., Wong, C. A., Schwartz, H. A., Sap, M., Ungar, L. H., & Asch, D. A. (2014). The 2013 US Government shutdown (#Shutdown) and Health: An emerging role for social media. *American Journal of Public Health, 104*, 2248-2250. doi:10.2105/AJPH.2014.302118
- Merriam Webster, Encyclopedia Britannica Company (2015). Online dictionary: Mass Media Retrieved from <http://www.merriam-webster.com/dictionary/mass%20medium>
- Meyer, E. M., & Post, L. (2013). Collateral intimate partner homicide. *Sage Open, 1- 11*. doi:10.1177/2158244013484235
- Pallotta, F. (n.d.). CNN Money Super bowl XLIX posts the largest audience in TV history. Retrieved from <http://money.cnn.com/2015/02/02/media/super-bowl-ratings/> November 27, 2015

- Park, B. K. & Calamaro, C. (2013). A systematic review of social networking sites: Innovative platforms for health research targeting adolescents and young adults. *Journal of Nursing Scholarship*, 45(3), 256-264. doi:10.1111/jnu.12032
- Patterson, C., Semple, S., Wood, K., Duffy, S., & Hilton, S. (2015). A quantitative content analysis of UK newsprint coverage of proposed legislation to prohibit smoking in private vehicles carrying children. *BioMed Centra Public Health*, 15, 1-7. doi:10.1186/s12889-015-2110-x
- PC Magazine Encyclopedia (2015). New Media. Retrieved From <http://www.pcmag.com/encyclopedia/term/47936/new-media>
- Pennington, R., & Birthisel, J. (2015). When new media make news: Framing technology and sexual assault in the Steubenville rape case. *New Media & Society*, 1-17. doi:10.1177/1461444815612407
- Pew Research Center. (2013). Health Online 2013. Retrieved from <http://www.pewinternet.org/2013/01/15/health-online-2013/>
- Pew Research Center. (2015). Mobile messaging and social media 2015. Retrieved from <http://www.pewinternet.org/2015/08/19/mobile-messaging-and-social-media-2015/>
- Pew Research Center. (2015b). Social Media Usage: 2005 – 2015. Retrieved from <http://www.pewinternet.org/2015/10/08/social-networking-usage-2005-2015/>
- Pew Research Center. (2015). The smartphone difference. Retrieved from http://www.pewinternet.org/files/2015/03/PI_Smartphones_0401151.pdf
- Qureshi, S. (2013). The emergence/extension of due diligence standard to assess the state

- response towards violence against women/domestic violence. *Research Journal of South Asian Studies*, 28(1), 55-66.
- Richards, T. N., Gillespie, L. K., & Givens, E. M. (2014). Reporting femicide-suicide in the news: The current utilization of suicide reporting guidelines and recommendations for the future. *Journal of Family Violence*, 29, 453-463. doi:10.1007/s10896-014-9590-9
- Robert Wood Johnson Foundation. (2015). Integrating prevention strategies into organizations that address intimate partner violence: The DELTA PREP project works with 19 state-level domestic violence coalitions. Retrieved from <http://www.rwjf.org/en/library/research/2013/07/integrating-prevention-strategies-into-organizations-that-address.html>
- Roberto, K. A., Brossoie, N., McPherson, M. C., Pulsifer, M. B., & Brown, P. N. (2013). Violence against rural older women: Promoting community awareness and action. *Australasian Journal on Ageing*, 32(1), 2-7. doi:10.1111/j.1741-6612.2012.00649.x
- Rosen, G. (1975). Historical evolution of primary prevention, *Bulletin of New York Academy of Medicine*, 51(1), 9-26.
- Spivak, H. R., Jenkins, E. L., VanAudenhowe, K., Lee, D., Kelly, M., & Iskander, J. (2014). CDC grand rounds: A public health approach to prevention of intimate partner violence. *Morbidity and Morbidity Weekly Report*, 63(2), 38-41.
- Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of risk-needs-responsivity-based family violence programs with male offenders. *Journal of*

Family Violence, 29, 151-164. doi:10.1007/s10896-013-9575-0

TMZSports. (2014, September 8). Ray Rice knocked out fiancé. Retrieved from

<https://www.youtube.com/watch?v=VbwTMJroTbI> November 27, 2015

Tsui, V. (2014). Male victims of intimate partner abuse: Use and helpfulness of services.

