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Safety Planning: Self-Management Approaches for Intimate Partner Violence in Ohio

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,

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Abstract

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MPH, Cleveland State University, 2012

MSW, Cleveland State University, 2010

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Education & Promotion

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Abstract

Intimate partner violence (IPV) is a global health education and promotion burden that has affected one in four women in the United States between the ages of 18-24, who are at increased risk of subsequent negative health outcomes of sexually transmitted inflections, mental health and substance abuse disorders, exacerbated suicidal ideations, and death. Exploring the health education needs and learning preferences of women affected by IPV who have utilized self-management strategies during safety planning interventions was the purpose for this phenomenological qualitative study and aligned the four research questions. SurveyMonkey was used to conduct interviews of 30 women align with a semi structured interview guide with open-ended questions. The data were thematically analyzed with Braun and Clarke's six step framework. The socioecological model was used to frame and ground the study. The results revealed five core themes: (a) Develop safety plan with a counselor who can relate; (b) Therapy facilitated accountability, behavior changes, and assisted with negative consequences of IPV; (c) Law enforcement facilitated linkage to other services and the negative consequences of IPV; (d) Lack of public awareness campaigns on IPV; and (e) Behavioral health workers promoted utilization of self-management techniques. Recommendations include conducting future research of the impact peer administered supports have when providing care to women affected by IPV. The results can promote positive social change by implementing evidenced based practices, such as teach back, targeted at providers to promote clear communications to influence safety planning interventions.

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Dedication

This research is dedicated to the generation of women who currently feel, or at one time felt, hopeless and alone in their journey. Generational curses must be broken, and women must be empowered to make informed decisions for healthier lifestyle choices. These decisions will teach future generations that intimate partner violence is never an option.

Acknowledgments

I am profoundly grateful for the opportunity to be guided by my chair, Dr. Linnaya Graf. Her compassion for the subject matter on IPV is immeasurable as well as the dedication to my work has been invaluable to my success. Also, I would like to thank my committee member, Dr. Carol Spaulding, and my URR reviewer, Dr. John Saison, for consistently ensuring that I present quality level doctoral work. I could not have accomplished any of this without the village that this team created.

Lastly, to my daughter, Meaghan Symone, you are the best gift that God has ever given me. Thank you for consistently telling me that you are proud of me. I am so proud of you and the woman that you have become.

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Chapter 1: Introduction to the Study

Intimate partner violence (IPV) is a preventable burden that has the potential to produce harmful, chronic health outcomes for women (Alvarez et al., 2017; Cadihac et al., 2015; Centers for Disease Control and Prevention [CDC], 2018; Childress et al., 2018; Doyle & Aizer, 2018; Holmes et al., 2018; Michaels-Igbokwe et al., 2016; O'Neal & Beckman, 2017; Sabri et al., 2019; World Health Organization [WHO], 2017). Women affected by IPV have been reported to be at an increased risk for recidivism of violence (Ali & McGarry, 2018; Niolon et al., 2017). IPV has also caused deaths, injuries, miscarriages, mental health disorders, and contributed to chronic diseases and permanent dysfunction (Ali & McGarry, 2018; Alvarez & Fedock, 2018; CDC, 2018; Finfgeld-Connett, 2017; Goncalves & Matos, 2016; Hamberger et al., 2017; O'Neal & Beckman, 2016; Hamberger et al., 2015; WHO, 2017).

As a fundamental violation of human rights, IPV represents one of the most prevalent types of domestic violence and abuse (Ali & McGarry, 2018; Kirk et al., 2017). At the national level, more than one in four women in the United States has experienced severe physical violence by an intimate partner (Kirk et al., 2017; Websdale et al., 2019). Women affected by IPV commonly experience this type of violence between the ages of 18-24 (Truman & Morgan, 2014). An important step in addressing this phenomenon was to determine what prevention and intervention efforts appeared to be effective with women affected by IPV. Although there was empirical literature supporting tertiary prevention as an intervention aiming to prevent the chronic and harmful effects associated with IPV, as well as prevent death and disability, there remained a gap in the

literature on an evidenced-based practice for safety planning intervention methods (Ellsberg et al., 2015; Hackett et al., 2016; Hegarty et al., 2016; Kirk et al., 2017; Logan & Walker, 2018; Messing et al., 2015; Murray et al., 2015). An identified pathway appropriate for tertiary prevention among women affected by IPV is health literacy (Kirk et al., 2017), as research has supported a correlation between women's health literacy skills and health outcomes (McCormack et al., 2017).

The current study applied the health education and promotion model of tertiary prevention in a phenomenological exploration of the lived experiences of women affected by IPV to provide insight into their health education needs and learning preferences using self-management strategies during safety planning interventions. Safety planning is a method that has assisted women affected by IPV in identifying healthy ways to decrease their exposure to further harm and address various fears and anxieties (Logan & Walker, 2018; Parker et al., 2016). Self-management strategies are done to improve quality of life, optimize health outcomes, and reduce health care costs while living with chronic conditions (CDC, 2016; Jonkman et al., 2016; Lorig & Holman, 2003; Sawin et al., 2017). Women affected by IPV have an obligation to actively take responsibility in their interventions and/or plan of care (Lorig & Holman, 2003; Sawin, 2017). Self-management skills include, but are not limited to, symptom management, adherence to treatment regimes, commitment to appropriate behavioral changes and the ability to deal with the psychological and physical consequences of IPV. Symptom management skills include psychoeducation and relaxation techniques (Shah et al., 2014), which can be used after a traumatic event (Warshaw et al., 2013; Wessely et al., 2008). But there is a lack of

empirical knowledge on best practices and protocols in safety planning with women affected by IPV.

Chapter 1 will review the purpose and the background of this phenomenological study, the problem statement, the conceptual framework, and the four research questions of the study. Next, the chapter will review the nature of the study, provide operational research definitions for the terms IPV, safety planning interventions, tertiary prevention, physical, sexual, and psychological IPV, health literacy, and self-management. Finally, Chapter 1 will conclude with the assumptions, scope and delimitations, limitations, and the significance of the study.

Background of the Study

As defined by the CDC (2018), the WHO (2017), and the American Psychological Association (2015), IPV is the intentional use of force, threatened or actual, that either resulted in or had a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. In women, the consequences of IPV include subsequent negative health outcomes such as deaths, injuries, miscarriages, mental health disorders, and chronic diseases and permanent dysfunction (Ali & McGarry, 2018; Alvarez & Fedock, 2018; Burelomova et al., 2018; CDC, 2018; Finfgeld-Connett, 2017; Goncalves & Matos, 2016; Hamberger et al., 2017; Hamberger et al. , 2015; Heyman et al., 2015; O'Neal & Beckman, 2016; WHO, 2017).

Evidence that IPV is a current burden includes statistics at the national level that indicated more than one in four women in the United States have experienced severe physical violence by an intimate partner (Kirk et al., 2017; Websdale et al., 2019). The

National Center for Injury Prevention and Control (2017) also estimated that domestic violence hotlines received close to 20,000 calls daily. This is a national problem, but specific states experienced disproportionate rates of IPV reports as well. The Ohio attorney general (2017) recorded 37,725 domestic violence dispute calls. Beyond disparities at a state level, there were further disparities identified at the city level. Ohio has six cities (Columbus, Cleveland, Cincinnati, Toledo, Akron and Dayton) with a population greater than 100,000 people, of which Cleveland had the highest mean rate of partner violence (World Population Review, 2019). In 2017, the Ohio Bureau of Criminal Identification and Investigation recorded 1,716 domestic violence charges filed with the Cleveland Police Department (Ohio attorney general, 2017). These statistics demonstrate that IPV is a relevant topic for study, as women affected by IPV are at an increased risk for recidivism of violence (Ali & McGarry, 2018; Logan & Walker, 2018).

Tertiary prevention is a health education and promotion intervention aimed to prevent the harmful effects associated with IPV (CDC, 2015), but there is a lack of empirical literature on an evidenced-based practice safety planning intervention method (Ellsberg et al., 2015; Hackett et al., 2016; Hegarty et al., 2016; Kirk et al., 2017; Logan & Walker, 2018; Murray et al., 2015). Tertiary prevention programs and services are essential for mitigating the short and long-term consequences of IPV among women as well as reducing the violence related health burden across the life span (Arroyo et al., 2017; Breiding et al., 2014). But there is a need for improved tertiary prevention interventions to serve women affected by IPV through addressing factors that cause health compromising behaviors (Trujillo et al., 2014). This study was needed in the field

of health education and promotion, as the data collected from this study contributes to understanding how the health literacy intervention of self-management influenced the health education needs and learning preferences of women affected by IPV. Best practices and protocols in safety planning with women affected by IPV was needed at the societal level, as they influence policies and procedures addressing outcome measures for women affected by IPV during safety planning interventions.

Problem Statement

IPV is not only a fundamental violation of human rights of women (Ali & McGarry, 2018; Kirk et al., 2017) but is a preventable, global burden that produces chronic health outcomes for women affected by IPV (Alvarez et al., 2016; Cadihac et al., 2015; CDC, 2018; Childress et al., 2018; Doyle & Aizer, 2018; Holmes et al., 2018; Michaels-Igbokwe et al., 2016; O'Neal & Beckman, 2017; Sabri et al., 2019; WHO, 2017). The problem addressed in this study was that there is a lack of knowledge of the self-management interventions used at the time of safety planning that have influenced the health education needs and learning preferences of women affected by IPV in Ohio. A safety plan is a personalized, detailed document that outlines safety strategies that women use to promote their safety across a myriad of situations (Murray et al., 2015). IPV safety planning interventions are activities offered to women affected by IPV that identify strengths and coping strategies, building support to access community resources and reducing risks for exposure to harm, associated fears, anxiety and emotional safety issues (Murray et al., 2015; Rizo, 2016). Though a new skill for many women affected by IPV to master, self-management strategies can empower and prepare them to manage

their health such as goal setting, action planning, and problem solving (Mackey et al., 2016). Exploring the health education needs and learning preferences of women affected by IPV is crucial when justifying the implementation of programs aimed at evidenced-based practice safety planning interventions.

This phenomenological study adds to the knowledge on what the health education needs and learning preferences of women affected by IPV using self-management strategies during safety planning interventions. Recent studies have demonstrated that although interventions continue to be used during safety planning, there is a lack of literature that supports an evidence-based practice and/or safety planning intervention (Hackett et al., 2016; Hegarty et al., 2016; Logan & Walker, 2018; Murray et al., 2015). The gaps in the literature were addressed in order to affect positive social change when implementing policies and procedures at the societal level to improve safety planning interventions for women affected by IPV. The current study applied the health education and promotion model of tertiary prevention in a qualitative exploration of the lived experiences of women affected by IPV to provide insight into their health education needs and learning preferences during safety planning interventions.

Purpose of the Study

The purpose of this phenomenological study was to explore the lived experiences of women affected by IPV who used the health literacy techniques of self-management as a health education and safety planning intervention. The study explored the health education needs and learning preferences of women affected by IPV that used self-management techniques of (a) being committed to behavioral changes, (b) willing to

adhere to treatment regimens discussed during safety planning interventions, and (c) describing strategies used to cope with the subsequent negative consequences of psychological and physical violence. Exploring the techniques through the lived experiences of women affected by IPV contributed to what is not known about how women coped with and move through their experiences of IPV with health education and safety planning interventions. Understanding their experiences can increase knowledge among community providers as to which self-management techniques are effective as well as help develop comprehensive policies and procedures in addressing the complex safety needs of women affected by IPV (Logan & Walker, 2018).

Research Questions

Research Question 1: What were the health education needs and learning preferences of women affected by IPV who were committed to behavioral changes during safety planning interventions?

Research Question 2: What were the health education needs and learning preferences of women affected by IPV who are committed to adhere to the treatment regimens discussed during safety planning interventions?

Research Question 3: How did women affected by IPV describe the strategies they used to cope with the negative consequences of psychological and physical violence?

Research Question 4: What were the lived experiences of women affected by IPV who used the health literacy technique of self-management as a health education and safety planning intervention?

Conceptual Framework

The use of theoretical frameworks helped researchers approach problems with a comprehensive perspective and best identified points of intervention (Alvarez et al., 2016; Grant & Osanloo, 2014). The theoretical framework used to ground this study was the socioecological model (SEM). Bronfenbrenner (1979) first introduced the SEM in the 1970s as a framework in qualitative studies that conceptualized how individuals were influenced by four levels which affected and defined principles of human behavior (Bronfenbrenner, 1979; CDC, 2017; Ma et al., 2017; Schölmerich & Kawachi, 2016; WHO, 2017). Bronfenbrenner's (1979) four levels of influence aligned with the purpose of the study, supported the research questions, as well as the operational definitions of the phenomenon of the study which anchored and guided the methods and analysis for this study.

The first level of influence is known as the individual level which examined the women's knowledge, attitudes, behavior, self-concept, and skills about IPV (Bronfenbrenner, 1979; CDC, 2017; Schölmerich & Kawachi, 2016; WHO, 2017). The second level of influence is known as the relationship level, which examined the formal and informal social network and support systems of the women (Bronfenbrenner, 1979; CDC, 2017; Eisenberg & Kleinman, 1980; Schölmerich & Kawachi, 2016; WHO, 2017). The third level of influence is known as the societal level of influence which examined the women affected by IPV social interactions with institutions and how those organizational rules and regulations affected women seeking support (Bronfenbrenner, 1979; CDC, 2017; Schölmerich & Kawachi, 2016; WHO, 2017). The fourth level of

influence is known as the community level of influence which examined the relationships among organizations, institutions and informal networks within boundaries that she defined as her community (Bronfenbrenner, 1979; CDC, 2017; Schölmerich & Kawachi, 2016; WHO, 2017).

There were two essential concepts of the SEM that should be considered: (a) the four levels of influence were used as a contextual lens that identified intervention points for promoting positive health outcomes for women affected by IPV (Glanz & Bishop, 2010) and (b) women affected by IPV both influenced and were influenced by those around them (Bronfenbrenner, 1979; CDC, 2017; Schölmerich & Kawachi, 2016; U.S. Department of Health and Human Services, 2010; WHO, 2017). Health education administrators have used the SEM that explored how the health literacy strategy of self-management was used to improve safety planning interventions with women affected by IPV (CDC, 2017; Schölmerich & Kawachi, 2016). Finally, the SEM was applied as a holistic approach to study women affected by IPV. More specifically, the SEM was used to guide the development of the open-ended interview questions for the phenomenological interview. This assisted with identification and understanding how IPV is experienced by women affected across the themes of the SEM level of influences. A more detailed explanation of the levels of influence and the SEM were illustrated in Chapter 2.

Nature of the Study

In determining an appropriate research and design method, the research questions drove the alignment of the design, measurement, analysis and reporting methods (Flick,

2018; Leedy & Ormrod, 2016; Patton, 2015; Simon & Goes, 2018). A phenomenological study design was appropriate which explored the health education needs and learning preferences of women affected by IPV that used the health literacy technique known as self-management during safety planning interventions (Flick, 2018; Simon & Goes, 2018). By examining multiple perspectives with the same phenomenon, I generalized what something is like from an insider's perspective (Leedy & Ormrod, 2016). The knowledge about how self-management strategies were perceived by women affected by IPV at the time services were being sought in the community were examined (Dao et al., 2019; Javadzade et al., 2018; Kokka et al., 2019). Understanding self-management techniques influenced safety planning interventions and improved women's ability to coordinate with community-based providers, enhanced understanding of discharge planning processes and further clarified expectations of women affected by IPV when safety planning (Logan & Walker, 2018).

The lived experiences of women affected by IPV was the phenomena being explored which provided insight into the health education needs and learning preferences of women affected by IPV using self-management strategies during safety planning interventions. The phenomenological approach selected for this study directed the process of data collection through in-depth, qualitative interviewing known as semi structured, open ended, individual interviews (Leedy & Ormrod, 2016; Simon & Goes, 2018). Purposive sampling was utilized to recruit 30 women affected by IPV that accepted to take part in the study from the social media platform of Facebook, the Walden Participant Pools and a social service agency in Cleveland, Ohio (Etikan et al.,

2017; Polit & Beck, 2017). This study also used an inclusion of snowball sampling, in the event I had difficulty in gaining the recommended number of participants for qualitative research (Leedy & Ormrod, 2016; Simon & Goes, 2018).

Individual interviews were captured within the SurveyMonkey research tool, then exported onto a Microsoft Excel spread sheet for organization and hand coded to reveal emergent themes surrounding the research questions. To yield meaningful and useful results from the transcribed interviews, a thematic data analysis method was conducted in a precise, consistent and exhaustive manner (Nowell et al., 2017). A rigorous thematic analysis was conducted which identified patterns or themes within the qualitative data that was useful in examining the diverse perspectives of the women affected by IPV, as well as produced trustworthy and insightful findings (Braun & Clarke, 2012; King, 2017).

Operational Definitions

Coercion: Various patterns and/or acts that involve assault, threats, humiliation and intimidation, or other abuse that is used to harm, punish, or frighten women affected by IPV (Ali & McGarry, 2018; Hamberger et al., 2017).

Health literacy: The degree to which women affected by IPV have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions (Geboers et al., 2018; Health Resources & Services Administration, 2017; WHO, 2016; CDC, 2017).

Intimate partner violence (IPV): Patterns of abusive and violent behaviors toward women affected by IPV that are coercive and/or controlling in nature, regulating the

woman's behaviors and depriving her of familial, community support, and independence as well as exploiting resources for personal gain. There are several forms of IPV such as physical, sexual, economic and psychological (Ali & McGarry, 2018; American Psychological Association, 2015; CDC, 2016; Choo, 2016; Gulina et al., 2018; Hamberger et al., 2017; Home Office, 2016; WHO, 2017).

Physical IPV: Physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes acts like throwing, grabbing, slapping, punching, using a weapon (gun, knife, or other object), and using of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts (CDC, 2016).

Psychological IPV: Use of verbal and nonverbal communication to harm or control. Psychological aggression is an essential component of IPV for several reasons. First, psychological aggression frequently co-occurs with other forms of IPV, and research has suggested that it often precedes physical and sexual violence in violent relationships. Second, acts of psychological aggression significantly influence the impact of other forms of IPV (e.g., the fear resulting from being hit by an intimate partner was likely be greater had the intimate partner previously threatened to kill the woman). Third, research has suggested that the impact of psychological aggression by an intimate partner is equally significant as that of physical violence by an intimate partner (CDC, 2016).

Sexual IPV: Sexual violence is defined as a sexual act that is committed or attempted by another person without the woman freely giving consent. It includes forced

or alcohol/drug facilitated as well as non-physically pressured unwanted penetration, intentional sexual touching, or non-contact, sexual acts. Sexual violence also occurs when a perpetrator forces or coerces a woman to engage in sexual acts with a third party (CDC, 2016).

Tertiary prevention: The implementation of policy and legislative changes as well as interventions focused on eliminating the chronic and harmful effects of IPV (CDC, 2017; Garcia-Moreno et al., 2017; Kirk et al., 2017; WHO, 2017).

Assumptions

Assumptions are circumstances accepted as plausible and/or true by myself as well as the community of health education and promotion professionals who read the paper and assume that certain aspects of the study were true given the phenomena of study (Simon & Goes, 2018). These assumptions were necessary to conduct the study (Simon & Goes, 2018). In this phenomenological study, it was assumed that the women answered interview questions and shared their lived experiences as truthfully as possible (Merriam & Tisdell, 2015). To address those assumptions, the women were informed that the study was voluntary, and they could withdraw at any time. Another way to address this assumption was to assure confidentially, which was outlined in the informed consent form. Next, it was assumed that women in the study were affected by IPV. To facilitate this, eligibility screenings were completed online by the participants.

