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Domestic Violence in Florence, Alabama

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COUN 6785: Social Change in Action:
Prevention, Consultation, and Advocacy

Social Change Portfolio

Isabella Sinda

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OVERVIEW

Keywords: Domestic violence, intimate partner violence, Florence, Alabama, Lauderdale County, Alabama

Domestic Violence in Florence, Alabama

Goal Statement: My goal would be to contribute to the prevention and reduction of domestic violence in Lauderdale County, Alabama, by raising awareness, supporting and empowering survivors, and advocating for system-wide changes promoting education, the allocation of necessary aid, and community well-being.

Significant Findings: Domestic violence (DV) is a serious public health issue negatively affecting people worldwide, including in the city of Florence, Alabama. DV can cause a host of mental and physical consequences, such as poor self-esteem, internalized anger or resentment, severe injury, and even death (American Psychiatric Association [APA], 2023). This issue can happen to individuals from all backgrounds and demographics. However, research suggests it is a gendered crime disproportionately impacting women, as well as other marginalized groups such as sexually diverse individuals and people of color (Connections for Abused Women and their Children [CAWC], 2023). Therefore, it is vital to incorporate various culturally relevant interventions to bring about positive change in Florence and prevent future violence.

Objectives/Strategies/Interventions/Next Steps: One strategy for effective DV prevention programming includes identifying and addressing the risk factors that may increase the likelihood of victimization or perpetration, such as heavy substance use, risky sexual conduct, previous history of experiencing or witnessing violence, reduced access to education, poverty,

unsafe conditions in the community, ineffective community sanctions related to DV, and more (Access Continuing Education, Inc., n.d.; CDC, 2024b; CDC, 2024c). It would also be crucial to partner with community-based agencies, such as One Place of the Shoals or Safeplace Inc., to provide support and services to survivors to encourage positive outcomes and effectively reduce revictimization. Other recommendations for approaching this issue include adhering to ethical guidelines, prioritizing cultural sensitivity and responsiveness, and advocating at the institutional, community, and local levels to remove barriers to assistance for DV survivors and effectively prevent future victimization.

INTRODUCTION

Domestic Violence in Florence, Alabama

I live in Florence, Alabama, where domestic violence (DV) is a public health issue, reflecting the worldwide trends of a rise in DV (Mineo, 2022). DV is a serious issue as it constitutes about 20% of all violent crimes (American Psychiatric Association [APA], 2023). Domestic violence can be challenging to identify, but it is typically characterized by abusive behaviors in which an individual has power over another in a romantic or familial relationship (Huecker et al., 2023). Unfortunately, it is a common issue that can have severe impacts on mental and physical health (Huecker et al., 2023). Thus, it is integral to effectively address domestic violence trends and attempt to circumvent this issue through prevention methods. To further my understanding of this public health issue, I will examine how it may impact those afflicted by it and society in multiple domains. I will begin conceptualizing the problem of DV by addressing the potential consequences that may come of it.

PART 1: SCOPE AND CONSEQUENCES

Domestic Violence in Florence, Alabama

The problem I identified and wish to address in my community is that of domestic violence (DV), also known as intimate partner violence (IPV). DV is typically violence against a partner or spouse in cohabitation or marriage, although it can also include abuse against elders or children in a domestic setting (World Population Review, 2024). DV can manifest as physical, emotional, psychological, financial, and sexual abuse (Huecker et al., 2023). It is a prevalent issue that impacts roughly 10 million people annually in the United States (Huecker et al., 2023). Violence has been highlighted as the eleventh most considerable health indicator in Alabama and can plague the victim far beyond the initial incident (Alabama Public Health, 2022). According to the World Population Review's breakdown of DV statistics per state, 37.5% of women and 29.5% of men in Alabama have experienced IPV in their lifetime (World Population Review, 2024). Based on this data, Alabama would rank 24th in terms of domestic violence by state in 2024 (World Population Review, 2024).