Social Work, 59(2), 121-130. doi:10.1093/sw/swu007

Turner, G. (2010). *Ordinary people and the media: The demonic turn*. Los Angeles, CA:

Sage.

UPMC Center for Health Security and the National Association of County and City

Health Officials. (2014). Riding the mobile wave: What local health departments need in order to adopt social media and mobile health technologies for emergency preparedness. 1-42. Retrieved from

http://archived.naccho.org/topics/emergency/upload/Report-Riding-the-Mobile-Wave_UPMCHHealthSecurity-and-NACCHO_Feb2014.pdfU.S. Bureau of Labor

and Statistics. (2014). Women in the work force: A databook. Retrieved from <http://www.bls.gov/opub/reports/cps/women-in-the-labor-force-a-databook-2014.pdf>

U.S. Department of Health and Human Services (HHS). (2015). Prevention and public health fund. Retrieved from <http://www.hhs.gov/open/prevention/index.html>

Vance, K., Howe, W., & Dellavalle, R. P. (2009). Social internet sites as a source of public health information. *Dermatologic Clinics*, 27, 133-136.

Van den Ameele, S., Keygnaert, I., Rachidi, A., Roelens, K., & Temmerman, M. (2013). The role of the healthcare sector in the prevention of sexual violence against sub-

Saharan transmigrants in Morocco: A study of knowledge, attitudes and practices of healthcare workers. *BioMed Central*, 13(77). doi:10.1186/1472-6963-13-77

White House, the. (n.d.). 1 is 2 many: About vice President Biden's efforts to end violence against women. Retrieved from <https://www.whitehouse.gov/1is2many/about>

World Health Organization. "Dr Aylward: 13,703 #Ebola cases have been reported so far; 13,676 cases in Guinea, Liberia & Sierra Leone." 29 Oct 2014, 6:46 a.m. Twitter post. <https://twitter.com/WHO/status/527456383445508096>.

World Health Organization. (2015). mhGAP Forum 2015. Retrieved from http://www.who.int/mental_health/mhgap/forum_2015/en/

Xavier University Library. (2014). How to write a position paper. Retrieved from http://www.xavier.edu/library/students/documents/position_paper.pdf

Young Adult Library Services Association. (2006). Guidelines for position papers and issue briefs. Retrieved from <http://www.ala.org/yalsa/aboutyalsa/yalsahandbook/whitepapers>

Appendix B: Consent Form

You are invited to take part in a research study of how primary prevention impacts domestic and intimate partner violence (DIPV) victims and perpetrators with mental illness or substance abuse related issues. The researcher is inviting licensed and provisionally licensed clinicians to participate in the study. Fully licensed clinicians with an unrestricted license and provisionally licensed clinicians who currently work or have worked with DIPV clients in the previous 12 months are eligible to be in the study. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Carol Jones, who is a doctoral student.

Background Information:

The purpose of this study is to explore and understand the impact of primary prevention on DIPV clients with mental health or substance abuse related issues.

Procedures:

If you agree to be in this study, you will be asked to:

- ☐ ____ participate in a 30 minute pre-interview session to review the purpose of the study, informed consent, respond to questions, and build rapport.
- ☐ ____ participate in a 45 minute interview to solicit your responses to semi-structured questions, and
- ☐ ____ participate in a 30 minute post interview to review a summary of the transcript for accuracy.

Here are some sample questions:

____ What specific prevention strategies have helped your DIPV clients?
What are your thoughts about how primary prevention does/does not impact DIPV clients?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, discomfort from sitting during the interview, and anxiety due to the topic of discussion. Being in this study would not pose risk to your

safety or wellbeing. Benefits include understanding and preventing DIPV, and an overall increase in awareness of the negative effects of DIPV.