Scope and Delimitations

There has been a lack of empirical data on the health education needs and learning preferences of women affected by IPV who sought support in the community, their

coping and resiliency strategies, and their experiences of how they used self-management strategies as a health education and safety planning intervention. To fill this gap in literature, this study addressed those concerns through a qualitative approach. Women affected by IPV were recruited from domestic violence social media platforms on Facebook, the Walden participant pools, and a social service agency in Cleveland, Ohio. Women were made aware of the study through a flyer, which provided the SurveyMonkey linked to the semi structured interview questionnaire used as the data collection method.

Delimitations are a set of circumstances that explain boundaries of research and limited the scope of the study, which are within researchers' purview (Simon & Goes, 2018). The study explored the gap in the literature of the health education needs and learning preferences of women affected by IPV when they used self-management strategies during safety planning interventions. In this study, purposive and snowballing sampling were used to sample women affected by IPV who met the five eligibility criteria: (a) female, (b) 18 years of age or older, (c) violence occurred six months ago or longer, (d) resided in Ohio, and (e) could read and write English. Another delimitation of this study was the choice to focus on women affected by IPV as opposed to other groups that experienced this same phenomenon.

Limitations

Limitations are possible weaknesses or constraints in the study that were out of my control, which would threaten the internal validity (Creswell & Guetterman, 2018; Simon & Goes, 2018). A limitation identified in this phenomenological research was the

use of a small purposive sample. To mitigate this limitation, snowball sampling was used to recruit additional women. A second limitation of this study was that the women had difficulty and/or were reluctant in sharing their lived experiences of trauma (Merriam & Tisdell, 2016). To mitigate this limitation in the data collection process, online interviews were conducted. The online interview incorporated language that advised the women that participation in the study was voluntary, and all data were collected without identifiers. A final limitation identified was researcher bias. To mitigate this limitation, I incorporated strategies such as expert review, a reflective journal (Ortlipp, 2008), and SurveyMonkey as the research tool, which organized and maintained the collected data. Mitigating researcher bias is further discussed in Chapter 3.

Significance

This research is significant to the discipline of health education and promotion, as it provides insight into best practices for crafting sound interventions, services, and health education tools aligned with the needs of women affected by IPV from their own life experiences and perspectives. Understanding the experience of safety planning interventions and how self-management techniques were utilized from the perspective of the population being served is a core tenet for health education and promotion services development (Colvin et al., 2016; Hackett et al., 2016; Hegarty et al., 2016; Logan & Walker, 2018; Murray et al., 2015). Safety planning is one practice used with women affected by IPV (Logan & Walker, 2018). Interventions guided by theory are empirically supported as more effective than those without a theoretical foundation (Glanz & Bishop, 2010). Insights from this study can improve how women affected by IPV experience

evidence-based tools during safety planning by leading to changes health education and promotion practices for safety planning interventions. Increased understanding of effective self-management interventions thus contributes to positive social change by improving health outcomes for women affected by IPV. Hence, the implications for positive social change include an impact on best practices to service providers in understanding the health education needs and learning preferences of women affected by IPV when they sought services in the community.

Summary

Chapter 1 began with a description of the phenomenon of the study and the rationale to support the research. In addition, Chapter 1 presented the conceptual framework used to guide the study and reviewed the research questions and the operational definitions. Finally, the chapter concluded with a discussion on the assumptions, limitations, and delimitations of the study; the potential social implications; and the significance of the research. Chapter 2 will provide a comprehensive review of the literature related to IPV in addition to a review of the conceptual framework.

Chapter 2: Literature Review

IPV represents one of the most prevalent types of domestic violence and abuse (Ali & McGarry, 2018; Kirk et al., 2017). The purpose of Chapter 2 is to provide a comprehensive review of the empirical literature related to the prevalence, incidences, and effects of IPV. Next, the chapter will review the conceptual framework, the four levels of influence, and the evolution of the term IPV. In addition, Chapter 2 will highlight the five categories of IPV, barriers to recovery, economic issues, the three levels of IPV interventions and safety planning. Lastly, the complexities and multidimensional phenomenon of IPV with both its global and domestic prevalence, coupled with the subsequent negative health outcomes effecting women affected by IPV. In addition, literature will present self-management as a tertiary prevention strategy for this population of women. Lastly, the chapter will identify gaps in the literature related to best practice interventions for IPV. The following section includes search strategies on how peer-reviewed articles were acquired as well as the inclusion and exclusion criteria.

Literature Search Strategy

Peer-reviewed articles were obtained through the virtual Walden University Library as well as Google Scholar. Research was conducted utilizing 11 electronic databases: ProQuest Central, Social Science Citation Index, PsycINFO, SocINDEX full text, MEDLINE, Nursing & Allied Health, Directory of Open Journals, CINAHL Plus with full text, SAGE full text collection, Educational Resource Information Center (ERIC), and EBSCO. The scope of the literature included scholarly works published between 2014 and 2020, not including published work of seminal researchers on IPV,

health literacy and the SEM. Phrases and keywords entered into the Boolean search engine included *intimate partner violence or battering, or domestic violence or abuse or violence against women, and women's' health, or health literacy, or low health literacy, or patient education, or health education strategies, or safety planning, or interventions, and stress management, and socioecological,* and *chronic diseases*. Credible, scholarly literature reviews were located, and a literature review matrix was utilized to organize the results of the search.

The criteria used for inclusion of an article in the literature review was related to women affected by IPV; their safety planning intervention needs and/or preferences; the various types, costs, and harmful effects of IPV; and health education and promotion models of prevention. Other articles met the inclusion criteria if they discussed health literacy, self-management techniques, and the SEM. An article was excluded if it did not explore interventions for women affected by IPV. Articles using the terminology of screening were not included in the literature review. Although screening was a valuable technique used by health education and promotion professionals in the field to detect IPV, it did not meet the operational definition of safety planning intervention. Lastly, articles not written in English or peer reviewed were excluded from the literature review. The review of pertinent literature began by examining the conceptual framework of the SEM which was used to ground this study. Articles older than 5 years were included if they were key articles to the seminal work for models, theories, or IPV development. Further, these articles were limited to citation in the conceptual framework and historical literature section. All other articles were limited to 2015 and more recent.

Conceptual Framework

Health education and promotion professionals use test models known as theoretical frameworks to approach the concepts which answered the who, what, when and why of health concerns from a holistic perspective when treating women affected by IPV (Alvarez et al., 2016). Bronfenbrenner (1979) was a key theorist who first introduced the SEM as a conceptual framework to understand human development, which was built on the premise that there are five spheres of influence—intrapersonal factors, interpersonal processes, institutional factors, community factors, and public policy—that affect behavior of individuals through vast dynamics and complex interactions (Bakhtari et al., 2019; CDC, 2015; Kilanowski, 2017; Lee et al., 2017; Scholmerich & Kawachi, 2016; WHO, 2017).

Over the past five decades, the theoretical approaches of the SEM have been modified (Bronfenbrenner, 1979; Carlson, 2010; CDC, 2017; Heise, 1998, 2011) in an attempt to comprehend the complexities of IPV and the levels of influence. Heise (1998, 2011) is one theorist who contributed to modifications of the SEM, examining the etiology of the risk and protective factors related to IPV. In contrast to the first SEM introduced by Bronfenbrenner (1979), the Heise model influenced health education and promotion programming surrounding gendered based violence outlining how IPV is influenced by a complex array of interconnected factors represented by four levels of influence: (a) individual, (b) relationship, (c) community, and (d) macro-social (societal) levels (Bakhtari et al., 2019; CDC, 2017; Fulu & Miedema, 2015; Heise, 1998, 2011; Kilanowski, 2017; McCormack et al., 2017; Yakubovich et al., 2018).

Previous researchers have used the SEM to examine different topics related to IPV and women's health. Judge et al. (2018) utilized the SEM to identify barriers to engagement when providing services to human trafficking women affected by IPV (see also Gibbs et al., 2015). In another study, Bakhtari et al. (2019) used the SEM to explore what factors were considered by Iranian women when choosing their method of deliver at the time they give birth. A convenience sample of 530 Iranian women were recruited from a prenatal center to take the Childbirth Experience Questionnaire (Dencker et al., 2010), which was used to measure women's fears surrounding giving birth, and the Iranian Childbirth Self Efficacy Inventory (Khorsandi et al., 2008), which was used to gain an understanding of women's feelings about their ability to give birth vaginally.

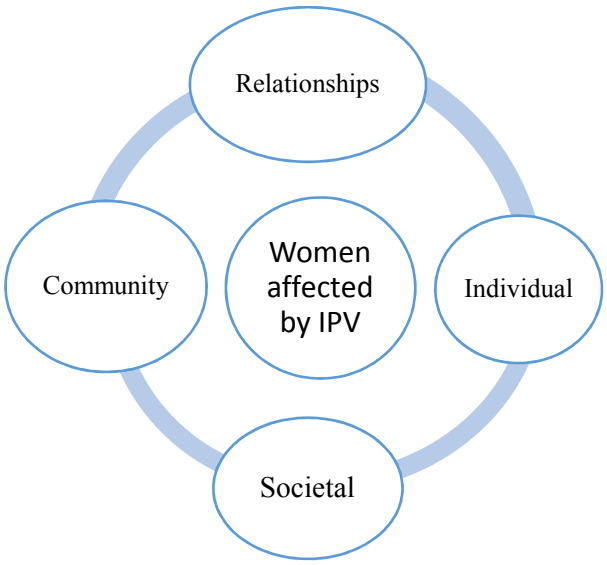
As a frequently used model by health education and promotion organizations like the CDC (2016) and the WHO (2017), the SEM was chosen to support this research by providing a comprehensive framework that explored how factors at the intrapersonal, interpersonal, organizational, and social levels affected behaviors of women affected by IPV, improved health outcomes, increased patient engagement, influenced the delivery of health education dissemination, and encouraged the development of self-management interventions (CDC, 2017; Dao et al., 2019; Heise, 1998/2011; Kilanowski, 2017; McCormack et al., 2017; Schoelmerich & Kawachi, 2016; WHO, 2017). The assumptions were that women affected by IPV had behavior changes that empowered them to identify self-management techniques that improved decision making abilities and quality of life outcomes when influenced by one or more levels of influence at the time of safety planning. The SEM was utilized to hypothesize what level of influence allowed the

women to describe their coping and resiliency strategies when they received services. The model was used to identify and implement best practice intervention ideas that promoted positive health outcomes for women affected by IPV and women affected by IPV both influenced and were influenced by those around them (CDC, 2017; McCormack et al., 2017; Toback, 2017; U.S. Department of Health and Human Services, 2010).

An example of a SEM specific to IPV (see Figure 1) illustrates the concept under study. This model demonstrates the connectiveness of a woman and her environment. The radial cycle graph emphasizes that both the woman affected by violence, which is in the center circle, and the four levels of influence represent by the outer rings highlighted the connectedness of the woman's behavior.

Figure 1

The Socioecological Model



Individual Level of Influence

There were multiple factors that influenced the behaviors of women affected by IPV. The first level or system of influence of the SEM is referred to by terms such as intrapersonal, ontogenic, or individual level (CDC, 2017; Cerulli et al., 2015; Sabbah, Chang, & Campbell-Heider, 2017; WHO, 2017). For purposes of this research, this level was referenced to as the individual level of influence. Individual risk factors for IPV include low self-worth, age, low income, low academic achievement, marital status, substance use and behavioral health disorders, impulsivity, and prior history of abuse that exacerbated the violence (CDC, 2017; Cerulli et al., 2015; O'Neal, Beckman, 2017; Yakubovich, et al., 2018). Biological and personal risk factors also increase the incidence rate of remaining or becoming affected by IPV (CDC, 2017; McCormack et al., 2017). This level can influence women's knowledge, health beliefs, fatalism, perceptions of risk and benefit, values and preferences for level of involvement, attitudes, behavior, self-concept, and self-management skills involving IPV (Bronfenbrenner, 1979; CDC, 2017; McCormack et al., 2017; WHO, 2018).

Socioecological assessments of women affected by IPV identified correlations between the social environment and maladaptive behaviors, which produced negative health outcomes (WHO, 2017). Health education and promotion interventions at the individual level have used a variety of strategies that improved women's understanding of educational content, which included use of plain language communication principles, decision aids, IPV health education sessions, teach back techniques, support groups and/or peer administered counseling, and asked related questions to ensure

comprehension (McCormack et al., 2017; National Adult Literacy Agency, 2016; Toback, 2017). Additional prevention strategies at the individual level include promoting education and life skills training for women affected by IPV, which improves their ability to deal effectively with the demands and challenges of everyday life (WHO, 2017). For an individual intervention to be effective, this level of influence is directed at changing the woman's knowledge about IPV and examining her attitudes, skill level, and willingness to comply with and/or adapt new behavioral norms (Eisenberg & Kleinman, 1980; Ferranti et al., 2018; McCormack et al., 2017).

Relationship Level of Influence

The second level of influence is referred to by terms such as interpersonal, microsystem, or relationships level (CDC, 2017; Cerulli et al., 2015; McCormack et al., 2017; Sabbah et al., 2017; WHO, 2017). For purposes of this research, the second level was referenced to as the relationship level of influence. Women affected by IPV demonstrate a higher susceptibility to risk factors at this level of influence when involved in unhealthy family relationships and associations with antisocial and aggressive peers or partners (Cerulli et al., 2015). Women's concerns relate to involving friends or family in their safety plan because they may be in danger from the perpetrator (Bacchus et al., 2016), but relationships that women possess are influences in the decision to visit a physician or leave the perpetrator (Eisenberg & Kleinman, 1980; McCormack et al., 2017). Other influences that impact a woman's risk factors include social isolation and/or lack of social support systems and being involved with those who exhibit jealousy, possessiveness, and negative emotions within an intimate relationship (CDC, 2017;

Cerulli et al., 2015). Women are impacted when the perpetrator prevents them from accessing needed health care services, which contributes to various negative health outcomes; however, their social circle of peers, partners, coworkers and family members influence their behavior and contribute to level of risk and range of violent experiences (Barrera, 1986; Bronfenbrenner, 1979; Heise, 1998, 2011; O'Neal & Beckman, 2017). Enhancing the interpersonal skills of health education and promotion professionals with increased staff training, an electronic medical record system, and a team-based approach and care coordination model can prompt women to acquire further treatment services and healthy support systems (McCormack et al., 2017). Additional prevention strategies at this level encompass having women link to family focused prevention programs, mentoring and peer administered programs designed to teach conflict resolution skills (WHO, 2017).

Community Level of Influence

The third level of influence is referred to by terms such as institutional, organizational, exosystem, or community level (CDC, 2017; Cerulli et al., 2015; McCormack et al., 2017; Sabbah et al., 2017; WHO, 2017). For purposes of this research, the third level was referenced to as the community level of influence. This level of influence addresses the community's perception of IPV as well as how the community's perceptions impact women affected by IPV (Breiding et al., 2015; Bronfenbrenner, 1979; CDC, 2017; McCormack et al., 2017; Murray et al., 2015; WHO, 2017). This level addresses the woman's settings such as schools, workplaces, and neighborhoods in which social relationships occurred and sought to identify the characteristics that were

associated with her experiences of IPV (WHO, 2017). Women affected by IPV are increasingly be impacted at this level than any other levels of the SEM, as women have experienced lack of support from either law enforcement officials and the criminal justice system (Murray et al., 2015; O'Neal & Beckman, 2017). Therefore, health care systems have encouraged the development of a systems approach that examines current processes, infrastructure that protects the confidentiality of women affected by IPV, and policies that hinder seeking treatment (Lee et al., 2017; McCormack et al., 2017; WHO, 2017). Women affected by IPV are also influenced by various social determinants of health in communities like poverty, underemployment, lack of employment opportunities, and lack of access to services (Reeves & Humphreys, 2018; Yakububovich et al., 2018).

Societal Level of Influence

The fourth level of influence is referred to by terms such as societal, macrosystem, or the public policy level (CDC, 2017; Cerulli et al., 2015; McCormack et al., 2017; Sabbah et al., 2017; WHO, 2017). For purposes of this research, this level was referenced to as the societal level of influence. The societal level was described by Bronfenbrenner (1979) as the level that influenced women through various local, state, and national laws and policies on IPV (CDC, 2017; Fulu & Miedema, 2015; Heise, 2011). This outer level of influence addresses society and political influences that have caused stigma, affected the woman's health, and led to any other form of discrimination (McCormack et al., 2017). Women are influenced by societal factors such as health care as well as economic, educational, and social policies that affect how their needs are met (Fulu & Miedema, 2015; McCormack et al., 2017; Reeves & Humphreys, 2018). In

addition, this level of influence aids in facilitating opportunities for women affected by IPV by examining economic or social inequalities that affect equitable distribution of services and resources (Ragavan, 2017).

In conclusion, the SEM was used as the conceptual framework for this study as it was applied to interventions and advocacy efforts as a holistic approach to address the subsequent negative health outcomes associated with IPV (Choo, 2016). The SEM assisted in the development of the research questions and the semi structured interview guide. Health education and promotion advocates have explored the needs and learning preferences of women affected by IPV. The SEM levels of influence increased the understanding of in what way self-management techniques improved treatment outcomes by understanding the barriers associated with IPV. Next, it was vital to develop and implement supportive relationships with women affected by IPV in the community, which were opportunities to teach self-management strategies during services they received (Choo, 2016; Ragavan, 2016). In the subsequent section, historical and contemporary views of IPV are discussed in detail.

Evolution of the Term Intimate Partner Violence

Historical

IPV has spanned for centuries. Historically, IPV was referred to as battering, wife beating, domestic violence, domestic abuse, spousal abuse, and domestic assault (CDC, 2017; Goncalves & Mato, 2016; Hegarty et al., 2016; McCormack et al., 2017; Reeves & Humphreys, 2018). Previous studies defined the historical context of IPV as a set of justified, traditional, community values led and ordained by a patriarchal society in which

women were thought of as inferior, targeted, and subjected to spousal correction, public executions, whippings, and mutilation (Amussen, 1994; Anderson & Zinsser, 1988; Davis, 1971; Fox, 2002; Lentz, 1999; McIntosh, 2012). One tradition that justified violence against women was known as the rule-of-thumb doctrine, which allowed husbands to chastise their wives with rods no bigger than her husband's thumb (Lentz, 1999). During medieval times, IPV was socially accepted to resolve conflict between a husband and wife and was described as commonplace (Kienzle & Nienhuis, 2005; McIntosh, 2012). Perpetrators and leaders of the medieval church also used Christian theological principles that men were the masters of the home, and women were to be obedient and endure pain and anguish as a way to share in Christ's suffering (Finfgeld-Connett, 2017; Fulu & Miedema, 2015; Kienzle & Nienhuis, 2005; O'Neal & Beckman, 2017; Sabbah et al., 2017). Historically, any form of interventions against violence, failing to fulfil marital duties, escape, or attempting to seek refuge in monasteries were met with banishment from the village and in some cases death (Kienzle & Nienhuis, 2005; McNamara, 1987; Weisberg, 2019).

Contemporary

This section presents a contemporary view of IPV, which demonstrates how the term originated and evolved. Understanding rates of IPV is important due to the extensive effects and outcomes associated with this health education and promotion burden. Globally, IPV has not only been described as the most common form of violence and human right violation perpetrated against women, it is the leading cause of death and maladaptive disorders among women (CDC, 2016; Chmielowska & Fuhr, 2017; Choo,

2016; Ellsberg et al., 2015; Ford-Gilboe et al., 2017; Goncalves & Mato, 2016; Hegarty et al., 2016; McCormack et al., 2017; Reeves & Humphreys, 2018; Sumner et al., 2015; Yakubovich et al., 2018). It is estimated that the prevalence of this health education and promotion burden globally represented 70% of women (Finfgeld-Connett, 2015a; Goncalves & Matos, 2016; Kirk et al., 2017; Reeves & Humphreys, 2018; Yakubovich et al., 2018).