The FBI's Uniform Crime Reporting Program's National Incident-Based Reporting System (NIBRS) reflects data on domestic violence in Alabama beginning in 2020. However, it stresses that these numbers are incomplete and should not be used to reflect overall statewide crime (Hudnall et al., 2025). Furthermore, many cases are not reported to law enforcement or health professionals, resulting in a dark figure of DV-related crimes (Huecker et al., 2023). While this information cannot be considered comprehensive, the data still offers some relevant information on the occurrence of DV in Alabama, including specific details on counties and

overall state statistics. According to the NIBRS, from 2020 to 2023, there were 1,263 reports of domestic violence-related crime in Lauderdale County, Alabama (Hudnall et al., 2025), where Florence is located. In comparison, there were 66,425 NIBRS reports of DV-related crimes in Alabama as a whole, including aggravated assault, homicide, rape, robbery, and simple assault (Hudnall et al., 2025).

Unfortunately, data indicates there has been a worldwide trend in which there has been an increase in the occurrence of DV in recent years (Boserup et al., 2020). Beyond the devastation COVID-19 unleashed on the world's population numbers, it also wreaked havoc in terms of an influx of DV rates. Due to the isolation enforced by stay-at-home orders, there was little access to social support systems. The shutdown of nonessential businesses fostered economic hardship and increased unemployment rates. Substance use, stress, and depression may have also heightened tensions within homes during quarantine mandates, which may have exposed DV survivors to increased victimization and abuse (Boserup et al., 2020). While information on how DV trends have been evolving as the world works to move past the COVID-19 pandemic is still emerging, it is evident that IPV is a serious issue that may have severe implications for victims.

According to the APA, DV can have significant adverse effects on health and overall well-being, including increased stress, fear, isolation, and a higher risk for PTSD, depression, and suicidality (2023). Survivors of DV are more likely to engage in self-harm, as well as be diagnosed with anxiety or a substance use disorder (National Domestic Violence Hotline, n.d.). Victims of IPV might internalize the abuse they experienced, leading to self-directed anger, blame, or resentment (APA, 2023). They may also struggle when establishing new relationships (APA, 2023). Additionally, DV victims may be afflicted by poorer perceived and actual health (APA, 2023). DV survivors may be plagued by decreased quality of life and productivity and

increased mortality risk (Huecker et al., 2023). Around 75% of female DV victims experience an injury related to the abuse, including often unrecognized forms of IPV, such as traumatic brain injury (TBI) and nonfatal strangulation (APA, 2023). Furthermore, female DV survivors may experience unplanned pregnancies or pregnancy complications. Finally, DV can lead to death, which is reflected in current trends, with over half of female homicide victims in the United States killed by males who are their current or ex-partners (APA, 2023).

According to the Centers for Disease Control and Prevention (CDC), roughly 1 in 5 women and 1 in 7 men in the United States have experienced intimate partner violence at some point in their lives (Alabama Public Health, 2022). Almost all healthcare workers will work with a client involved with DV (Huecker et al., 2023). Thus, as a future clinical mental health counselor, I will undoubtedly work with a client affected by this issue. Therefore, per the CDC's suggestions, the goal of this portfolio is to explore prevention methods for domestic violence, mainly promoting healthy relationships by examining and addressing risk and protective factors for intimate partner violence at intrapersonal, interpersonal, communal, and societal levels (Centers for Disease Control and Prevention [CDC], 2024a).

PART 2: SOCIAL-ECOLOGICAL MODEL

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The socio-ecological model is based on the principles of Bronfenbrenner's ecological systems theory, which maintains that people and their development are affected by various interconnected environmental systems (Guy-Evans, 2020). This theory posits that different levels of environments influence people's behavior and progress, ranging from their immediate surroundings to broader societal structures. It examines and provides a perspective on the reciprocal relationship between personal characteristics, influential environmental variables, and

temporal factors. Amongst the ecological systems are the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Guy-Evans, 2020).