Payment:

There is no compensation for participation in this study, participation is completely voluntary.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept securely locked when not in use. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at carol.jones1@waldenu.edu or by phone at 910-818-5048. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is [REDACTED]. Walden University's approval number for this study is 03-25-14-0141860 and it expires on March 24, 2015.

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of Consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix C: Consent Form

You are invited to take part in a research study of how primary prevention impacts domestic and intimate partner violence (DIPV) victims and perpetrators with mental illness or substance abuse related issues. The researcher is inviting licensed and provisionally licensed clinicians to participate in the study. Fully licensed clinicians with an unrestricted license and provisionally licensed clinicians who currently work or have worked with DIPV clients in the previous 12 months are eligible to be in the study. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Carol Jones, who is a doctoral student.

Background Information:

The purpose of this study is to explore and understand the impact of primary prevention on DIPV clients with mental health or substance abuse related issues.

Procedures:

If you agree to be in this study, you will be asked to:

- ☐ ____ participate in a 30 minute pre-interview session to review the purpose of the study, informed consent, respond to questions, and build rapport.
- ☐ ____ participate in a 45 minute interview to solicit your responses to semi-structured questions, and
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What are your thoughts about how primary prevention does/does not impact DIPV clients?

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This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, discomfort from sitting during the interview, and anxiety due to the topic of discussion. Being in this study would not pose risk to your safety or wellbeing. Benefits include understanding and preventing DIPV, and an overall increase in awareness of the negative effects of DIPV.

Payment:

There is no compensation for participation in this study, participation is completely voluntary.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept securely locked when not in use. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email at carol.jones1@waldenu.edu or by phone at 910-818-5048. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is [REDACTED]. Walden University's approval number for this study is 03-25-14-0141860 and it expires on April 8, 2016.

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of Consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix D: Research Question 1

Q 1: What are mental health clinicians' perceptions of positive influences from the NCCADV 10-year primary prevention plan on DIPV victims diagnosed with mental illness or substance abuse issues?

1. How has primary prevention influenced the mental health of your DIPV clients?
2. What prevention strategies do your DIPV clients have access to?
3. How has the NC 10-year plan impacted your DIPV clients with MH/SA?
4. How has exposure to prevention strategies impacted instances of reporting DIPV?
5. What are your thoughts about how primary prevention does/does not impact DIPV clients?
6. How does exposure to primary prevention influence DIPV victims with MH/SA issues?
7. What primary prevention do your MH/SA clients most refer to?
8. What would you recommend to stakeholders responsible for designing DIPV primary prevention?
9. How aware do you perceive your fellow clinicians are about the benefits or drawbacks of the NCCADV 10-year primary prevention plan?
10. Is there a question I did not ask that you wished I had asked?
11. Do you have any other comments to add before we close this session?

Appendix E: Research Question 2

Q2: What are mental health clinicians' perceptions of the NCCADV 10-year primary prevention plan in preventing further mental illness and substance abuse of DIPV victims?

1. What impact has primary prevention had on the number of DIPV cases?
2. What specific prevention strategies have helped your DIPV clients?
3. How has your DIPV clients responded to interventions?
4. Has there been an increase or decrease in DIPV awareness?
 - a. To what do you attribute this increase/decrease?
 - b. What specifics have clients reported?
5. What prevention strategies have your clients reported were most helpful?
6. Has there been any evidence or instances of DIPV resulting from exposure to primary prevention?
7. Based on your involvement with DIPV clients with MH/SA issues has exposure to primary prevention benefited or harmed clients?
8. What is your understanding of primary prevention?
9. Are there primary prevention strategies identified by your agency that you have found successful or unsuccessful?
10. Is there a question I did not ask that you wished I had asked?
11. Do you have any other comments to add before we close this session?