National statistics on IPV reported one in four women have experienced some form of severe physical violence by an intimate partner in her lifetime (Breiding et al., 2015; Kirk et al., 2017; Websdale et al., 2019; WHO, 2017). Women affected by IPV commonly experienced this type of violence between the ages of 18-24 (Truman & Morgan, 2014). The National Center for Injury Prevention and Control (2017) estimated that domestic violence hotlines received close to 20,000 calls daily. In 2017, The State of Ohio received 37,725 domestic violence dispute calls (Ohio attorney general, 2017). With a population greater than 100,000, Cleveland, Ohio had the highest mean rate of partner violence as illustrated by The Cleveland Police Department reported 1,716 domestic violence charges being filed in 2017 (Ohio attorney general, 2017). In the subsequent section, the categories of IPV were discussed in detail.

Categories of Intimate Partner Violence

IPV encompassed patterns of abusive and violent behaviors that were coercive and/or controlling in nature which often resulted in regulation of the women affected by IPV behaviors that reduced them to a state of subordination, isolation, deprivation of familial, community support, and independence, as well as exploited their resources for

personal gain (Ali & McGarry, 2018; CDC, 2016; Choo, 2016; Hamberger et al., 2017; Home Office, 2016; WHO, 2017). Coercion referred to various patterns and/or acts involving assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten women affected by IPV (Ali & McGarry, 2018; Hamberger et al., 2017). Women experienced these forms of severe maltreatment and found difficult and/or embarrassment when they accessed help (Alvarez & Fedock, 2018; Logan & Walker, 2018) Five categories of IPV were examined in this study: psychological, financial/resource abuse, verbal, sexual and physical IPV (Ali & McGarry, 2018; Breiding et al., 2015; Finfgeld-Connett, 2017; García-Moreno et al., 2015; Goncalves & Matos, 2016; Hamberger et al., 2017; Ragavan, 2017). It should be noted that the patterns of abusive and violent behaviors often overlapped from one category to the other.

Physical

Studies conducted revealed that women continued to be the primary target of violence (Choo, 2016). Any physical forms of assault causing harm to women is known as physical IPV. Examples of physical IPV included beating, throwing objects, pushing or throwing her down steps, kicking, slapping, punching, denying access to food, burning the woman with various objects and/or with the use of an accelerate, holding her down, hair pulling, shoving, dragging, biting, stabbing, scratching, choking, hitting, and the use of a gun, knife or any other weapon to cause physical harm (Ali et al., 2016a; Breiding et al., 2015; CDC, 2018; Ferranti et al., 2018; Garcia, 2015; Joint Commission, 2018; Kalokhe et al., 2015; McCormack et al., 2017; Olff, 2017; Reeves & Humphreys, 2018; WHO, 2017).

Financial

Although physical forms of IPV continued to dominate the reports at a global level and in the media (Goncalves & Matos, 2016), financial abuse was identified as an invisible form of maltreatment against women affected by IPV (Kalokhe et al., 2015; O'Neal & Beckman, 2017; Postmus et al., 2015; Postmus et al., 2018; Ragavan, 2017). Financial abuse was commonly referred to as economic abuse and the terms were used interchangeably in research (Kalokhe et al., 2015). For purposes of this study, the term financial abuse was used to describe another form of abuse that perpetrators used to control a woman and keep her financially dependent and socially isolated (Ali & McGarry, 2018; King et al., 2017). Financial abuse was defined as deliberate patterns of behaviors that controlled, exploited and/or sabotage used against women to undermine her economic resources which included current or future employment opportunities (Choo, 2016; Daoud et al., 2016; Ferranti et al., 2018; Goncalves & Matos, 2016).

Financial abuse took various forms such as taking or breaking her phone or computer, disabling her mode of transportation, taking her keys and/or purse, making her quit her job, running up substantial debts and sabotaging her efforts to go to school or work (Bacchus et al., 2016; Kalokhe et al., 2015; King et al., 2017; Valentine & Breckenridge, 2016). Research offered insight that financial abuse lead to housing insecurity by damaging property or not making the rent or mortgage payments by reducing access to savings and assets (Daoud et al., 2016; Ferranti et al., 2018; Valentine & Breckenridge, 2016). In addition, women also reported food insecurities and lacked

proper nutrition through denial of access to fresh foods (Choo, 2016; Ferranti et al., 2018).

Psychological

Psychological IPV was categorized as two forms of maltreatment known as emotional and verbal abuse directed toward women affected by IPV (Brownell, 2015; Kokka, 2019). As with any of the other forms of maltreatment, this category presented overlaps of abuse which included threatening the family, friends and/or pets of the woman, as well as coerced her to submit to the perpetrator's requests (Ali & McGarry, 2018; Ferranti et al., 2018; Kalokhe et al., 2015; WHO, 2017). Other examples of psychological IPV included denying or restricting access to physicals, wellness exams, and/or social services that eliminated the violence and remove the perpetrator's control (Ali & McGarry, 2018; Ferranti et al., 2018). Women affected by IPV also reported neglect of physical or emotional needs, accusations of affairs, making her account for time away from the home, criticizing her friends, family or peers, monitoring her conversations, blaming and/or undermining her authority in front of the children (Bacchus et al., 2016; Finfgeld-Connett, 2017; Olff, 2017). Research conducted by Bacchus et al., (2016) revealed that women affected by IPV felt as if they were prisoners in their homes because the perpetrator watched and accounted for all their movements.

Verbal

The CDC (2017) and The WHO (2016) defined verbal abuse as any remark made to or about the woman effected by violence, which reasonably was perceived to be demeaning, disrespectful, humiliating, intimidating, racist, sexist, homophobic, ageist or

blasphemous. Additional examples of verbal abuse took the forms of consistently blaming her for problems in the relationship, making sarcastic remarks, using a condescending tone of voice or using excessive and unwanted familiarity (CDC, 2017; Howells-Johnson, 2000; UKCC, 2002). Other forms of verbal abuse included, but not limited to: yelling, name calling, threats to hurt or kill her, any friends she may have, family, pets, or peers, degrading women in general, criticizing her appearance, belittling her accomplishments, constantly blaming her (CDC, 2017; Health & Safety Commission, 1997). Cañete-Lairla & Gil-Lacruz (2018) conducted a study which highlighted that verbal abuse was common form of aggression by the perpetrator; but in contrast with emotional abuse, it was as damaging to the woman as a physical attack (Becze, 2018; Debono et al., 2017; Hazrati et al., 2017; Joint Commission, 2018).

Sexual

Women affected by IPV have described the events which lead up to a sexual assault as the perpetrator verbally demanding sex in which she refused, he became angry and used bodily force which resulted in what is known as a sexual assault and/or sexual IPV (Kalokhe et al., 2015; Lovell et al., 2019; Olff, 2017). Sexual IPV included reports of forced sex, forced pregnancies, abortions, sexual assault, unwanted sexual acts, demeaning remarks toward her that engaged in humiliating sexual acts either with the perpetrator, his friends or other sexual aggressions, sexual victimization, being made to penetrate someone else and demanding sex after abuse. (Bagwell-Gray et al., 2015). In the subsequent section, the effects of IPV were discussed in detail.

Barriers to Recovery and Economic Issues of IPV

To fully comprehend how the categories of IPV effected the lives of women and the myriad of factors that influenced the ability in disclosing their experiences were examined. Bacchus et al., (2016) conducted a study which revealed an under reporting of experiences of IPV and lacked seeking medical care, subsequent to the stigma associated with IPV, retaliation by the perpetrator, fear of health care providers disbelief of their experience, being labeled and/or judged (Ali et al., 2016; Kennedy & Prock, 2016; Murray et al., 2015; Ragavan et al., 2017; Reeves & Humphreys, 2018; Sabbah et al., 2017; Sawyer et al., 2016). The experience was challenging for women to acknowledge because of feelings of low self-worth, shame, fear, embarrassment and hopelessness (Ali & McGarry, 2018; Bacchus et al., 2016; Finfgeld-Connett, 2017; Matheson et al., 2015; Ragavan et al., 2017). Additional barriers related to women affected by IPV that sought help involved a lack of alternative means of economic support, weak community sanctions against IPV, an inability to be vulnerable with family, friends and service providers relating to confidentiality, attempts to intervene and confront the perpetrator, blaming the woman, validating the perpetrator's behavior, and/or advocating for relocation (Finfgeld-Connett, 2017; Ragavan et al., 2017; Rizo, 2016; Wuerch et al., 2019; WHO, 2017).

Recent literature estimated the annual economic impact to provide care to women affected by IPV in the US was over $750 billion per year in healthcare spending and loss of wages, $6 billion for the care of physical assault, $460 million for sexual assault, and $461 million for stalking victims (CDC, 2017; Cerulli, 2015; Davidov et al., 2017; King

et al., 2017; Office of National Statistics, 2017). Finally, it was estimated that over $1 billion per year financed fatality review boards and criminal justice investigations (CDC, 2017; Choi & An, 2016). Additional studies revealed that women affected by IPV perceived their health as poor, subsequent to higher incidences of comorbidities in chronic health issues of musculoskeletal, neurological and gastrointestinal concerns, cancer, cardiovascular diseases, asthma, irritable bowel syndrome, sleep disturbances, sexually transmitted inflections (STIs), sexual / reproductive health concerns, adverse obstetric outcomes, poor oral care, and behavioral health disorders which exacerbated risk for suicidal ideations, mortality and morbidity (Alvarez & Fedock, 2018; CDC, 2017; Choo, 2016; Ferranti et al., 2018; Hamberger et al., 2017; Hamberger et al., 2015; Handley et al., 2015; Hegarty et al., 2016; King et al., 2017; Kirk et al., 2017; Kokka et al., 2019; Lopez-Martinez et al., 2016; Ragavan et al., 2017; Murray et al., 2015; Reeves & Humphreys, 2018; Sugg, 2015; Yakubovich et al., 2018). The subsequent section outlined interventions for IPV discussed in greater detail.

IPV Interventions

There were numerous interventions designed to assist women affected by IPV, yet empirical evidence was limited in identifying an evidenced based practice, safety planning intervention methods (Ellsberg et al., 2015; Hackett, 2016; Hegarty, 2016; Logan & Walker, 2018; Murray et al., 2015). Traditionally, interventions for women affected by IPV often focused on immediate safety concerns of shelter, advocacy, and counseling which neglected women's ability to increase her quality of life (Cattaneo & Goodman, 2015; Ghandour et al., 2015; King et al., 2017, Van Hecke et al., 2017). Given

the reported rates of IPV and its economic impact, a vital step in addressing IPV was to determine what intervention strategies appeared to be effective and sustainable with this population. There were three types of health education and promotion prevention models which were labeled as primary, secondary and tertiary (García-Moreno et al., 2015; Hegarty et al., 2015; Kirk et al., 2017).

Primary

Although, the health education and promotion prevention model encompassed three levels, the first level is acknowledged by providers as a highly desired level (CDC, 2015; Garcia-Moreno et al., 2017). Primary prevention was defined as activities implemented to prevent IPV before it occurs (CDC, 2017; Garcia-Moreno et al., 2017; Ogundipe et al., 2018). A recent study (Ragavan et al., 2017) illustrated the importance of systems that validated the experiences of women affected by IPV, encouraged therapeutic alliances among the health care system, law enforcement and other women (Choo, 2016; WHO, 2017). Recognized examples of primary prevention were women that sought services in the community which tested her knowledge, attitudes and behaviors of IPV that influenced relationships with individuals and the community in which she resided.

Secondary

The second level of prevention involved activities that prevented further injury and/or violence against women (CDC, 2017; Garcia-Moreno et al., 2017). An example of this level of prevention occurred in emergency rooms as women affected by IPV sought medical treatment for their injuries (CDC, 2017; Garcia-Moreno et al., 2017). This level of prevention was obtained by women that linked to a therapist which prevented further

emotional distress that has been documented as one of the subsequent negative health consequences from IPV (García-Moreno et al., 2017; Kokka et al., 2019).

Tertiary

The CDC (2017) examined studies that highlighted tertiary prevention as the implementation of policy and legislative changes, as well as interventions which focused on eliminating the chronic and harmful effects of IPV (Garcia-Moreno et al., 2017; Kirk et al., 2017). The health education and promotion model of tertiary prevention was encompassed in the conceptual framework that explored the health education needs and learning preferences of women affected by IPV using self-management strategies. Tertiary prevention programs and services were essential for mitigating the short and long-term consequences of IPV, as well as reduced the violence related health burden across the life span (Choi & An, 2016; King et al., 2017; WHO, 2017). Empirical data supported the theory that supplying patients with illness-related information aided in improving their level of health (Mughairbi et al., 2019). The subsequent section discussed safety planning interventions.

Safety Planning for IPV

In this study, the operational definition for the term safety planning represented a tertiary prevention strategy used to address the needs of women affected by IPV and was critical as it contributed knowledge needed to develop best practices and protocols during treatment. Research highlighted best practice strategies of safety planning being conducted as an interactive process in which service providers engaged women in identifying coping skills that enhanced safety (Bacchus et al., 2016). Although there is

limited empirical evidence on safety planning interventions, Bacchus et al., (2016) conducted research which reflected how women affected by IPV articulated how safety planning was a useful resource (Colvin et al., 2016; Goodman et al., 2015; Hackett et al., 2016; Hegarty et al., 2016; Logan & Walker, 2018; Murray et al., 2015). Safety planning interventions were activities which offered guidance to women affected by IPV that identified strengths, coping strategies, building support to access community resources, reduced risks for exposure to harm, associated fears, anxiety and emotional safety issues (Choo, 2016; Ford-Gilboe et al., 2017; Logan & Walker, 2018; Murray et al., 2015). Further, there is no current literature that explored the experience of women affected by IPV that used this tool in their health decisions (Bacchus et al., 2016; Logan & Walker, 2018). The subsequent section highlighted how self-management strategies were used during safety planning interventions.

Safety Panning Through Self-Management

To build on the current research, this study explored the lived experiences of women affected by IPV and their self-management strategies used improve health outcomes. Self-management was a specific tertiary prevention strategy of health literacy that affected depression, anxiety, and consequences of trauma/abuse of women affected by IPV (García-Moreno et al., 2017; Kokka et al., 2019). To comprehend the importance of self-management, the term health literacy was defined. In this study, the operational definition for health literacy was the degree to which women affected by IPV possessed the capacity to obtain, process, and understand basic health information needed to make

appropriate health decisions (CDC, 2017; Health Resources & Services Administration, 2017; WHO, 2016).

McCormack et al. (2017) conducted a study that outlined a link between health literacy skills and health outcomes for women affected by IPV (Kim, 2016). The operational definition for self-management was defined as the ability to perform tasks that increased quality of life (Van Hecke et al., 2017). Self-management strategies for women affected by IPV were influenced by the four levels of the SEM (Dao et al., 2019) and were significant skills that included symptom management, adherence to treatment regimes, commitment to appropriate behavioral changes and the ability to deal with the psychological and physical consequences that improved health decisions (Ferrati et al., 2018; Van Hecke et al., 2017). Mughairbi et al. (2019) reported that clinicians progressively placed more emphasis on the knowledge that a person had about their condition as a vital factor in coping. Self-management was influenced by low health literacy, insufficient knowledge of medical conditions, difficulty understanding and completing forms, social isolation, patient / provider communication, availability of services, goal setting, action planning, and problem solving (Dao et al., 2018; Menear et al., 2016; Toback & Clark, 2017). While a new skill for women affected by IPV, self-management strategies were used to create behavioral changes which empowered and prepared them to manage their health, improved quality of life outcomes and enhanced their understanding of discharge planning processes (Logan & Walker, 2018). An increased understanding about the value of self-management-based interventions led to improved health outcomes for women affected by IPV (Kokka et al., 2019).

Social Change Implications of IPV Interventions

The positive social change implications for this study illustrated how adopting a multidimensional intervention framework such as the SEM, each level of influence provided guidance when women affected by IPV received services (McCormack et al., 2017). Providing holistic and integrated safety planning intervention to women affected by IPV was critical to future researchers and aided in the development and tailoring of policies that addressed the health education needs and learning preference of women affected by IPV (Ferraiti et al., 2017; Goncalves & Matos, 2016). Logan and Walker (2018) presented research that highlighted safety planning was a commonly used intervention with women affected by IPV. This research was significant to the discipline of health education and promotion, as it contributed to fill the gap in the literature on best practices for safety planning with this population of women (Colvin et al., 2016; Hackett et al., 2016; Hegarty et al., 2016; Logan & Walker, 2018; Murray et al., 2015).

The SEM was a conceptual framework used to impact positive social change at various levels of influence as indicated by Figure 1. Researchers understood that interventions guided by theoretical frameworks were empirically supported as more effective than those without a foundation (Alvarez et al., 2016). Exploring the perspective of women affected by IPV using self-management safety planning interventions contributed to positive social change through improved health outcomes. Hence, the implications for positive social change had profound impact on best practices for each level of influence represented on the SEM. These implications assisted policy makers, health care providers, law enforcement, court personnel and violence advocates in

understanding the health education needs and learning preferences of women affected by IPV when they sought services in the community.

Summary and Conclusions

In conclusion, Chapter 2 presented concepts that supported IPV being a preventable, health education burden. Concepts were presented through operational research definitions of terms, themes which explored traditionally held belief systems, historical and contemporary perspectives on IPV, and self-management as a safety planning intervention. In addition, this chapter outlined barriers and the economic impact on society with increased health care costs, lost productivity and increased criminal justice resources associated with IPV (Bacchus et al., 2016; Buzawa & Buzawa, 2017; King et al., 2017). Cited as the most common form of violence perpetrated against women, this human right violation contributed to the leading cause of death, decreased quality of life and subsequent negative health outcomes among women (CDC, 2016; Sumner et al., 2015; WHO, 2017).

The literature presented in this chapter identified a tertiary prevention strategy, addressed symptoms of IPV, and improved quality of life through safety planning interventions known as self-management. Women affected by IPV using self-management strategies as a health education safety planning intervention, increased coping strategies for symptom management, compliance with treatment regimes, identified behavioral changes, and improved health education decisions that increased quality of life (Ferrati et al., 2018; Van Hecke et al., 2017). As there was limited empirical evidence which explored the experiences of women affected by IPV using this

safety planning intervention tool in health decisions, this study explored a gap in the literature and have social change implications for service providers.

Chapter 3 will review the qualitative research design, rationale, role of the researcher, and mitigating researcher bias. Next, the chapter will highlight the importance of the phenomenological approach, description of the target population that met the inclusion criteria, and the sampling methods to recruit the participants. Finally, the chapter will conclude with instrumentations, data analysis plan, trustworthiness and how ethical considerations will be extended to the research participants.

Chapter 3: Research Method

The purpose of this phenomenological study was to explore the health education needs and learning preferences of women affected by IPV who used the health literacy technique known as self-management during safety planning interventions. Knowledge was also examined regarding how self-management strategies were perceived by women affected by IPV at the time services were sought in the community (Dao et al., 2019; Javadzade et al., 2018; Kokka et al., 2019). Understanding self-management techniques can influence safety planning interventions and improve a woman's ability to coordinate with community-based providers, enhance understanding of discharge planning processes, and further clarify expectations of women affected by IPV when safety planning (Logan & Walker, 2018).

Chapter 3 will highlight the specific qualitative research design and rationale utilized to conduct this study, the research questions and phenomenon of interest, the role of the researcher, and the methodological strategies such as participant recruitment and sampling procedures. Next, this chapter will outline the instrument that I developed, saturation, data collection and data analysis plan, how content validity was established, and procedures for recruitment. This chapter will also explain issues of trustworthiness and ethical concerns. The chapter will conclude with a summary of the main highlights and transition to Chapter 4.