The microsystem focuses on a person's bi-directional relationship with their immediate environment, including the individual, family members, friends, neighbors, teachers, school administrative staff, classmates, employers, and coworkers (Guy-Evans, 2020). The mesosystem is the interconnection between various microsystems. The exosystem includes extended family members, friends' parents, mass media, and governments. The macrosystem focuses on culture, social norms, and economic and political systems. Finally, the chronosystem relates the role of time, examining the shifts and transitions over the lifetime and their impact on development (Guy-Evans, 2020).

Mental health professionals must consider risk and protective factors when doing prevention work (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). Risk factors are biological, psychological, familial, communal, or cultural variables associated with a higher risk of adverse outcomes (SAMHSA, n.d.). Protective factors are similar characteristic variables but are associated with a lower likelihood of poor outcomes (SAMHSA, n.d.). Effective prevention encourages the reduction of risk factors and prioritizing protective factors related to the presenting problem (SAMHSA, n.d.). According to the CDC, the risk of being a perpetrator or victim of domestic violence may be increased or decreased by an amalgamation of various factors at the individual, relational, communal, and societal levels (2024b).

Risk and Protective Factors at the Individual Level

There are risk and protective factors at the individual level that may increase or decrease the likelihood that an individual will experience or perpetrate domestic violence. For instance,

variables such as age, educational level, annual income, history of abuse, and use of substances are relevant when examining DV at the individual level (CDC, 2024c). Risk factors for victimization include being female, being young, heavy substance use, previous history of DV, lower educational level, risky sexual conduct, witnessing or enduring violence in childhood, and unemployment (Access Continuing Education, Inc., n.d.). Additionally, race and ethnicity may play a role in increasing the likelihood of DV victimization. For example, when men have a different ethnicity from their partner, they are more likely to be subjected to DV. Furthermore, African American women and American Indian/Alaska Native women may also be at a higher risk of being victimized (Access Continuing Education, Inc., n.d.).

Risk factors for the perpetration of DV include variables such as a history of abuse in childhood, poor self-esteem, heavy substance use, depression and suicidality, low education, low income, being young, history of aggression or delinquency in childhood, and anger issues (CDC, 2024b). A lack of problem-solving skills, antisocial personality traits, conduct issues, characteristics associated with borderline personality disorder, social isolation, impulsiveness and lack of emotional self-control, history of being abusive, unemployment or other economic stress, emotional dependence, insecurity, aggression towards women, and more have also been linked to an increased likelihood of perpetrating DV (CDC, 2024b). Finally, belief in gender roles and wanting power in the relationship are also variables that may increase the risk of DV perpetration at the individual level (Ohio Domestic Violence Network [ODVN], n.d.).

Some protective factors for DV at the individual level may include life, conflict resolution, socio-emotional, and healthy relationship skills (CDC, 2024c). Additionally, measured, calm temperament, management skills, and the tendency to accept and take accountability are linked to a reduced risk of DV victimization (ODVN, n.d.). Furthermore, the

ability to be empathetic and respectful toward others, the capacity to spread positivity to others, and media literacy may be protective factors for DV victimization (ODVN, n.d.).

Risk and Protective Factors at the Relationship Level

There are also risk and protective factors at the relationship level that can increase or decrease the risk that a person may suffer or commit DV. This level focuses on social relationships with peers, romantic partners, friends, and family members and how these connections may affect an individual's DV experiences (CDC, 2024c). Risk factors for victimization at the relationship level include pairings in which the couple experiences educational, income, or career disparities (Access to Continuing Education, Inc., n.d.). When one partner is domineering and controlling, it can also raise the chance that DV will occur (Access to Continuing Education, Inc., n.d.). Relationship factors that may increase the risk of perpetrating DV include economic stress, marital instability, marital conflict, and unhealthy family dynamics (ODVN, n.d.). Additional relationship risk factors for perpetrating DV include jealousy, possessiveness, parents with a level of education below a high school degree, and association with antisocial or hostile peers (CDC, 2024b). Finally, an individual may have a higher chance of engaging in DV as the abuser due to occurrences in childhood, including a history of witnessing violence between parents, experiencing poor parenting, and undergoing physical punishment (CDC, 2024b).