Research Design and Rationale

In alignment with the purpose statement and supported through empirical literature, four research questions were developed that provided direction for the

measurement, data collection, analysis, and reporting methods (Leedy & Ormrod, 2016; Patton, 2015; Simon & Goes, 2018). Using this guidance, the research questions postulated for this study were:

Research Question 1: What were the health education needs and learning preferences of women affected by IPV who were committed to behavioral changes during safety planning interventions?

Research Question 2: What were the health education needs and learning preferences of women affected by IPV who were committed to adhere to the treatment regimens discussed during safety planning interventions?

Research Question 3: How do women affected by IPV describe the strategies they used to cope with the negative consequences of psychological and physical violence?

Research Question 4: What were the lived experiences of women affected by IPV who used the health literacy technique of self-management as a health education and safety planning intervention?

In selecting a research design, phenomenology and ethnography were two traditions with different analytical approaches that were considered for this qualitative study (Merriam & Tisdell, 2016; Moser & Korstjens, 2018). Ethnography is a qualitative design to interpret the processes of cultural behavior of documenting human experiences and ways of living (Thorne, 2000). A researcher utilizing ethnography to explore the lived experiences of women affected by IPV would immerse themselves into the cultural of IPV through fieldwork or participant observation (Marshall & Rossman, 2016; Morse, 1994; Thorne, 2000). Ethnography transcripts encompass observations, focus groups, and

field notes, and the data analysis process begins immediately at the time the researcher enters the field (Korstjens & Moser, 2017; Marshall & Rossman, 2016; Moser & Korstjens, 2018). When comparing themes in ethnography, researchers have used maps, flow charts, organizational charts, and matrices to illustrate the comparison graphically (Merriam & Tisdell, 2016; Moser & Korstjens, 2018). Although the qualitative approach of ethnography would have acquired in-depth knowledge of the culture and belief systems of the women affected by IPV (Grossoehme, 2014; Marshall & Rossman, 2016), it was not my intention to directly participate in the lives of the women affected by IPV during data collection.

In contrast, phenomenology is an approach that allowed me to fully grasp the lived experiences of the group and phenomenon being studied (Moustakas, 1994). Phenomenology is a method to understand and process the rich, lived experiences of individuals through rigorous analysis (Eberle, 2014; Thorne, 2000). This method was an avenue to draw closer to the phenomenon, which evoked feelings and a sense of connectedness with the women affected by IPV (Creswell & Miller, 2000). As a researcher using phenomenology to explore the health education needs and learning preferences of women affected by IPV using self-management strategies, I was able to describe safety planning as these women would understand the experience (Thorne, 2000). I created a phenomenological transcript to ask in-depth, open-ended questions through a semi structured interview guide (Jacob & Furgerson, 2012; Simon & Goes, 2018).

There are two approaches to phenomenology: descriptive and interpretive (Hanna et al., 2016; Husserl, 1964, 1967, 2001; Lopez & Willis, 2004; Shardonofsky, 2019; Sloan & Bowe, 2014), but descriptive phenomenology was used for this study (see Crocker, 2017; Hanna et al., 2016; Husserl, 1964, 1967, 2001; Lopez & Willis, 2004; Marchetti et al., 2019; Shardonofsky, 2019; Sloan & Bowe, 2014). Husserl's (2001) methodology supported an individualized interaction with women affected by IPV, which assisted me in understanding their reality (Shardonofsky, 2019). Descriptive phenomenology encouraged me to set aside my prior personal knowledge about the phenomenon of study in order to grasp the essential lived experiences of the participants (Giorgi, 2012; Hanna et al., 2016; Lopez & Willis, 2004; Sloan & Bowe, 2014; Sorsa et al., 2015). Previous researchers have also used descriptive phenomenology successfully to examine topics related to health as well as women affected by IPV (Marchetti et al., 2019; Shardonofsky, 2019; van der Wath et al., 2016).

There were three advantages for choosing a descriptive phenomenological design. First, I required the use of words and images when using a phenomenological design (Aborisade, 2013). Second, this design enabled me to understand the experiences of women affected by IPV when they shared their stories of their health education needs and learning preferences (Creswell & Creswell, 2018; Merriam & Tisdell, 2016; Moustakas, 1994; Patton, 2015; Reeves & Humphreys, 2018; Vagle, 2016). Lastly, this design helped mitigate bias by suspending common ideologies about IPV when the qualitative interview guide was used (Kennedy et al., 2015; Sailakumar & Naachimuthu, 2017). Husserl's descriptive approach supported me using a technique known as bracketing (Lopez &

Willis, 2004; Polit & Beck, 2012; Shardonofsky, 2019; Sorsa et al., 2015), which was used to recognize my individual biases, epistemological position, and ontological perspective and set aside my personal knowledge, preconceived ideas, and judgements (Shardonofsky, 2019; Sorsa et al., 2015). Bracketing was used to conduct open ended, semi structured interviews, which added scientific rigor and validity to qualitative research (Morse, 1991; Shardonofsky, 2019; Sorsa et al., 2015). The goal of bracketing was also to not influence the women's understanding of the phenomenon, as the study was focused on the women's experiences from their viewpoints (Shardonofsky, 2019; Sorsa et al., 2015). A descriptive phenomenological study helped to examine the relationship between "the what" and "the how" of the experiences of women affected by IPV, which supported the belief that each woman influenced her own environment (Husserl, 1964, 1967, 2001; Lopez & Willis, 2004; Marchetti et al., 2019; Shardonofsky, 2019; Sloan & Bowe, 2014).

Role of the Researcher

In this qualitative research, I was the primary instrument for data collection and interpretation to make informed decisions pertaining to data analysis (Moser & Korstjens, 2018). I had the primary role of upholding human research ethical principles and exploring potential research biases, assumptions, and conflict of interests (Korstjens & Moser, 2017; Mecca et al., 2014; Nnamuchi, 2018; Sanjari et al., 2014). There are three strategies that improve the validity and credibility of research studies: (a) striving for balance, fairness and completeness in data analysis and interpretation; (b) carefully documenting the analysis procedures; and (c) being upfront about personal biases at the

onset of the study (Leedy & Ormond, 2016; Simon & Goes, 2018). In the role of researcher, it was my responsibility that I ensured the credibility of the study and facilitated an understanding of the health education needs and learning preferences of women affected by IPV using self-management strategies during safety planning interventions. Personal values and connections between myself, participants, and the research site are explored in the following sections (Creswell, 2016; Leedy & Ormrod, 2016; Patton, 2015, Simon & Goes, 2018).

Potential Conflict of Interest

To abide by ethical research requirements, I was not employed by the social service agency in which some of the participants were recruited. I had no prior knowledge of a therapeutic relationship, nor did I act as a therapist on behalf of the social service agency where some participants were recruited for the study. Over the past 21 years working as a therapist in Ohio, I have provided services to countless women affected by IPV. It was conceivable that I had encountered participants at previous social service agencies in Cleveland, Ohio during my career. To ensure that participants did not feel coerced to participate in the study, ethical measures were taken to protect participants and make them feel safe in disclosing their experiences. These procedures are addressed in greater detail at the end of Chapter 3 in the Ethical Considerations section. In the event the study caused emotional harm, the participants were provided a community resource guide that assisted them in linking to the appropriate level of care that addressed the emotional distress (see Appendix D).

Potential Research Bias

It was important that I acknowledge any potential biases that I brought to the study. As a therapist, licensed by the state of Ohio, I have worked with women affected by IPV for the past 21 years. In my role as a therapist, I have provided crisis intervention, individual and group counseling, conducted psychosocial evaluations, and linked women affected by IPV to various community resources.

A three-pronged approach was utilized that mitigated potential researcher bias. First, a semi structured interview guide (Appendix C) was prepared and followed, which decreased leading or biased questions (Simon & Goes, 2018). Second, to improve the credibility and rigor of the research, an expert review process was utilized (Barusch et al., 2011; Liao & Hitchcock, 2018; Lincoln, 1995; Lincoln & Guba, 1985). I obtained feedback from outside experts in the field of the phenomenon to assess the quality of the study and inform decision making (Johnson & Christensen, 2014; Liao & Hitchcock, 2018; Tsang et al., 2017). This study utilized four professional advocates in the field of IPV who reviewed the semi structured interview guide, informed consent form, participant research flyer, community resource guide, and the screening and demographic surveys. Lastly, a published, online research tool, SurveyMonkey, was utilized and assisted me with data management, and storage, though it did not function as a substitute for my analysis (Bazeley, 2007; Bringer et al., 2004; Houghton et al., 2015; Lathlean, 2006).

Potential Ethical Concerns

First, in order to learn about research involving human participants, I completed a research ethics and compliance training program sponsored by the Collaborative Institutional Training Initiative. Next, I followed the standards of the Walden University IRB protocol and obtained approval before I began any phase of recruitment and data collection that ensured that the study met ethical standards. In addition, I abided by the Belmont Reporting Standards (1978) of (a) respect for the participant, (b) beneficence, and (c) justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research [NCPHS], 1978). These ethical concerns are discussed in further detail at the end of Chapter 3 in the Ethical Considerations section.

The use of contingency management methodologies posed another potential ethical concern that in order to motivate participant attendance, a financial incentive of a $20 Walmart gift card was offered at the end of the online interview. Contingency management is a system to deliver financial incentives, which influences participants' behaviors (Mitchell et al., 2018). Empirical data supported that financial incentives were the most common motivator effectively used to target short term outcomes (Bassett et al., 2015; Doshi et al., 2013; Mfutso-Bengo et al., 2015; Mitchell et al., 2018). However, ethical codes and guidelines stipulate that excessive inducement arises when a financial incentive causes participants to ignore and/or compromise their individual values and participate in the research nonetheless (Cryder et al., 2010; Dickert & Grady, 2008; Mfutso-Bengo et al., 2015; NCPHS, 1978).

At the conclusion of the survey, the women were given instructions to email me for the $20 Walmart gift card code. It should be noted that only 20 out of 30 women requested a financial incentive, as 10 women did not contact me for the incentive. Of those 20 women, 3 were emailed the gift card code and the remaining 17 women called me, provided a pseudonym, and requested that their gift card be taken to the social service agency for them to retrieve.

Methodology

The purpose of this section is to outline the methods for the study of women affected by IPV so that it can be replicated by other researchers. Replication of research results can measure something accurately only when measured consistently (Leedy & Ormrod, 2016). Increasing reliability can be accomplished with standardization such as in the use of the instrument from one participant to the next (Leedy & Ormrod, 2016). This section will include subsections on participant selection, sampling, instrumentation, procedures for recruitment, participation, data collection, and the data analysis plan.

Participant Selection Logic

After I obtained Walden University IRB approval (05-27-20-0413919), participant recruitment was initiated. First, I set up an appointment with an executive of a social service agency in Cleveland, Ohio to introduce myself and the research study, and I requested permission to post research flyers in common areas of the agency. Next, I made two requests from the Walden University IRB. First, to post the research study in the Walden University participant pool, which is a virtual bulletin board where members of the Walden community participated in studies conducted by Walden students and

faculty. The bulletin board provided women with a link which accessed the survey via the SurveyMonkey research tool. The second request was to post the research flyer on various domestic violence support group sites via the social media platform of Facebook.

In the selection of participants, the specific population identified for this study was limited to women affected by IPV. The women were recruited using three web-based approaches: (a) accessing the research study through the SurveyMonkey web link advertised on the participant research flyer, (b) assessing the Walden participant pools, and (c) via a domestic violence support group on Facebook. Therefore, while the platform of recruitment varies, the recruitment method for each participant was the same. On average, the survey took less than 15 minutes to complete. I contacted the SurveyMonkey organization and obtained permission to use this research tool (see Appendix E). All data were collected and stored within the SurveyMonkey platform for this study.

Sampling

A qualitative sampling plan was the formal procedure that not only outlined how many interviews were needed to ensure that the findings contributed rich data but also described an appropriate setting, sampling method techniques, a sample size, and manner of recruiting participants that represented the phenomenon of interest (Fusch & Ness, 2015; Moser & Korstjens, 2018; Polit & Beck, 2017; Sailakumar & Naachimuthu, 2017). Research participants in qualitative sampling plans are continually sampled intentionally and not at random (Moser & Korstjens, 2018). Sampling is dependent on many factors

such as the vulnerability of the participants, access, time, characteristics of the setting and the community stakeholders (Moser & Korstjens, 2018).

Research participants for this study were recruited through purposive and snowball sampling techniques until saturation was achieved. Many factors affected sample size in qualitative research; thus, researchers used a well-established standard of sampling data to the point where there is a sense of closure or saturation (Polit & Beck, 2017; Sailakumar & Naachimuthu, 2017). Empirical data supported these sampling strategies were the most appropriate for qualitative sampling (Kalokhe et al., 2015; Mfutso-Bengo et al., 2015; Moser & Korstjens, 2018). Purposive sampling occurred in this study when the participants, based on their insight and lived experiences, also met the five criterion of being: (a) a women, (b) 18 years of age or older, (c) affected by IPV six months or greater, (d) resided in The State of Ohio, and (e) could read and write English (Etikan et al., 2016; Gentles & Vilches, 2017; Moser & Korstjens, 2018; Polit & Beck, 2017). Snowball sampling was a second method that supported the identification and recruitment of additional participants to achieve saturation (Merriam & Tisdell, 2016; Polit & Beck, 2017). This sampling technique worked under the assumptions that current participants knew other women affected by IPV and would refer them to the study.

Recent studies supported that sampling sizes for phenomenological studies differ contingent on the study but tend to be smaller than quantitative studies and consisted of fewer than ten participants (Moser & Korstjens, 2018; Sailakumar & Naachimuthu, 2017; Slabbert, 2017). Although, Korstjens (2017) reported that in qualitative research, the proposed sample size was between 10 – 12, as qualitative research used smaller sample

sizes; there were 30 participants which met the eligibility criteria for this study. There were two rationales that supported the increased sample size for this study. First, Arigo et al. (2018) conducted research which highlighted that social media platforms offered researchers an abundance of opportunities that increased recruitment efforts; as social media platforms, such as Facebook, have increased its popularity for sharing stigmatized health topics among diverse audiences (Caparro et al., 2014; Greenwood et al., 2016). Lastly, I collected and reviewed data daily and saturation had not been obtained at the proposed sample size of 12.

Instrumentation

At the time this research study was conducted, empirical literature had not published an instrument which sufficiently answered the research questions in this phenomenological study. Hence, I created a demographic survey and semi-structured interview guide that collected data through the published, online research tool known as SurveyMonkey. SurveyMonkey was founded in 1999 by Ryan Finley and Chris Finley as an online survey development cloud-based software company. SurveyMonkey was used in academia for students to conduct surveys that explored the attitudes and behaviors in domains such as: business, politics and health. The cloud-based software system would allow a researcher to survey people around the world. Appendix E was a permission to conduct research letter from SurveyMonkey which outlined that one of their most common use cases were students and other type of researchers using this tool to conduct academic research. The collected data was kept confidential and not accessed by anyone outside of myself, as I bear the sole responsibility for the data collection process. The

sources of data allowed me to explore the health education needs and learning preferences of women affected by IPV that used self-management strategies during safety planning interventions.

As the primary instrument of research in this study, it is imperative that I was aware of my ontological positions as it related to IPV (Xu & Storr, 2012). Establishing qualitative credibility techniques known as expert checking promoted rigor and credibility to this study (Barusch et al., 2011; Johnson & Christensen, 2014; Liao & Hitchcock, 2018; Lincoln, 1995; Lincoln & Guba, 1995). Expert checking established content validity by using outside experts in a certain field to assess the quality of the research study (Johnson & Christen, 2014). For this research study, four professional advocates in the field of IPV reviewed the semi-structured interview guide, informed consent form, participant research flyer, community resource guide, the screening and demographic surveys to provide feedback to amend any content which does not support the culture of women affected by IPV.

A structured interview required the use of a questionnaire and were primarily open-ended questions (Aborisade, 2013). The primary instruments used for this online study were the semi-structured interview guide and the demographic survey, as it had precise, open-ended questions in which the participants typed in their responses, which, unfortunately, did not allow me to ask follow up questions (Aborisade, 2013; Sailakumar & Naachimuthu, 2017). The semi-structured interview guide (Appendix C) allowed me to explore the lived experiences of participants health education needs and learning preferences when using the self-management strategies while seeking services in the

community. As a result of the research questions being aligned with the conceptual framework and interview guide, this allowed me to accurately report the health education needs and learning preferences of the participants.

Procedures for Recruitment, Participation, and Data Collection

Prior to all recruitment, participation, and data collection, a fundamental ethical research standard outlined that approval was granted from the Walden University IRB. To ensure that participants met the eligibility requirements, the SurveyMonkey research tool was constructed with several templates with "if-then" decision trees embedded into every template that guided participants through the research study. All responses were typed in by the participants, which was organized in SurveyMonkey and created transcripts.

The first template in the study was the screening survey which determined eligibility if they met the five criterion of: (a) being a woman, (b) 18 years of age or older, (c) affected by IPV six months or greater, (d) resided in The State of Ohio, and (e) could read and write English. The geographic area of Cleveland, Ohio was identified as of importance by the Ohio attorney general (2017) as being one of the six cities with a population greater than 100,000 with the highest mean rate of partner violence. When participants answered no to any of the five eligibility questions, the survey ended and provided a custom messaged that thanked them for their time and indicated they were not eligible to take the survey at this time. If the participant answered yes to each question, they were taken to the informed consent section of the survey.

The challenge in the data collection process of participants was a reluctancy to discuss traumatic experiences. This challenge was addressed by the second template in the study. The informed consent template provided guidance as to the nature and procedures of the study, outlined that the study was voluntary and they could withdraw at any time, highlighted any risks and benefits of being in the study, discussed the financial incentive, privacy, contact information for the researcher and/or the research participant advocate of Walden University. Finally, the template provided instructions on how to access the $20.00 Walmart gift card code. If the woman understood the informed consent, and desired to participate in the research study, she was instructed to click on the button marked yes, which then took her to the demographic survey. If she indicated that she did not fully understand the study and did not wish to participant, she was instructed to click on the button marked no, at which time she was taken to a customized message which instructed her that the research study had concluded and thanked her for taking the time to review the informed consent form.

As stated earlier, the collected data was kept confidential and not accessed by anyone outside of myself, as I bear the sole responsibility for the data collection process. Data collection was in the form of the SurveyMonkey research tool, the individual transcripts and a Microsoft Excel spread sheet stored on a password protected computer. The raw data will be destroyed five years after the publication date of the dissertation as per university regulations.

Finally, ethical codes and guidelines stipulated that the amount of a financial incentive to prospective research participants should not appear to substantially exceed

compensation for their time, which promoted unduly influence and/or coercion to consent against the women's better judgement and expose them to risk (Cryder et al., 2010; Mfutso-Bengo et al., 2015; NCPHS, 1978; Singer & Couper, 2008). Participants were compensated with a $20 Walmart gift card to acknowledge their time they contributed to the research study. Twenty dollars is an amount believed to be sufficient to incentivize participation, but low enough as to avoid ethical concerns of coercion or impairment of autonomy (Dickert & Grady, 2008).

Data Analysis Plan

To yield meaningful and useful results as qualitative research was conducted, best practices have indicated that research be conducted in a rigorous and methodical manner which produced credible results (Maguire & Delahunt, 2017; Nowell et al., 2017). Empirical literature defined thematic analysis as a process that identified, analyzed, organized, described and reported themes found within a data set (Braun & Clarke, 2012; Maguire & Delanunt, 2017). Qualitative researchers supported thematic analysis as a useful method which examined the perspectives of different participants, highlighted similarities and differences, and generated unanticipated insights (Braun & Clarke, 2012; King, 2004; Sutton & Austin, 2015). Current empirical data (Avenier & Thomas, 2015; Braun & Clarke, 2012; Gallagher, 2016; O'Brien et al., 2014) supported researchers implementing a six-phase guide as a framework to conduct a thematic data analysis:

a) **Become familiar with the data**: The qualitative data from the transcripts were exported from the SurveyMonkey research tool onto a Microsoft Excel

spread sheet. I became familiar with the data by reading the transcripts and journaling any initial thoughts.

b) **Generate initial codes**: I developed a coding framework which consisted of a list of codes used to index and divide the data into descriptive emergent topics across the data set (Braun & Clarke, 2012; Bringer et al., 2004). Next, I labeled the relevant phrases, words or sentences that described concepts, processes, activities or actions of the participants. This process of labeling was known as first cycle and second cycle coding (Miles et al., 2014; Patton, 2015).

c) **Searching for themes**: I used the technique of hand coding to uncover emergent themes that captured ideas that surrounded the research questions (Maguire & Delanunt, 2017). An activity known as table method was the method used to conduct this process by cutting out codes and moving them around on the spread sheet.

d) **Reviewing themes**: I reviewed the themes that I highlighted on the spread sheet, which assisted with organizing the vast number of data and codes in relation to the entire data set (Braun & Clarke, 2012).

e) **Defining and naming themes**: Themes were used to conduct a final analysis and produced a scholarly report of the data, as it refined the specifics of each theme and the overall story the analysis told, generating clear definitions and named each theme (Braun & Clarke, 2012).

f) **Producing the report**: This step represented the final opportunity used to conduct an analysis of the data (Braun & Clarke, 2012). The most compelling examples were used to conduct the final analysis of recurrent extracts which related back to the research questions and literature (Braun & Clarke, 2012).

A strategy that improved validity in qualitative research was known as negative case or discrepant case analysis (Barusch et al., 2011; Hamilton, 2020). Morse (2015) outlined the value of discrepant cases which were cases that were contradictory to the overall analysis of the study (Patton, 2015). The experiences of each woman affected by IPV was valuable, complex and represented a myriad of diversity as she articulated her health education needs and learning preferences of using self-management strategies during safety planning interventions. No discrepant cases were identified in this research study.

Evidence of Trustworthiness

Qualitative researchers strive to ensure that studies have trustworthiness, which is conceptualized as the extent to which one had confidence in the findings of the study (Adams et al., 2015; Lincoln & Guba, 1985). The criterion for qualitative research were described as credibility, transferability, dependability and confirmability (Amankwaa, 2016; Korstjens & Moser, 2018). In establishing trustworthiness protocols in qualitative research, I used several strategies for guidance during the study to ensure rigor. The next sections defined each criterion and illustrated how the four criteria for trustworthiness apply to this study.

Credibility

Credibility was conceptualized as the confidence of the accuracy of the research findings which are drawn from the in-depth interviews (Amankwaa, 2016; Korstjens & Moser, 2018; Lincoln & Guba, 1985). There were two concepts utilized that established credibility in this online research study. First, the concept known as data triangulation was used to establish credibility in this study by gathering data from multiple sources which included the demographic survey and the semi-structured interview guide. Lastly, each woman typed in individualized responses to the questions; this provided an opportunity for them to consistently review their responses before submitting them. This method of data collection is known as continuous member checking and was used to validate the trustworthiness and/or credibility of the qualitative research (Amankwaa, 2016; Birt et al., 2016; Chang, 2014; Fusch & Ness, 2015; Harvey, 2015; Koelsch, 2013; Korstjens & Moser, 2018; Naidu & Neil-Prose, 2018).

Transferability

Transferability was conceptualized as the degree that the results of the research transferred to other women affected by IPV receiving safety planning interventions at other social service agencies. Denzin (1989) outlined that features of thick description provided context of an act, state the intentions and meanings which organized the actions of the women and the action should be presented as a test that can be interpreted. In this study, the online research tool generated a verbatim transcript that I utilized to draw out the actions, context and the intentions of the women affected by IPV experiences in such a rich descriptive manner that allowed future researchers an opportunity to understand the

sample rationale and size, inclusion and exclusion criteria, and reviewed of the semi-structured interview guide (Amankwaa, 2016; Fusch & Ness, 2015; Korstjens & Moser, 2018; Lincoln & Guba, 1985).

Dependability

Dependability was conceptualized as the stability of findings over a length of time. Dependability involved the evaluation of the findings, interpretation and recommendations of the study such that were supported by the data as received from the women affected by IPV that participated in the study (Amankwaa, 2016; Korstjens & Moser, 2018; Lincoln & Guba, 1985). In this study, I created a reflective journal that captured my personal thoughts throughout the research process (Amankwaa, 2016; Fusch & Ness, 2015; Korstjens & Moser, 2018; Lincoln & Guba, 1985; Merriam & Tisdell, 2016; Ravitch & Carl, 2016).

Confirmability

Confirmability was conceptualized as the capacity to which the findings of the research study had the ability to be validated by future researchers when establishing that the data, the findings, interpretations and recommendations were valid and clearly originated from the data collected (Amankwaa, 2016; Korstjens & Moser, 2018; Lincoln & Guba, 1985). I provided confirmability in the study with the implementation of an audit trail, which increased transparency by describing the research steps taken from the start of the research project to the development and reporting of the findings (Korstjens & Moser, 2018; Lincoln & Guba, 1985; Merriam & Tisdell, 2016; Ravitch & Carl, 2016). In this study, I documented the concept of researcher as instrument and the mitigation of

potential sources of bias (Amankwaa, 2016; Fusch & Ness, 2015; Korstjens & Moser, 2018; Lincoln & Guba, 1985).

Ethical Protection of Human Participants

As this phenomenological study was conducted with human participants, there were ethical considerations and implications (Crann & Barata, 2016; Flasch et al., 2017). Empirical data supported that it is my obligation to develop and adopt strategies that empowered them to respect the promise of confidentiality to the participants (Turcotte-Tremblay & McSween-Cadieux, 2018). Prior to participant recruitment and data collection, I followed all the safety and confidentiality protocols that were established by using the ethical guidelines of the Walden University Institutional Review Board (IRB) and I completed a research ethics and compliance training implemented through the Collaborative Institutional Training Initiative. During the Collaborative Institutional Training Initiative certification process I observed how the principles of: (a) respect, (b) justice, and (c) beneficence were highlighted in the Belmont Report and during every aspect of the research study (NCPHS, 1978).

To abide by ethical research requirements, I was not employed by the social service agency in which the women were recruited. Ethical issues such as confidentiality arose in this study as participants discussed sensitive issues around their experiences and views on IPV. Breaches of confidentiality posed harm to participants which would hinder the trust relationship between me and the participant (Turcotte-Tremblay & McSween-Cadieux, 2018). To ensure that participants did not feel coerced to participate in the study, ethical measures were taken to protect participants and demonstrate respect.

Bickford and Nisker (2015) described anonymity as strategies used by a researcher in which the identity and responses of a participant cannot be easily linked back to the participant of the study

All participants were advised of the purpose and nature of the research as they participated in the online research. Beneficence was utilized to decrease emotional distress which included a clause in the informed consent that the women had the right to withdraw from the study at any time (McTate & Leffler, 2017; Slabbert, 2017). Another example of beneficence utilized in this research occurred as a community resource guide (Appendix D) was provided at the end of the survey which provided options for additional support.

Summary

Chapter 3 represented the research method portion of this study. The research design and rational was outlined for completing phenomenological qualitative design research. Two research traditions of qualitative studies were discussed, and the literature supported using a phenomenological approach with this target population. Next, the role of the researcher, mitigating bias, participant recruitment and sampling procedures were discussed. Finally, Chapter 3 concluded with the researcher developed instrument, data collection, analysis plan and issues of trustworthiness were highlighted. As with all research conducted with human participants, ethical considerations and implications were discussed.

The research transitioned to Chapter 4 and will begin with an introduction to the findings of the descriptive, phenomenological research. Next, the setting and the

demographics will be outlined, in addition to the steps of data collection, and issues of trustworthiness with a thematic analysis. Finally, Chapter 4 will conclude with interpretation and recommendations from the research.

Chapter 4: Results

The purpose of this phenomenological study was to explore the lived experiences of women affected by IPV who used health literacy as a health education and safety planning intervention. One in four women have experienced severe physical violence by an intimate partner (Kirk et al., 2017; Websdale et al., 2019), which has the potential to produce chronic, negative health outcomes (Alvarez et al., 2017; Cadihac et al., 2015; Childress et al., 2018; Doyle & Aizer, 2018; Holmes et al., 2018; Michaels-Igbokwe et al., 2016; O'Neal & Beckman, 2017; Sabri et al., 2019; WHO, 2017). The current study sought to contribute to the gap in literature by exploring the health education needs and learning preferences of women who used the three self-management techniques: (a) committing to behavioral changes, (b) willing to adhere to treatment regimens discussed during safety planning interventions, and (c) describe strategies to cope with the negative consequences of psychological and physical violence. There were four research questions that addressed these management techniques and the women's lived experiences and perceptions. This chapter will outline the research setting, participant recruitment, and participant demographic information. Next, the data analysis process and findings will be discussed. Finally, evidence of trustworthiness of the study will be examined.

Setting

I was granted permission from the Walden University IRB to post the research study in the Walden University participant pools, on various domestic violence support groups via Facebook, and in common areas at a social service agency in Cleveland, Ohio. An organizational condition that influenced the women and their experience at the time

of the study was the emergent public health crisis of COVID-19. On January 31, 2020, the Health and Human Services declared a public health emergency for the United States subsequent to the diagnosis of a respiratory disease that has resulted in serious illness or death that has not previously been identified in humans and was easily spread from person to person (CDC, 2020). In order to be compliant with the CDC, state, and local guidelines established to reduce the spread of COVID-19, the women were offered six interview options: phone, email, teleconference, mail, online, or in person. Any interviews conducted in person would have used the recommended 6-foot social distancing guidelines, and each woman would have been provided hand sanitizer and a single use medical face mask.

Demographics

The participants in this study were required to meet the inclusion criteria of being a female, 18 years of age or older, residing in Ohio, experienced IPV 6 months or greater, and can read and write English. Participants for the study ranged in age from 20 to 57, with the mean age being 34. Participants reported a range of education from 11th grade to a master's degree. The mean income of the participants was $31,000. The mean length of time the violence last transpired was 6 years ago. The SurveyMonkey research tool used to collect data for this online survey protected the anonymity of the women by programming the system to disable all IP addresses. A visual presentation of participants demographic characteristics was illustrated in Table 1. Figure 2 depicts the ethnic composition of the 30 participants recruited for this study.

Table 1

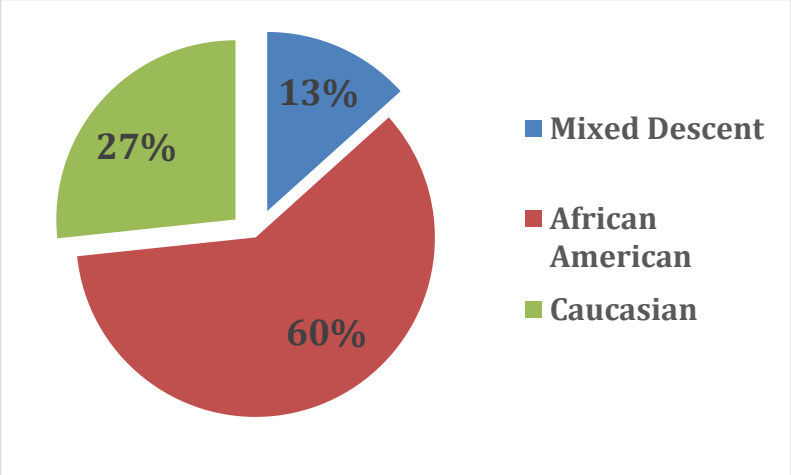
Participants Demographics

Participant	Age	Educational level	Income	Violence last occurred	Ethnicity
1	20	Bachelor	n/a	2 years	African American
2	27	Bachelor	$42,000	2 years	African American
3	25	Bachelor	$37,000	1.5 years	African American
4	25	HS diploma	$25,000	2 years	Caucasian
5	43	Associates	$35,000	4 years	Caucasian
6	26	Bachelor	$48,000	5 years	African American
7	50	Masters	$63,000	22 years	African American
8	46	Associates	$30,000	18 years	Caucasian
9	57	HS diploma	$10,000	5 years	Caucasian
10	55	Associates	$31,000	1 year	Caucasian
11	35	Bachelor	$32,000	9 months	African American
12	25	HS diploma	$42,000	7 months	Mixed Descent
13	27	Masters	$40,000	12 years	Caucasian
14	23	Associates	$24,000	1 year	African American
15	22	HS diploma	$16,000	3 years	African American
16	52	Bachelors	$28,000	4 years	Caucasian
17	34	HS Diploma	$40,000	3 years	Caucasian
18	46	HS Diploma	$11,000	5 years	Mixed Descent
19	44	Bachelors	$47,000	1 year	African American
20	37	HS Diploma	$0	1 year	Mixed Descent
21	47	HS Diploma	$30,000	1 year	African American
22	26	1 yr college	n/a	3 years	African American
23	48	1 yr college	$32,000	23 years	African American
24	50	Associates	$30,000	8 months	African American
25	54	1 yr college	n/a	7 months	African American
26	57	11^{th} grade	n/a	3 years	African American
27	53	3 yrs college	$0	4 years	Caucasian
28	51	HS Diploma	$0	8 years	African American
29	44	HS Diploma	$0	3 years	African American
30	46	1 yr college	$0	8 months	Mixed Descent

Note. $0 refers to participants who were unemployed and did not have income; n/a refers to participants that indicated they were employed but declined to report their income for the study.

Figure 2

Ethnic Composition of Participants



Data Collection

The data collection and recruitment processes for this phenomenological study were initiated after obtaining Walden University IRB approval. Data were collected between July 2, 2020 and July 17, 2020 from 30 women. The first steps in Braun and Clarke's framework (2012) illustrated the importance of compiling unbiased data through the demographic survey and semi structured interviews. Additionally, establishing a study database creates organization and aids with documentation as well as enhances reliability of the study (Yin, 2018). The SurveyMonkey online research tool housed the questions and sorted the data either by respondent or question. The women typed in their unique responses, which created transcripts. I programmed the online research tool to disable all participant IP addresses from being recorded and permitted only one submission per participant, which this ensured that there was no identifying information collected and maintained participant anonymity.

The demographic survey captured the woman's age, highest level of education, ethnic background, employment and income status, and the length of time the IPV last occurred. Guided by the research questions, the semi structured interview consisted of 12 questions intended to capture the lived experiences of women affected by IPV. The women were then provided with a list of community resources in the Cleveland area. Finally, a custom message instructed each woman to email me for the access code to the $20 Walmart gift card.

In the initial data collection process, 47 surveys were submitted. The raw data were reviewed, and 15 of the 47 surveys were excluded for incompleteness. Only the demographic questionnaire was completed in these 15 cases, and the participant did not move on to the semi structured interview questionnaire. Next, two of the 47 survey responses were excluded because they identified themselves as men, which did not meet the inclusion criteria of the study. Finally, there were 30 remaining surveys that met all the inclusion criteria and completed all the survey templates which took, on average, less than15 minutes to complete.

Empirical studies have supported that data collection should cease upon replication of data findings, referred to as saturation (Yin, 2018). Two criterion must be presented for saturation: (a) There was sufficient data collected to replicate the study, and (b) No additional information could be obtained by continuing the study (O'Reilly & Parker, 2012). On July 17, 2020 after 30 interviews were completed, I was unable to identify any additional themes that emerged from the coding processes during data analysis (Fusch & Ness, 2015; Saunders et al., 2018).

The original recruitment and data collection plan varied from the plan presented in Chapter 3 when the IRB approved the addition of two settings, which included the Walden University participant pools and Facebook. These variations were implemented to comply with the CDC guidelines that decreased the transmission of COVID-19, which allowed for virtual procedures and pathway options. However, though participants were initially offered six different settings in which to participate in the study, all 30 participants chose to have their experiences captured through the online hosted platforms using the SurveyMonkey research tool.

Data Analysis

Once data were collected, it was then sorted, and the coding process began (Auerback & Silverstein, 2003; Nowell et al., 2017). It is important to yield beneficial results by conducting research in a rigorous and methodical manner that produces credible research (Maguire & Delahunt, 2017). In this study, a thematic analysis was conducted following Braun and Clarke's (2012) 6-step framework (Nowell et al., 2017).

Become Familiar with the Data and Generate Initial Codes

The first step in the Braun and Clarke's (2012) framework involved developing familiarity with the data, which commenced with exporting data from SurveyMonkey into a password-protected Microsoft Excel spreadsheet that documented and journaled my initial thoughts. Interview transcripts were created as each participant typed in their own unique responses, which reflected their insights and lived experiences on IPV. SurveyMonkey housed the questions and sorted the data either by respondent or question; each participant was labeled Respondent 1 through 30 (R1–R30).

After becoming familiar with the data, I began the second step, which involved the development of a coding framework that consisted of a list of codes used to index and divide the data into descriptive, emergent topics across the data set (Braun & Clarke, 2012; Bringer et al., 2004). As a result of coding being an iterative process, I conducted a process known as table method, which was facilitated by cutting out codes and moving them around on the excel spread sheet (Saldana, 2013); I used various colors to delineate frequently used terms by each respondent.

Next, I labeled the relevant phrases, words, or sentences that described concepts, processes, activities, or actions of the participants; the process of labeling is known as first and second cycling coding (Miles et al., 2014; Patton, 2015). The coding framework consisted of codes that I expected would be used to index and divide the codes into themes. Qualitative researchers support using the coded data to draw out significant features in a systematic process across the data set (Braun & Clarke, 2015; Bringer et al., 2004).

Structural and in vivo were two elemental coding methods used as the primary approaches to this qualitative data analysis (Saldana, 2013). Structural coding is question-based coding to a portion of the data that relates to a specific research question (MacQueen, 2008). Researchers have supported the use of structural coding in qualitative studies that recruited multiple participants and utilized semi structured data gathering protocols and interview transcripts (Guest et al., 2008; MacQueen et al., 2008; Namey et al., 2008).

Searching for, Reviewing, and Naming Themes

Once I completed coding of the data, I began to conceptualize themes from the codes. Steps 3 through 5 of the framework consisted of hand coding to uncover emergent themes that captured ideas that surrounded the research questions (Maguire & Delanunt, 2017). Each question was evaluated exploring similarly expressed experiences by the respondents and then color coded for easier identification of prevalent themes. Themes began to emerge as early as Interview Question 1, which sought to understand their perception of safety planning. I reviewed the highlighted themes on the Excel spread sheet, which assisted with organizing the data and themes in relation to the entire data set (Braun & Clarke, 2012). Finally, in vivo coding helped with using verbatim terms and concepts drawn from the women's experiences (Stringer, 2014).

Producing the Report

Step 6 was the final one in conducting an analysis of the data (Braun & Clarke, 2012). The most influential themes were used to conduct the final analysis, which related back to the research questions and literature and produced a scholarly report of the data because it refined the specifics of each theme and the overall story the analysis told, generating clear definitions and names for each theme (Braun & Clarke, 2012). Table 2 depicts these methods during first and second cycle coding processes, which were labeled and organized by the 12 interview questions.