Protective factors for DV at the relationship level may include strong parent-child communication, healthy peer norms, and interpersonal problem-solving skills (CDC, 2024c). Research indicates that supportive social networks and strong, positive relationships with others are protective factors for the perpetration of DV (CDC 2024b). Additionally, clear behavioral

standards for the family, parent-child bonding, efficient levels of love and support, and familial values of nonviolence are also protective factors for engaging in DV (ODVN, n.d.).

Risk and Protective Factors at the Community Level

Additionally, risk and protective factors at the community level may raise or lower the chance of being a victim or perpetrator of DV. Risk factors at this level may include poverty, unsafe conditions, residential segregation, community instability, and an increased number of alcohol outlets (CDC, 2024c). Other community factors that may increase the likelihood of DV victimization and perpetration are overcrowding, low social capital, and ineffective community sanctions against DV (Access Continuing Education, Inc., n.d.). Additionally, a lack of educational and economic opportunities, high unemployment rates, and a lack of community engagement and support are community risk factors for DV perpetration (CDC, 2024b). Finally, communities with an increased degree of violence, a high crime rate, and easy access to drugs may be at a higher risk for DV occurrence (CDC, 2024b).

Community protective factors include access to safe and stable housing, economic assistance, and healthcare (CDC, 2024b). Community engagement, support, and coordination of resources among various agencies have also been indicated as community protective factors for DV (CDC, 2024b). Finally, other community protective factors include social, cultural, and religious activities organized by the community, neighbors that work together to monitor young people and their behavior, strong sanctions against DV, and schools that ensure the teachings of healthy beliefs (ODVN, n.d.).

Risk and Protective Factors at the Societal Level

Finally, societal risk and protective factors may increase or decrease the likelihood that an individual will experience or engage in DV. Risk factors at this level include societal and

cultural norms that encourage violence to resolve conflicts (CDC, 2024c). Policies regarding health, the economy, education, and society also contribute to the occurrence of DV (CDC, 2024c). Furthermore, gender norms, such as attitudes about women in the workforce or the appropriate submissiveness of a woman in a relationship, are societal factors that may contribute to the occurrence of DV (ODVN, n.d.). Additional societal risk factors for DV include societal income inequality as well as poor, ineffective health, educational, economic, and social legislation or policies (CDC, 2024b). Social protective factors against the perpetration of DV include appropriate and ethical portrayal of violence against women in the media, oppression intolerance, and the cultivation of DV awareness as a public health human rights issue (ODVN, n.d.).

PART 3: THEORIES OF PREVENTION

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Social cognitive theory (SCT) may be applied efficiently to a DV prevention program. This approach focuses on the reciprocal relationship between individual factors, behavior, and the social environment (National Cancer Institute, 2005). Those in the social environment include coworkers, friends, family, health professionals, etc. The SCT is one of the most widely used health behavior techniques as it examines the interactions between individuals, their environments, and related psychosocial factors. Furthermore, this theoretical technique posits that goals, outcome expectations, and self-efficacy beliefs primarily influence an individual's likelihood of changing health behavior. SCT incorporates the concept that people learn from observation, modeling, and social experiences of Bandura's Social Learning Theory (SLT)

alongside integrating cognitive, behavioral, and emotional behavioral change models and processes (National Cancer Institute, 2005).

The SCT examines how social modeling may shape an individual's cognition and behavior (Williams, 2024). For example, the perpetration of DV may be passed on throughout generations as children witness IPV, model their environment, and learn these behaviors to go on and eventually continue the cycle (Williams, 2024). Applying SCT to DV could be helpful as it might provide insight into how social experiences and interactions may influence behavioral outcome expectations and learned behaviors when it comes to victimization and the perpetration of violence (Williams, 2024). This theory may illustrate how interpersonal violence is learned over time ("Social Cognitive Program," 2008). It also analyzes how this learning occurs as patterns of thinking and behavior associated with violence and aggression develop ("Social Cognitive," 2008).