Table 2

First and Second Order Coding

#	Interview questions	First order codes (structural and in vivo)	Second order cycling	Themes
1	Safety planning	Structured plan; plan of action A way to escape the violence; keep me safe Allows me to brainstorm; Preparing in advance A counselor will help me to develop it. (Counselors are: social worker, therapist, mental health case worker, child protective services worker and domestic violence advocates) Women's group	Safety planning is important because… Who will support me if I develop it?	Safety planning is important and can be accomplished with a support system
2	Community resources	Protection; protection order, DV court What actions to take next; women's shelter, DV help line, 2-1-1, YWCA, rape crisis center, ER, domestic violence child advocacy center	Law enforcement involvement	Law enforcement involvement is an important community resource
3	Best way to learn about creating a safety plan	In person, phone, text, email Don't judge me; someone with the same experiences Written instructions; make ensure no loopholes in plan; what to do (examples); If-then trees; provide additional resources Confidentiality; meet at another location	Ways to communicate with me When communicating with me, it's important to…	Communicate in person with someone who can relate to my experiences
4	How will safety plan benefit you	Prepare for future; no return to abuse; means of escape; next steps; I will make better decisions; tips & resources; I know there's help I'm worthy; empowering; I can help myself and not wait on others; I can be calm and not enraged; I will make better decisions	Instruct me how to be safe	Safety planning is important and can be accomplished with a support system
5	What or who is your support system	Family, friends, neighbors; other DV survivors Therapist, DV advocate	Support system	Support systems are important
6	Best way to learn or teach you about safety planning	Seeing, Listen, Education, Repeat back, classroom, Talk & write back, Written, Website, Phone Give me Something to write with, Email, Group, Email, Phone, Visual presentation, Website, Homework to get me to apply those changes Talk with another survivor because they can relate; how to react better, process ideas; Talk about my strengths; Remind me that I have a right to be safe; Written reminders of what behaviors to change	Learning preferences Communicate with me in person	I prefer to learn from someone in person who has similar experiences as I do and can relate

(table continues)

#	Interview questions	First order codes (structural and in vivo)	Second order cycling	Themes
7	Best way to learn or teach you about behavior changes	Talk with another survivor because they can relate to my experiences Therapy; Counselor reminds me via text; I would keep appt if counselor shared what our next meeting; someone explaining the schedule and ID barriers	Communicate with me in person	I prefer to learn from someone in person who has similar experiences as I do and can relate
8	Best way to learn or teach you about keeping appts	Talk with another survivor because they can relate to me A counselor can communicate why it is important to keep the schedule; evidenced based practices	Communicate in person What are the gold standards evidenced based practices	I prefer to learn from someone in person with similar experiences to teach proven practices
9	What strategies or plans used to deal with physical abuse?	Don't go around anyone when I am bruised; leave; Walk away; run; remove that person; Find exits to safety; Find safe place; escape plan; hide Police / Court; ER; ask for help; Use code words with friends to call 9-1-1; document abuse; Self defense Stay and comply with his wishes to decrease violence; I would inflict pain on him. I would lie about bruises when family/friends asked. Make up story before hand	Strategies to decrease recidivism Strategies that support recidivism	Interventions and barriers of IPV
10	What strategies or plans used to deal with emotional abuse?	Remember abuser doesn't care about me; Tell abuser how I feel; I have no boundaries; Isolate; stay to be loved and not be alone; verbal abuse does not bother me Leave, remove person, Divorce, document the abuse I'm worthy of better treatment; Counseling for rage, reach out for help; positive self-talk, support system; talk with others survivors	Strategies that support recidivism Strategies to decrease recidivism	Interventions and barriers of IPV
11	Who or what in your life would support or help you follow a safety plan?	Family; Friends Mental health services; safety plan age appropriate; made me aware how important following the plan was for my children; I think about my future Billboards, signs, ads; apps on your phone for DV; publicize problem and bring attention to problems which creates hope if you don't feel alone	Support systems Lack of community awareness	Community awareness of IPV supports me
12	Concluding thoughts	Safety planning needs to be done as a team Not counselor driven, but process options and let you decide It takes many supportive people to consistently remind you that you are worthy		

Note. DV = domestic violence

Evidence of Trustworthiness

In establishing evidence of trustworthiness protocols in qualitative research, several strategies were used during the study to ensure rigor. Trustworthiness is conceptualized as the extent to which one had confidence in the findings of the study (Adams et al., 2015; Lincoln & Guba, 1985). The criterion for qualitative research were described as credibility, transferability, dependability and confirmability (Amankwaa, 2016; Grossoehme, 2016; Hamilton & Finley, 2019; Korstjens & Moser, 2018). The next sections defined each criterion and validated how the four criteria for trustworthiness were applied to this study.

Credibility

Chapter 3 previously defined credibility, which is also known as internal validity, as the confidence of the accuracy of research findings which in this study was drawn from in-depth interviews (Amankwaa, 2016; Korstjens & Moser, 2018; Lincoln & Guba, 1985). In order to set aside any biases that I may bring to the study, a semi-structured interview guide was used to elicit the health education and learning preferences of women affected by IPV. In addition, Chapter 3 outlined that the credibility of this study would be established though a strategy known as continuous member checking. As a result of the impact COVID 19 had on The State of Ohio, all 30 participants chose to conduct their interview using the online survey monkey tool. Although the participants were always in control of their interpretation of the data because they manually entered their responses, continuous member checking could not be performed as I did not have an opportunity to ask additional or probing questions for clarification.

Qualitative authors have defined methodological triangulation as the utilization of various methods of obtaining thorough data about the participants (Abdalla et al., 2018). Methodological triangulation established credibility in this study by utilizing the screening and demographic surveys. The screening survey was used to identify if the participants were women, 18 years of age or older, could read and write English, and experienced IPV six months or greater (see Appendix A). Next, the demographic survey was used to identify the age, ethnicity, educational level, income status, and what length of time the violence last occurred (see Appendix B). Finally, credibility was established by using three forms of online research tools known as the SurveyMonkey and The Walden Participant Pools; which provided each participant with the research questions.

Transferability

Korstjens and Moser (2018) defined transferability, which is also known as external validity, as the degree to which the results of this research can be applied to other women affected by IPV receiving safety planning interventions. This phenomenological study explored the health education and learning preferences of women affected by IPV who used self-management strategies during safety planning interventions. Transferability was established in this study by using the strategy of thick description; which described the behaviors, experiences and various settings of the participants so that the experiences become meaningful to an outsider (Lincoln & Guba, 1985; Sim & Sharp, 1998).

Dependability

Flick (2018) defined dependability, which is also known as validity, as the production of reliable and recurrent research results. Korstjens & Moser (2018) conceptualized the method of developing an audit trail to establish dependability in qualitative research. Dependability was established in this study through a step by step guidance of the methodology of data collection, analysis and conclusions of the research. All raw data was entered by participants on a survey monkey research tool. Next, the raw data was exported onto an excel spreadsheet for further analysis. Finally, data analysis and synthesis were delineated in Chapter 4 as how the raw data underwent first and second cycling coding methods which themes and sub themes emerged. Implementation of the audit trail increased transparency by describing the research steps taken from the start of the study to the development and reporting of the findings (Korstjens & Moser, 2018; Lincoln & Guba, 1985; Merriam & Tisdell, 2016; Ravitch & Carl, 2016).

Confirmability

Korstjens and Moser (2018) defined confirmability, which is also known as objectivity, as ensuring that the data is based on the participants experiences and all interpretations of the research are biased free. Confirmability was established in this study by having all the participants answer the same research questions as outlined in the semi-structured interview guide (See Appendix C). Each participant reported that they understood that the study was voluntary and that they had the opportunity to discontinue taking the survey and still can receive the incentive of the $20 Walmart gift card.

Results

The purpose of this qualitative research study was to explore the health education needs and learning preferences of women who used the three self-management techniques: (a) committed to behavioral changes, (b) willing to adhere to treatment regimens discussed during safety planning interventions, and (c) describe strategies to cope with the negative consequences of psychological and physical violence. Data was thematically analyzed using Braun and Clarke's (2012) six step framework. Maguire & Delahunt (2017) illustrated that the goal of a thematic analysis is to identify patterns in the data that are significant and use them to address the research phenomenon. This section of the chapter will be organized by the four research questions this study addresses.

Research Question 1

Research Question 1: What were the health education needs and learning preferences of women affected by IPV who were committed to behavioral changes during safety planning interventions? Six interview questions were used as a basis to gather data for analysis regarding Research Question 1. Through the process of structural and in vivo coding methods, Table 3 depicted the final analysis groupings which resulted in the identification of six codes, three categories and two themes that described the health education and learning preferences of women affected by IPV who were committed to behavioral changes during safety planning. The two final themes identified were labeled as (a) develop safety plan with counselor with similar experiences, and (b) therapy facilitated behavior changes over time with various support systems. Tables 3 through 6

represented structural and in vivo coding of thematic analysis for each of the four research questions.

Table 3

Thematic Analysis Research Question 1

Structural and In Vivo Codes	Categories	Themes
Structured plan to escape the violence and keep me safe	Safety planning instructs me how to be safe	Develop safety plan with counselor with similar experiences
Written instructions with no loopholes		
Non-judgmental counselor will meet in person to help me develop confidential plan		
Talk with counselor with similar experiences	Communication in person with therapist (DV survivor) who can relate to my experiences	Therapy facilitated behavior changes over time with support systems
Therapy in person to discuss my strengths, reason to keep appointments and consequences of not changing behavior		
Publicize problem with billboards, radio ads and DV apps	Therapy and support systems helped change my behaviors	

Note. DV = domestic violence

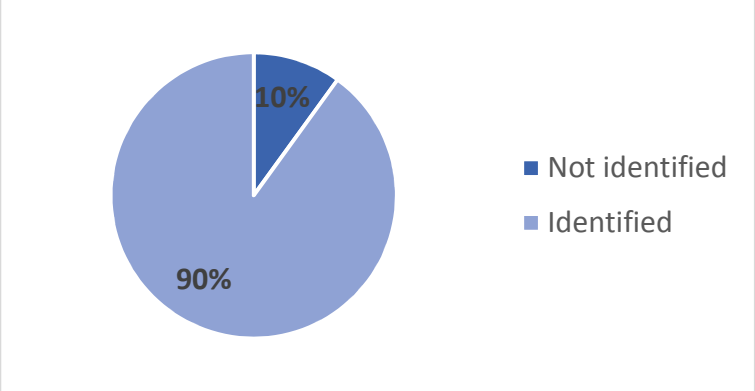
Theme 1: Develop Safety Plan with Counselor with Similar Experiences

The first theme that emerged from the participant's responses was the concept of how developing a safety plan provided guidance in changing their behaviors that reduced further violence. Out of 30 participants, 27 described how their learning preferences in the development of a safety plan was that it must be created in person with other women who had been affected by IPV as well. Figure 3 depicts the percentage of participants that identified the importance of the safety plan changing their behaviors; as well as those participants that either did not know about safety planning or participated in safety planning and it did not help them with behavioral changes.

Participant 8 stated “I’m not sure; I have never reached out.” Participants 2 and 11 respectively stated “Hearing examples from survivors and what worked best for them helped”; “Creating a safety plan would be beneficial because it would help keep me more calm in the situation. You would have ideas of what you need to do next, rather than freaking out, trying to figure it out in a high stress situation.”

Figure 3

Percentage of Participants who Identified Development of a Safety Plan Facilitated Behavioral Changes



Theme 2: Therapy Facilitated Behavior Changes Over Time with Various Support Systems

The second theme that emerged from the participant’s responses was the concept of therapy helped them with behavioral changes over time. All 30 participants recounted how they prefer health education from such professionals as a therapist, counselor, social worker and mental health workers to change their behaviors over time. All participants identified the importance of talking with a professional in person over time helped change their behaviors.

Participant 2 stated “counseling helped my uncontrollable rage.” Participant 12 recounted “Having a conversation with my counselor and her writing down reminders of behavioral changes helped me; also, by giving me literature help.” Participants 8 and 9 respectively recounted “talking with my counselor helped me learn how to react in better ways.” “I would prefer to learn from someone with similar experiences whose come out of them. I’m one who likes to thoroughly talk things out, so just being able to talk to someone about it who can relate.” Participants 12 and 15 respectively stated “going to therapy gave me positive affirmation about myself; its empowering.” “My counselor helps me to know my worth as a person.” Finally, Participant 23 shared “I won't feel stuck and helpless when I talk to my counselor.”

Research Question 2

Research Question 2: What were the health education needs and learning preferences of women affected by IPV who were committed to adhere to the treatment regimens discussed during safety planning interventions? Four interview questions were used as a basis to gather data for analysis regarding Research Question 2. Through the process of structural and in vivo coding methods, Table 4 depicted the final analysis groupings which resulted in the identification of six codes, three categories and two themes that described the health education needs and learning preferences of women affected by IPV who were committed to adhere to treatment regimens discussed during safety planning. The three final themes identified were labeled as (a) law enforcement presence facilitated linkage to other services, (b) therapy facilitated increased accountability and (c) lack of public awareness campaigns.

Table 4

Thematic Analysis: Research Question 2

Structural and In Vivo Codes	Categories	Themes
Police helped me obtain a protection order; referred me to DV court and ER	Law enforcement Involvement	Law enforcement facilitated linkage to other services
Talk with counselor, discuss my strengths, reason to keep appointments and consequences of not changing behavior	Talk in person with therapist who can relate to my experiences	Therapy assisted with accountability
Publicize problem with billboards, and radio ads	Increase awareness of the IPV	Lack of public awareness campaigns
Learn about IPV from website and apps on phone		

Note. DV = domestic violence

Theme 1: Law Enforcement Presence Facilitated Linkage to Other Services

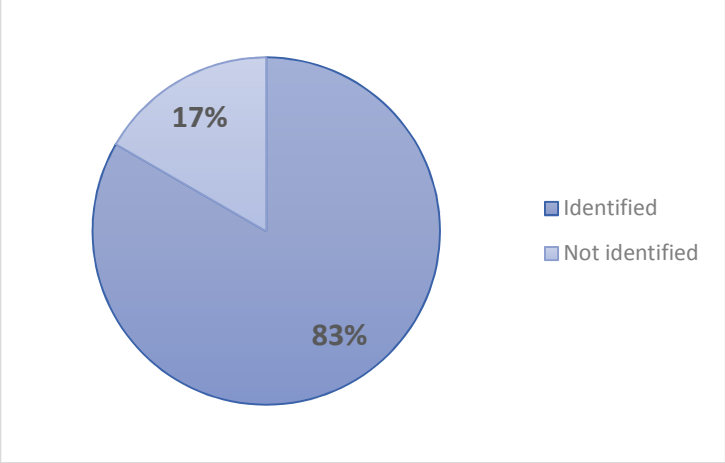
The first theme that emerged from the participant's responses was the concept that adhering to safety planning would increase when there was law enforcement involvement. The participants defined law enforcement involvement as police, courts with special dockets called domestic violence court, other criminal justice systems, as well as domestic violence advocates. Figure 4 depicts a visual presentation that 25 participants out of 30 or 83% of the women indicated the importance of having law enforcement involved increased their chances of adhering to a safety plan. The participants reported that the police can remove the abuser, and work with the prosecutor to link them to the domestic violence court docket. The participants understood that police also have the ability to help them seek medical care; then the emergency room can provide them with linkage to an emergency women's shelter, The Rape Crisis Center, The Domestic Violence Child Advocacy Center, The YWCA, and/or resources from The

United Way's First Call for Help, 24 hour hotline. Finally, the participants believed that the police and domestic violence advocates can outline the next steps in court and advocate for a protection order.

Participant 16 stated "I would call the police and seek medical attention." Participants 17, 13 and 7 respectively reported "I would call the police to have the person removed from my life. I'm not sure of any other way than to call the police"; "I would run, fight back and have 9-1-1 already dialed"; and "I would contact 9-1-1 for help, if not able to call myself. I would take photos of injuries and document the abuse myself to keep a timeline, if able." Finally, 17% of participants did not believe that law enforcement involvement would assist them in adhering to safety planning. Participants 10, 11 & 12 respectively indicated "I'm unsure"; "I'm not sure, I never reached out"; and "I don't believe we have any resources that could help."

Figure 4

Percentage of Participants who Identified Having Law Enforcement Present Increased Adherence to Safety Planning



Theme 2: Therapy Facilitated Increased Accountability

The second theme that emerged from the participant's responses was the concept of therapy providing health education on the importance of adhering to treatment regimens discussed during safety planning interventions. All the participants Identified that talking to a therapist changed their behavior over time; the same applies to this theme. Participants indicated that a therapist assisted them in being committed with adhering to the treatment regimens discussed during safety planning interventions. A constant underlying theme that the participants shared is that they would like to meet with someone in person and discuss their experiences with someone who could relate. Participant 1 and 16 stated "I schedule appointments in advance and my therapist reminds me via text. She suggested that I keep a calendar." "My counselor gives me information about experiences of what was successful for them and other. Also, what the possibilities to expect with each decision [for the treatment regimens]. If I call the police, the perpetrator will or will not be arrested." Participants 7, 8, and 13 respectively reported "My therapist has in depth conversations about how the schedules would fit into my existing schedule to identify barriers"; "…to thoroughly talk about the plan to make sure there are no lose ends"; and "I would like to know the evidence behind certain things like safety planning and treatment schedule. As in …is it really worth it."

Participants 15, 18 and 28 respectively reported "I would keep appointments if the counselor shared what we were going to talk about that day and the importance of keeping the appointment"; "I need to see examples and listen and then have her make me repeat it back"; and "I need the counselor to be straight forward with me and do not sugar

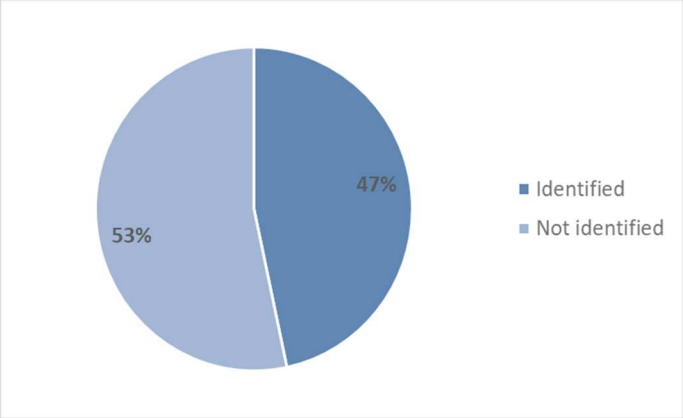
coat anything; explain what would happen to me if I did not keep the appointment and not being consistent." Participant 30 stated "It might help me if my counselor talks to me face to face about it; I am a note taker. I am a verbal and visual person and writing it down [the importance of adhering to the treatment regimens] can help me so it goes in my brain better." Finally, Participant 27 reported "I need my counselor to make me accountable for my willingness to participant and to hold me accountable for what I need to get done; I was raised on a military base so I have that accountability for keeping things on schedule and following through."

Theme 3: Lack of Public Awareness Campaigns

The third theme that emerged from the participant's responses was the concept of there being a lack of public awareness on IPV. Out of 30 participants, 16 reported they would be able to commit in adhering to treatment regimens discussed during safety planning interventions if there were more public awareness campaigns. Participant 15 and 8 respectively stated "It took many supportive people to consistently remind me that I was worthy of staying safe and living a life without fear." "I'd prefer to learn more about safety planning from a website with lots of information." Finally, Participant 27 reported "I would say that the community needs to add more public awareness; it occurs more than people realize. Domestic violence is not just isolated and related to a spouse, you can be in any situation and still have domestic violence occur."

Figure 5

Percentage of Participants who Identified a Lack of Public Awareness of IPV



Research Question 3

Research Question 3: How did women affected by IPV describe the strategies they used to cope with the negative consequences of psychological and physical violence? Six interview questions were used as a basis to gather data for analysis regarding Research Question 3. Through the process of structural and in vivo coding methods, Table 5 depicted the final analysis groupings which resulted in the identification of six codes, four categories and three themes that described the strategies they used to cope with the negative consequences of psychological and physical violence? The three final themes identified were labeled as (a) law enforcement involvement assisted with negative consequences of IPV, (b) therapy assisted with negative consequences of IPV, and (c) lack of public awareness campaigns.

Table 5

Thematic Analysis: Research Question 3

Structural and In Vivo Codes	Categories	Themes
Police involvement made reports, obtained protection orders and linked to ER	Law enforcement involvement	Law enforcement presence facilitated assistance with negative consequences of IPV
DV court and advocates assisted	Communication in person with therapist (DV survivor) who can relate to my experiences	Therapy assisted with negative consequences of IPV
IPV creates trauma	Therapist provides strategies to cope with IPV	
Non-judgmental, trauma informed therapists teach coping skills		
Publicize problem with billboards, and radio ads	Increase awareness of IPV	Lack of public awareness campaigns
Learn about IPV from website and apps on phone		

Note. DV = domestic violence

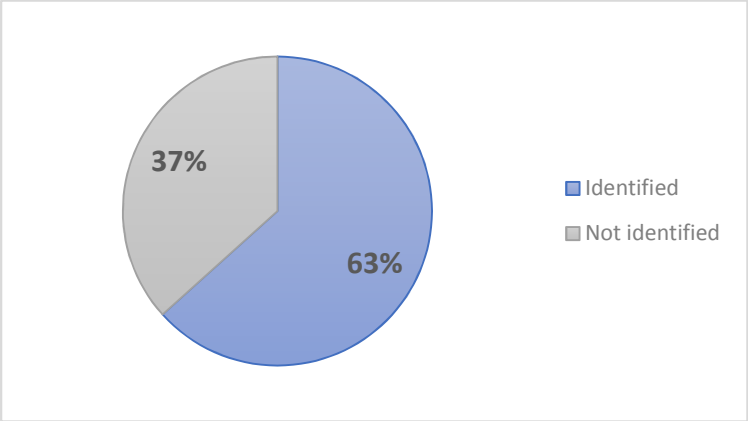
Theme 1: Law Enforcement Presence Assisted with Negative Consequences of IPV

The first theme that emerged from the participant's responses was the concept of law enforcement involvement being used to cope with the negative consequences of psychological and physical violence. As previously identified in Table 3 (Theme 1) the participants defined law enforcement involvement as police, criminal justice systems, and domestic violence advocates. Figure 6 depicts that 19 participants out of 30 indicated the importance of having law enforcement involved to cope with negative consequences of IPV. Participants 21 and 25 respectively reported "… make police reports and find a safe place to live" and "Run, fight back and have 9-1-1 already dialed." Participants 13 and 28

respectively recounted “I have had this happen, I used police and court involvement” and “…call the police and seek medical attention.” Finally, Participant 19 stated “I would use self-defense strategies if applicable. I would use a code word through a text with a trusted person to contact 9-1-1 for help if not able to call myself. I would take photos of injuries, document the abuse for myself to keep a timeline if able.”

Figure 6

Percentage of Participants who Identified Law Enforcement Presence was Used to Cope with Negative Consequences of IPV



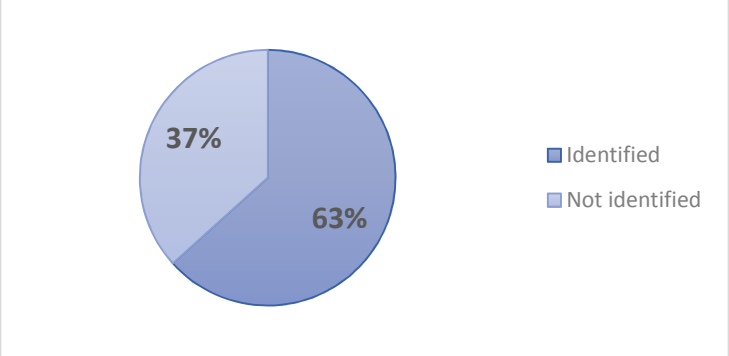
Theme 2: Therapy Assisted with Negative Consequences of IPV

The second theme that emerged from the participant’s responses was the concept of linking with a therapist who can provide health education on the vast number of strategies used to cope with the negative consequences of IPV. As previously illustrated with Research Question 1, all 30 participants shared the importance of therapy. In addition, Research Question 1 – Theme 2, the participants discussed their learning preferences as having a therapist who has also experienced IPV. Figure 7 depicts the visual representation of this data. Participants 6 and 9 respectively stated “I would like to talk to other women who have been in domestic violence situations” and “I would prefer

to learn from someone with similar experiences who has come out of it; it's important if they can relate to what I have been through." Participant 2 recounted "It was helpful them giving me information about experiences of what was successful for them and others." Finally, Participant14 stated "I believe that only through the help of those who survived the similar abuse, was I able to escape and start over.

Figure 7

Percentage of Participants who Identified Their Therapist Must Have Experienced IPV

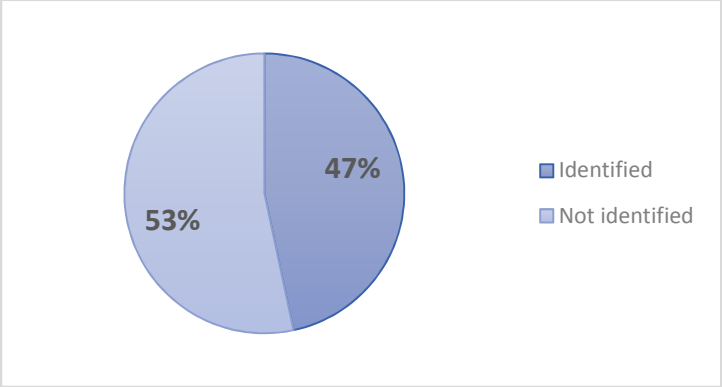


Theme 3: Lack of Public Awareness Campaigns

The third theme that emerged from the participant's responses was the concept of the lack of health education awareness campaigns on IPV which can help them cope with the negative consequences of violence. As previously highlighted, Research Question 2, Theme 3, visually represented by Figure 5 demonstrated this outcome in the data analysis. Participant 8 stated "I think there should be more billboards, signs, ads, and maybe even apps about domestic violence. If people are seeing more about it everywhere, maybe it'd help someone get out of an abuse relationship. Maybe they wouldn't feel so helpless in their situation and have some type of hope."

Figure 8

Percentage of Participants who Identified a Lack of Public Awareness Campaigns for IPV



Research Question 4

Research Question 4: What were the lived experiences of women affected by IPV who used the health literacy technique of self-management as a health education and safety planning intervention? All 12 interview questions were used as a basis to gather data for analysis regarding Research Question 4. Through the process of structural and in vivo coding methods, Table 6 depicted the final analysis groupings which resulted in the identification of four codes, one category and one theme that described the lived experiences of women affected by IPV who used the health literacy techniques of self-management as a health education and safety planning intervention. The final theme identified was labeled as: behavioral health systems promote utilization of self-management techniques.

Table 6

Thematic Analysis: Research Question 4

Structural and In Vivo Codes	Categories	Themes
Therapy facilitated better decision making Meet therapist in person to discuss self-management Skill building Therapist with similar experiences to teach health education on IPV Non-judgmental, trauma informed therapists teaching coping skills	Therapy	Behavioral health workers promote utilization of self-management techniques

Theme 1: Behavioral Health Workers Promoted Utilization of Self-Management Techniques

The overarching theme reported by 100% of the participants consistently identified that therapy was the catalyst to learn self-management techniques to become committed to behavioral change, to adhere to treatment regimens and develop strategies to cope with the negative consequences of psychological and physical violence. In addition, the participants identified they would prefer to learn health education from a non-judgmental, therapist with similar experiences as they had.

Participant 4 reported she prefers to learn about IPV by "having my counselor talk me through the process and give me recommendations and guide me in the right directions and get the plan in place and when necessary implement it." Participants 15, 22 and 27 respectively recounted "I would like to sit down with other counselors and listen to their experiences." "I'm one who likes to thoroughly talk things out, so just being able to talk to a counselor about it who can relate" and "…with counseling, I now know that I am worthy to not go through this type of violence." Finally, Participant 27 stated that she

would prefer to learn about behavior changes by "I believe this can be done in counseling. I do not know if this can be done at one time visit. I would need someone to give me homework to apply the principles of behavior change.

Summary

This section addressed the results from this qualitative research study. The four research questions answered were (a) what were the health education needs and learning preferences of women affected by IPV who were committed to behavioral changes during safety planning interventions, (b) what were the health education needs and learning preferences of women affected by IPV who were committed to adhere to the treatment regimens discussed during safety planning interventions, (c) how did women affected by IPV describe the strategies they used to cope with the negative consequences of psychological and physical violence, and (d) what were the lived experiences of women affected by IPV who used the health literacy technique of self-management as a health education and safety planning intervention.

A synopsis of the results indicated that the learning preferences of women affected by IPV who used the three self-management techniques of (a) being committed to behavior changes, (b) having a willingness to adhere to treatment regimens discussed during safety planning interventions, and (c) developed strategies to cope with the negative consequences of IPV were that they preferred to develop a safety plan face to face, with a non-judgmental counselor who had similar experiences as they did so they could relate to them. Finally, the women described that their health education needs could be met by providing them with written documentation to remind them of being

accountable, positive self-talk and through an evidenced-based practice known as teach back. Chapter 5 will discuss the conclusion and recommendations resulting from these findings.

Chapter 5: Discussion, Conclusions, and Recommendations

IPV remains one of the most common forms of gender-based violence in which women are disproportionally affected (Black et al., 2010; WHO, 2012). The purpose of this phenomenological study was to explore the health education needs and learning preferences of women affected by IPV who used self-management techniques during safety planning interventions to address a gap in the literature (Hackett et al., 2016; Hegarty et al., 2016; Logan & Walker, 2018; Murray et al., 2015). The self-management techniques that this study examined were (a) being committed to behavioral changes, (b) willing to adhere to treatment regimens discussed during safety planning interventions, and (c) using strategies to cope with the negative consequences of psychological and physical violence. The objective of this study was to inform social policy to effect positive social change for women affected by IPV during safety planning interventions.

Results indicated that women affected by IPV described their health education and learning preferences as the ability to incorporate self-management techniques when there was law enforcement involvement and to develop a safety plan with a therapist who had similar experiences of IPV. Further, participants identified a lack of IPV public awareness campaigns within the community. Chapter 5 presents the interpretation and context of the study results within the conceptual framework and literature addressed in Chapter 2 and further explores the implications of these findings for future research and understanding. Additionally, this chapter presents study limitations, recommendations, and positive social change implications.

Interpretation of the Findings

Research Question 1

Research Question 1: What were the health education needs and learning preferences of women affected by IPV who were committed to behavioral changes during safety planning interventions? The data analysis confirmed that women affected by IPV in this study identified two health education needs and learning preferences in order to commit to behavioral changes during safety planning interventions.

Interpretations from Theme 1

Ninety percent of the women identified that when developing a safety plan, their health education needs and learning preferences were to meet in person with a non-judgmental therapist who protected their confidentiality and related to their experiences of IPV. A theory known as collective efficacy was developed by Albert Bandura in the 1970s that supports these findings reported by the women as to their health education needs and learning preferences (Bandura, 1997). Bandura defined collective efficacy as a perception of a "group's shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments" (Bandura, 1997, p. 477). In this case, the women had a shared belief that if they had peer administered support, they collectively would organize and execute a successful safety plan to overcome the subsequent negative effects of IPV.

These findings confirmed existing knowledge in the field, adding to the literature on women affected by IPV. Bradbury-Jones et al. (2015) confirmed that women affected by IPV expected that health care professionals would judge them and thus they did not

disclose their abuse when seeking services (Valpied & Hegarty, 2015). Additional research highlighted that when disclosure did occur, clinicians were most effective when they offered an empathetic response that was informed by the patient's preferences and personal circumstances (Liebschutz & Rothman, 2012; McCaw et al., 2001).

The identified health education needs and learning preferences as interpreted under Theme 1 also related to the individual level of the SEM, a component of this study's conceptual framework. An intervention that would impact women at this level occurred at the time they sought services and screened for IPV. For instance, an in-house victim advocate such as a community health worker who had similar experiences may conduct the triage process, which allows for increased communication and building rapport quicker than other clinical staff. Stockman et al. (2015) also confirmed that multilevel interventions were required for patient–provider communication and help-seeking behaviors, which influences health outcomes and appropriately responds to the health education needs of women affected by IPV. Lastly, an objective of Healthy People 2020 confirmed the importance of SEM at the societal level by outlining its objective to increase the percentage of people who reported health care providers exhibiting respect for the sensitive information shared (Office of Disease Prevention and Health Promotion, 2020).

Interpretations from Theme 2

All the women identified that when developing a safety plan, their health education needs and learning preferences were linking to therapy, which facilitated behavior changes over time. The women defined counselors as behavioral health staff

like therapists, mental health case workers, domestic violence advocates, and social workers. These findings confirmed existing knowledge in the field. Hameed et al. (2020) also suggested that psychological therapies can reduce depression and anxiety among women affected by IPV, and dialectical behavioral therapy is empirically supported as a treatment resulting in the achievement of behavioral control and improved quality of life for this population of women (see also Carmel et al., 2016).

The identified health education needs and learning preferences as interpreted under Theme 2 also relate to the individual level of the SEM. An intervention that influences the attitude and beliefs toward IPV is therapists conducting classroom-based sessions that use health education curriculums to teach strategies to cope with disappointment as well as learn warning signs for depression (CDC, 2016). However, women affected by IPV experience difficulty during psychotherapeutic therapy (Pogarell et al., 2019), as therapists explore biographical details and impart how they can use coping skill for IPV symptoms (Obianujua, 2020). But primary care practices have explored the importance of the application of client-centered interventions such as personal safety and the utilization of community resources (Miller & Brigid, 2019).

Research Question 2

Research Question 2: What were the health education needs and learning preferences of women affected by IPV who were committed to adhere to the treatment regimens discussed during safety planning interventions? The data analysis confirmed that women affected by IPV in this study identified three health education needs and

learning preferences to be committed to adhering to treatment regimens discussed during safety planning interventions.

Interpretations from Theme 1

Eighty-three percent of the women identified that in order to be successful in adhering to treatment regimens discussed during safety planning, their health education needs and learning preferences were facilitated by the presence of law enforcement. The women defined law enforcement entities as the police and domestic violence advocates in addition to a protection order and being on the domestic violence court docket. The women reported that the presence of law enforcement facilitated their linkage to other services such as the emergency room, domestic violence crisis services, obtainment of a protection order, domestic violence court, and various other services. Like the other themes, these findings confirm the existing knowledge in the field. Based on the 2010 National Intimate Partner Sexual Violence Survey, 53% of women affected by violence contact police (Black et al., 2011; Page et al., 2016; Truman, 2011). Several other studies have also outlined a correlation between physical injury caused by IPV and subsequent police contact (Ackerman & Love, 2014; Addington & Perumean-Chaney, 2014).

Additionally, the identified health education needs and learning preferences as interpreted under Theme 1 related to the community level of the SEM. An intervention that would impact women at this level includes community partnerships across sectors to promote healthy and safe environments such as crisis shelters where they can access help. In light of the recent initiatives around the country to defund police departments (Johnson, 2020), such policy changes will impact the 63% of the women in this study

who identified that the presence of law enforcement facilitated their ability to cope with the subsequent negative consequences of IPV. In addition, policy changes at the community levels where funds would be reallocated from law enforcement budgets and invested into community needs such as affordable housing, quality healthcare, addressing educational inefficiencies, and social service programs (Bourne, 2020; Johnson, 2020) would impair the 83% of the women in this study who identified that law enforcement facilitated their ability to adhere to the safety plan they developed.

Interpretations from Theme 2

All the women indicated that in order to commit to adhering to treatment regimens discussed during safety planning interventions, therapy facilitated increased accountability. These findings confirmed the existing knowledge in the field illustrating that women who experienced controlling behaviors demonstrated help seeking behaviors and an increased motivation to change (Chang et al., 2010; Eisenberg & Kleinman, 1980; Seamark & Gabriel, 2018). Theme 2 also supported the individual level of the SEM. An intervention that would impact women at this level is health education programs to build self-esteem, facilitated by therapists who discuss strategies that improve their self-care regimes when stressed. It is important for behavioral therapists to recognize that the pathway to safety and healing from trauma occurs at different stages for women; therapy should be individualized to each woman when delivering psychological therapy (Garcia-Moreno, 2015).

Interpretations from Theme 3

Forty-seven percent of the women indicated that in order to commit to adhering to treatment regimens discussed during safety planning interventions, having increased public awareness on IPV is important. The women reported that they preferred to learn about IPV through an app on their phone, billboards, or ads on television. These findings both extended and confirmed the existing knowledge in the field. Healthy People 2020 identified health communication and health information technology as a need to be improved on within the United States (Office of Disease Prevention and Health Promotion, 2020). An interactive decision-support aid, available online or as a mobile app, can assist women affected by IPV by helping explore their values, make informed decisions about safety, and conduct a cost–benefit analysis on the risks of IPV (Miller & Brigid, 2019; Rosenbaum et al., 2018). Interactive support apps demonstrate increased safety behaviors and reduce psychological and violent sexual victimization among women affected by IPV (Glass et al., 2017).

Theme 3 also tied to the community and individual levels of the SEM. Interventions at the community level impact women when community level institutions such as the local health departments and community advocacy groups disseminate health information on IPV, which reduces social isolation. An example of an intervention at the individual level is health communication and health information technology objectives to increase the percentage of people who use mobile devices to develop self-management skills and easily retrieve health information (Office of Disease Prevention and Health Promotion, 2020).

Research Question 3

Research Question 3: How did women affected by IPV describe the strategies they used to cope with the negative consequences of psychological and physical violence? The data analysis confirmed that women affected by IPV identified three health education needs and learning preferences used to cope with the subsequent negative consequences of psychological and physical violence.

Interpretations from Theme 1

Sixty-three percent of the women indicated that in order to cope with the subsequent negative consequences of psychological and physical violence, having law enforcement present was important. Several studies also confirmed that women who experienced controlling behaviors such as those exhibited in psychological abuse or severe physical abuse demonstrated increased motivation to seek help from law enforcement (Cattaneo & DeLovah, 2008; Cattaneo et al., 2007; Cheng & Lo, 2015; Deans et al., 2018). Additionally, the findings aligned with the individual and societal levels of the SEM. The presence of law enforcement represents an intervention at the individual level, as it influences women's ability to initiate timely treatment for IPV. Interventions at the societal level imply the need for collaborative work by police, social workers, and similar advocates to ensure that disadvantaged women affected by IPV have knowledge to access community resources (Cheng & Lo, 2019; Ward-Lasher et al., 2017). A recent example of this intervention was implemented in California, as the sheriff's department has paired therapists with deputies when responding to non-violent mental health calls (Moon, 2020).

Interpretations from Theme 2

Sixty-three percent of the women indicated that in order to cope with the subsequent negative consequences of psychological and physical violence, having a therapist who similarly has experienced IPV was important. Previous research has also reported that clients value the shared experiences with recovery coaches (Jack et al., 2018). Recovery coaches, peer administered support, community health workers, and paraprofessionals are synonymous terminology used to describe this form of support. Pairing clients with peer administered supports or recovery coaches who are not professionals but who have experienced similar problems may substantially reduce the barriers to services (Bryan & Arkowitz, 2015). This finding relates to the individual and community levels of the SEM. Interventions at these levels promote health education programs by various organizations that are facilitated by peer administered supports during screenings, which can influence women to build social, emotional, and behavioral skills to build positive relationships.

Interpretations from Theme 3

Forty-seven percent of the women indicated that in order to cope with the subsequent negative consequences of psychological and physical violence, having increased awareness of IPV through campaigns can aide in reducing social isolation. Research has confirmed the importance of women becoming aware of the warning signs of IPV as well as its seriousness (Eden et al., 2015; Moracco et al., 2005; Randell et al., 2012; see also Walker, 2000). Additionally, Theme 3 related to the societal level of the SEM. Interventions at this level examine the strategies of local health departments to

diffuse health promotion programs that support behavioral changes. For example, information dissemination through health-related websites and apps are beneficial for health-related knowledge (Rosenbaum et al., 2018).

Research Question 4

Research Question 4: What were the lived experiences of women affected by IPV who used the health literacy technique of self-management as a health education and safety planning intervention? The data analysis confirmed that women affected by IPV identified one health education need and learning preference when they used the health literacy technique of self-management as a health education and safety planning intervention.

Interpretations from Theme 1

All the women reported that behavioral health workers promoted the utilization of self-management techniques as a health education and safety planning intervention. These findings related to previous research on effective clinical responses to IPV regardless of where the patient accessed medical care (McCaw, 2001; Murry & Welch, 2010; Sorensen et al., 2012). Additional research confirmed that clinicians and other workers have a responsibility to advocate for women affected by IPV by aiding them in goal identification and identifying their needs (Rivas, 2015).

The identified health education needs and learning preferences as interpreted under this theme align with the societal level of the SEM. Organizations can implement this intervention by creating and promoting that implemented an effective systems approach where site services are provided by behavioral health clinicians that triage for

mental health as well as the safety planning process of women affected by IPV. Organizations that support women's crisis shelters employed staff which implemented health education interventions which promoted the utilization of self-management techniques during safety planning intervention. In addition, Bair-Merritt et al. (2019) conducted research that confirmed the existing research which illustrated that interventions in primary care practices for women who reported IPV have shown a reduced risk of subsequent violence (Bair-Merritt et al., 2014). Lastly, a study conducted by Weishaar et al. (2019) demonstrated that community facilities were petitioned by The National Action Plan on Literacy (2018) to contribute in raising awareness of and improving health literacy skills such as those explored in this study (Schaeffer et al., 2018).

Limitations of the Study

Theofanidis and Fountouki (2018) defined limitations in research as potential weaknesses that are usually out of the researcher's control and are closely associated with the research design. Merriam and Tisdell (2015) illustrated that a significant limitation of qualitative research, is its weak transferability to other populations. Chapter 3 previously discussed the specific measures utilized in this study to strengthen transferability. However, the first limitation identified in this study is that its results may not be applicable to the population of men who have been affected by IPV. The WHO (2012) outlined that women are disproportionally affected by violence than men (Black et al., 2010).

As a result of the public health pandemic caused by COVID 19, the governor of Ohio mandated shelter in place orders (Ohio Department of Health and Human Services, 2020). An executive from the social service agency advised me that they were abiding by the governor's orders and I would not be able to come into the agency to conduct interviews. It is suspected that the shelter in place mandate was the reason why all 30 participants used the online platform as their setting in which to participate in the study. The women participated in self-administered online surveys which resulted in two additional limitations. First, the research study relied on self-reported data which can be subject to response bias, which could have influenced the results of this study (Althubaiti, 2016). Secondly, an inherit limitation of self-administered surveys, questionnaires and/or interviews, is that I was unable to control the course of the investigation, ask probing questions to clarify any questions from participants (Theofanidis & Fountouki, 2018). Although it is important to acknowledge limitations, this dissertation carefully applied strategies to minimize the impact of potential limitations on the findings, as discussed in Chapter 3.

Recommendations

This qualitative study was designed in response to the research gaps documented in the review of the literature. The objective was aimed at understanding the lived experiences of women affected by IPV who used self-management techniques during safety planning interventions; as well as address the gap in the literature regarding the health education needs and learning preferences of this population. Based on the data

analysis of Chapter 4, and the current literature, various recommendations were made for future research.

Portions of the data analysis from Chapter 4 illustrated that to be committed to behavior changes during safety planning, women affected by IPV identified their health education and learning preferences as developing a safety plan in person with a non-judgmental, therapist who valued confidentiality and could related to their experiences. Healthy People 2020 identified an objective to increase the percentage of people reporting health care providers exhibiting respect for the sensitive information shared (Office of Disease Prevention and Health Promotion, 2020).

Healthy People 2020 identified an objective to increase the percentage of people reporting their health care provider presented them with clear instructions to facilitate self-management skills at the time of discharge (Office of Disease Prevention and Health Promotion, 2020). Wennerstrom et al. (2018) conducted research identifying a gap in the literature of community health workers being used to address issues presented by women affected by IPV. Future research could explore the use of community health workers when providing care to women affected by IPV. There is an opportunity at an organizational level to investigate the impact of recruiting and providing professional development to community health workers providing care to this population of women (Wennerstrom et al., 2018).

Furthermore, the women identified that being linked to a therapist increased their accountability when adhering to treatment regimens to address any subsequent negative consequences of IPV. Previous research identified a gap in the literature as to the impact

of patient outcomes if a technique known as teach back was used while providing services (Dewalt et al., 2003). The teach-back method is an evidenced-based technique which allows the provider to continue to adjust and re-phrase their explanations and teachings until the patient fully understands what is being communicated. Therefore, there is an opportunity for future research to explore safety planning treatment outcomes of women affected by IPV when teach back is utilized. A quantitative research study would explore the therapists and the participants in a double-blind study. In this future study, neither therapist nor participant would be aware of who receives the teach back techniques. The women affected by IPV would be the independent variable that the therapists are attempting to manipulate.

Implications

This study has implications for positive social change. The overall data analysis conducted in Chapter 4 explored the health education and learning preferences of women affected by IPV who used the health literacy technique of self-management during safety planning interventions. Next, the analysis demonstrated that women affected by IPV were committed to behavioral changes and adherence to treatment regimens during safety planning interventions when certain factors were present. Finally, the study addressed how women affected by IPV described strategies to cope with subsequent negative consequences of psychological and physical violence. These findings have the potential to affect positive social change at the individual, community, and societal levels. The next section will outline the social implications with respect to each of the four research questions.

Research Question 1

The social change implications from Research Question 1 were grounded upon how women committed to behavioral change during safety planning interventions identified their health education and learning preferences. At the individual level, women affected by IPV who were able to identify their learning preferences when developing a safety plan may be able to enhance their ability to receive health education, as well as improve their ability to make informed health decisions, if their therapist implemented an evidenced-based technique known as teach back. Developing literature supports this technique in promoting effective communication between women affected by IPV and their providers (Klingbeil and Gibson, 2018).

At the societal level, the SEM demonstrated that women affected by IPV would be influenced by health, economic, and educational policies (CDC, 2018). The results of this dissertation and the evidence from the empirical literature demonstrated that not only can the teach back technique be implemented at an individual level, but at the organizational level as well. Therefore, organizations have a responsibility to support the promotion of self-management strategies with women affected by IPV. For example, Klingbeil and Gibson, (2018) highlighted that the teach-back method produced an environment that eliminated shame and judgement by converting abstruse health education into layman's terms which provided the women an opportunity to ask questions; thus, assisting them with understanding medical decisions and instructions (Brega et al., 2015). The teach back method was recognized by the National Quality

Forum (NQF) (2018) as the chosen technique for validating patient's understanding of the health education being discussed.

Another social change implication from Research Question 1, centered around the development of a safety plan, woman affected by IPV identified their learning preference was to meet with a therapist who could relate to their experiences. At the individual level, women who were able to identify their learning preferences may feel better connected to the process if they were linked with a community health worker. The results of this dissertation and the evidence from the empirical literature demonstrate that community health workers can be used to improve the cultural appropriateness of service delivery in developing new IPV interventions (Humphry & Kiernan, 2019; Wennerstrom et al., 2018). Community health workers have been defined as essential members of teams with a unique set of skills and experiences that serve communities that lack resources to provide reliable health information to the population being served (Wennerstrom et al., 2018).

Research Question 2

The social change implications from Research Question 2 were grounded upon how women committed to adhering to the treatment regimens discussed during safety planning interventions identified their health education and learning preferences. At the community level, women identified not only the presence of law enforcement involvement in order to facilitate linkage to other services, but linkage to a therapist to enhance their accountability to these services. An IPV awareness campaign through television, billboards and/ or radio may link these health education and learning

preferences needs by offering a community based partnership among law enforcement agencies, behavior health and health care systems to provide training, conduct IPV education and outreach for women affected by IPV to become aware of the seriousness and the negative consequences from IPV (Cheng & Lo, 2019).

The results of this dissertation and the evidence from the empirical literature from Fernandez et al. (2019) outlined how evidence-informed health intervention planning that encompasses theoretical and empirical evidence, as well as engages key stakeholders and community members, such as women affected by IPV in the planning process results in interventions that are more effective. Lastly, research conducted by Wennerstrom et al. (2018) outlined that despite surmounting evidence of the negative health consequences of IPV victimization, a gap remains in the implementation of culturally appropriate services (Sugg, 2015). Fernandez et al. (2019) illustrated health education programs derive from an understanding of the unique needs of the population, but they are also supported by theoretical and empirical research.

Research Question 3

The social change implications from Research Question 3 were derived as a result of how women explored their coping mechanisms related to the negative consequences of psychological and physical consequences of IPV. At individual and societal levels the SEM demonstrates women that identified the presence of law enforcement, therapy and increased presence of IPV campaigns were tools to cope with the negative consequences of IPV and may be able to benefit from a community awareness campaign with key stake

holders from a multidisciplinary approach on the negative health outcomes of IPV (Hardesty & Ogolsky, 2020).

Research illustrated that women affected by IPV may become anxious and/or overwhelmed by an inordinate amount of information, thus implementing self-management techniques may be increasingly challenging during times of stress (Brega et al., 2015). For example, the Agency for Healthcare Research and Quality suggested that safety goals, as well as specific health behaviors and outcomes can be improved by addressing health literacy self-management techniques at each encounter with the women (Brega et al., 2015). The body of evidence from the research conducted by Hameed et al. (2002) supports trained healthcare and other workers offering and delivering psychological therapies with women who have experienced any form of IPV, as they probably reduced depression and symptoms of anxiety.

Research Question 4

Finally, the social change implications from Research Question 4 were derived as a result of women affected by IPV identified behavioral health workers as encouraging the utilization of self-management techniques as a health education and safety planning intervention. The first social implication may occur at an individual level Klingbeil and Gibson (2018) illustrated that health literacy at the individual level focuses on the communication qualities and strategies involved in care between the therapist and/or health care professionals and the woman. Behavioral health workers may be able to improve their ability to build rapport to provide IPV health education to women by implementing what the ARHQ defined as health literacy universal precautions. One

objective of health literacy universal precautions is targeted at communicating clearly and confirming the level of understanding the woman has which will identify any miscommunications (Brach et al., 2012). Healthy People 2020 identified an objective to increase the percentage of people reporting providers explaining health education in plain language that is understandable (Office of Disease Prevention and Health Promotion, 2020).

In addition to positive social change implications at the individual level, the potential for implications is more prominent at the organization level, as limited health literacy is common and is difficult to recognize, at this level; thus behavioral health systems have the obligation to support the promotion of universal precautions with women affected by IPV. Behavioral health systems should assume that each level of the SEM may experience difficulty comprehending IPV health information and thus communicate in ways in which everyone can understand. A study conducted by Brega et al. (2015) illustrated that the Agency for Healthcare Research and Quality suggested making the office environment and health systems easier to navigate, as well as supporting women's efforts to improve their health. In addition, Healthy People 2020 identified an objective to increase the percentage of health care providers' offices offering patients assistance in completing forms (Office of Disease Prevention and Health Promotion, 2020). The positive social implications being suggested for this research question confirm and extend the existing knowledge in the field. Research conducted by Kripalani and Weiss (2006) outlined the importance of communicating clearly which gives people the sense of being more involved in their health care and increases the

chances adherence to treatment planning (Owen-Smith et al., 2016). This research also indicated that health literacy has the potential to successfully be used to influence political debates concerning health system reform, patient empowerment, and collaborative decision making (Weishaar et al., 2019).

Conclusion

Empirical literature has shown that IPV effects one in four women nationally and can lead to negative health outcomes (Alvarez et al., 2017; CDC, 2018). However, few studies have explored the health education needs and learning preferences of women affected by IPV using self-management techniques during safety planning (Hackett et al., 2016; Hegarty et al., 2016; Logan & Walker, 2018; Murray et al., 2015). By addressing four research questions, this study explored these gaps in the literature through the qualitative research process. The results of the study are significant as they confirm and extend the empirical literature on IPV, which has the potential to improve health education programs targeting this population of women. In addition, the recommendations can effect positive social change at various levels reflected on the socioecological model including individual, societal and organizational. Therefore, if utilized to implement health education programs in the community, the results of this research could facilitate evidenced-based practices targeted at providers to promote clear communication, which can foster a learning environment for women affected by IPV to identify their health education needs and learning preferences during safety planning.

In conclusion, healthcare providers and first responders are frequently the first individuals that have an opportunity to influence how women affected by IPV use self-

management techniques during safety planning interventions. Research has validated the correlation between implementing health education programs and how people manage their symptoms (Desnous et al., 2013; Zabolypournet et al., 2020). Ultimately, such programming could incorporate evidenced-based techniques such as teach back that can be individually tailored for women affected by IPV which could contribute to not only a commitment toward behavioral changes and a willingness to adhere to treatment regimes, but also develop skills needed in addressing the subsequent physical and psychological negative consequences of IPV.

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Appendix A: Screening Survey

Thank you for taking the time to consider participating in this research study. Completing the **screening survey**, will determine if you are eligible to continue as a participant. Please answer "yes" or "no" for each of the six questions. All responses are anonymous and confidential.

Screening survey:

1.	Are you a female?	Yes	No
2.	Are you 18 years of age or older?	Yes	No
3.	Are you a woman effected by domestic violence?	Yes	No
4.	Did the domestic violence happen 6 or more months ago?	Yes	No
5.	Can you read and write in English?	Yes	No
6.	Do you reside in The State of Ohio	Yes	No

*** IF YOU ANSWERED "**NO**" TO ANY OF THE ABOVE QUESTIONS, YOU ARE NOT ELIGIBILE TO PARTICIPATE IN THE RESEARCH STUDY. THANK YOU FOR TAKING TIME TO COMPLETE THE SCREENING SURVEY

Appendix B: Demographic Survey

Congratulations, you are eligible to participant in the survey. The goal of this study is to collect information from the lives of females who have experienced domestic violence and how they prefer to learn about safety planning interventions when seeking help in the community. Please write in your responses below if you agree to participant in the research study. All responses are anonymous and confidential.

Demographic survey:

1. How old are you? _____
2. What is your race / ethnic background? _____
3. What is your highest level of education **completed**? _____
4. Are you employed? (yes or no) _____
    a. If so, how much do you earn in a year? _____
5. The abuse last happened when? _____

Appendix C: Semi structured Interview Guide

Introduction to the study:

Hello, my name is Yvette Clemons and I would like to thank you for agreeing to participate in this research study about safety planning and domestic violence. I am in the PhD program at Walden University and my role in this research study is to interview you and explore your experiences as a women affected by domestic violence and what, if any, strategies you would use during safety planning interventions.

Please respond to all of the interview questions based on your experience of being a woman affected by domestic violence. I understand that your experiences may be a sensitive topic. I have chosen this private interview room to ensure that you feel safe and that your information will be kept confidential. Please understand that this research study is voluntary, which means that you are free to accept or turn down the invitation to be interviewed. If, at any time, you feel uncomfortable with the questions being asked, please let me know and we can move to another question. No one will treat you differently or deny you services if you decide not to participate in the study. Are you ok to continue with what has been explained to you so far?

Lastly, I respect your time today and we will attempt to stay on topic but do not hesitate to add to your responses if you believe it would assist me in understanding your experiences of safety planning and domestic violence. Do you have any questions before we begin?

Interview questions:

1) When you hear the term safety planning, what does that mean to you?
2) Tell me what services or programs are available in your community to help you with safety planning?
3) If someone helped you with creating a safety plan, what is the best way that you prefer for them to teach you about it?
4) Tell me how creating a safety planning would be a benefit or strength to you?
5) Tell me who or what you would identify as your support system if you created a safety plan?
6) Tell me how you would prefer to learn or the best way for someone to teach you about safety planning?
7) Creating a safety plan may ask you to think about certain behaviors to keep yourself safe. Tell me how you would prefer to learn or the best way for someone to teach you about behavior changes important in keeping you safe?
8) Creating a safety plan may ask you to think about promising to complete certain treatment schedules. Tell me how you would prefer to learn or the best way for someone to teach you about the importance of keeping those treatment schedules?
9) Women affected by violence may experience physical or bodily abuse. Tell me what strategies or plans you would use to deal with this type of abuse?
10) Women affected by violence may experience emotional or verbal abuse. Tell me what strategies or plans you would use to deal with this type of abuse?

11) Tell me who or what in your life would support or help you follow a safety plan that was created to help keep you safe?
12) Finally, is there anything you would like to add that may have been missed that you feel is important about your experiences?

Conclusion of interview:

I would like to thank you for your time in sharing your experiences with me. At this time, I would like to present you with a $20.00 gift card from Walmart.

Appendix D: Community Resource Guide

AGENCY	PHONE NUMBERS / HOTLINES	Y/H
Police, Fire, EMS/Ambulance	9-1-1	H
Rape Crisis Center Hotline (local)	216-619-6192	H
AIDS Task Force	216-621-0766	H
Battered Women / Domestic Violence Hotline	216-391-4357	H
Laura's Home (women's shelter)	216-472-5500	H
Cleveland Food Bank	216-738-2067	H
LGBT Center (Cleveland)	216-651-5428	H
Legal Aid – Tenant information line	216-861-5955	
Cuyahoga County benefits application hotline (childcare, food, medical, Ohio Works First, PRC)	1-844-640-6446	
First Call for Help (social service referral)	2-1-1 or 216-436-2000	H
Human Trafficking Hotline	1-888-373-7888	
Witness / Victim Service Center	216-443-7345	H
Women's Shelter (Norma Herr)	216-479-0020	H
Northeast Ohio Coalition for the Homeless	216-432-0540	H
Project Star (sex trafficking local hotline	855-431-7827	
Regional Transit Authority (RTA)	216-621-9500	H
Child Abuse Hotline (local)	216-696-5437 (KIDS)	H

MENTAL HEALTH / COUNSELING

AGENCY	PHONE NUMBERS / HOTLINES	Y/H
Mobile Crisis Team (suicide hotline / mental health)	216-623-6888	
Care Alliance Behavioral Health Centers	216-781-6724	Y
Murtis Taylor Multi Service Center	216-283-4400	H
St. Vincent Charity Psychiatric ER	216-363-2538	H
Cleveland Clinic Health Center	216-767-4242	H
Alcohol and Drug Addiction Mental Health Board	216-421-3400	
Centers for Families & Children Behavioral Health	216-651-2037	H

LEGEND: Y = Facility is accessible to physically disabled
H = Facility has an individual able to speak Spanish

Appendix E: Permission to Conduct Research using SurveyMonkey

To Whom It May Concern:

This letter is being produced in response to a request by a student at your institution who wishes to conduct a survey using SurveyMonkey in order to support their research. The student has indicated that they require a letter from SurveyMonkey granting them permission to do this. Please accept this letter as evidence of such permission. Students are permitted to conduct research via the SurveyMonkey platform provided that they abide by our Terms of Use at https://www.surveymonkey.com/mp/legal/terms-of-use/.

SurveyMonkey is a self-serve survey platform on which our users can, by themselves, create, deploy and analyze surveys through an online interface. We have users in many different industries who use surveys for many different purposes. One of our most common use cases is students and other types of researchers using our online tools to conduct academic research.

If you have any questions about this letter, please contact us through our Help Center at help.surveymonkey.com.

Sincerely,

SurveyMonkey Inc.