SCT could also be appropriate to address DV due to its emphasis on self-efficacy, which refers to an individual's sense of control over their actions and environment (Schwarzer & Luszczynska, n.d.). A person's sense of agency directly influences changes in their health behavior. Their self-efficacy beliefs impact how the change will be initiated, how much effort will be invested to enact it, and how long it will be maintained when faced with challenges and failures. Furthermore, self-efficacy affects resilience, intention, and goal-setting behaviors, influencing how high an individual might set goals and approach challenging situations (Schwarzer & Luszczynska, n.d.). According to Rezaee et al., lower levels of self-efficacy can result in a higher perceived occurrence of IPV (2024). Therefore, applying SCT to DV may be insightful as it prioritizes an individual's self-efficacy, which impacts changes in health behavior.

Some research indicates support for the validity of the SCT for the perpetration of IPV (Williams, 2024). For instance, prior research suggests that children who witness IPV or are exposed to other types of abuse are at an increased likelihood of aggression in adulthood (Williams, 2024). Data indicates that around 60-70% of abusive men had also experienced abuse in childhood, further suggesting the role observation and modeling play in learned behaviors (Williams, 2024). An additional example of how SCT may be linked to DV is the role the media plays in the perpetration of violence. According to a previous study in Honduras, males who listened to the radio at least twice a week had higher approval rates of IPV (Williams, 2024). Therefore, there may be evidence to suggest the role that witnessing aggression and exposure to violence play. However, research indicates that social cognitive programs may effectively prevent and intervene in violent behaviors (“*Social Cognitive*,” 2008).

According to the Community Preventive Services Task Force (CPSTF), prevention programs and interventions aimed at reducing IPV typically focus on promoting healthy relationships, teaching healthy relationship skills, promoting positive social norms, combating violence, and creating protective environments (n.d.). Furthermore, social cognitive programs designed for violence prevention and treatment prioritize adapting thinking regarding violence and social experiences to change behavior (“*Social Cognitive*,” 2008). They typically aim to impact the procession of social information to influence how an individual understands, interprets, and responds to stressful social scenarios exhibiting interpersonal conflicts (“*Social Cognitive*,” 2008).

Examples of evidence-based interventions that draw on some of the theoretical constructs of the SCT are programs that target DV prevention efforts for adolescents and young adults, such as Wolfe et al.’s (2009) and Temple et al.’s (2021) *The Fourth R: Strategies for Healthy Teen*

Relationships Primary Prevention Program, Peskin et al.'s (2014) It's Your Game... Keep It Real Primary Prevention Program, Peskin et al.'s (2019) Me and You: Building Healthy Relationships Primary Prevention Program, and Foshee et al.'s (1996, 1998, 2000, 2004) The Safe Dates Project Primary Prevention Program (Chawla et al., 2024). These programs attempt to intervene ahead of time with school-age adolescents to prevent DV from becoming an issue down the road. Each approach incorporates lessons or sessions and other related activities and resources focused on DV perpetration, peer violence perpetration, adolescent relationship abuse, and DV victimization. Furthermore, some of the programs address different kinds of DV perpetration and victimization, including emotional, physical, and psychological domains. Finally, some of these social cognitive DV prevention programs attempt to highlight other avenues of victimization and perpetration, including cyber and sexual violence. Each of the studies assessing these programs has indicated that adolescent relationship abuse and DV rates were lower in the intervention groups than in the control groups after undergoing DV prevention programs (Chawla et al., 2024). As such, it can be inferred that prevention programs that incorporate the SCT may be effective in reducing rates of DV victimization and perpetration.

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

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Specific Population Especially Impacted by DV

People of all races, genders, ethnicities, economic backgrounds, and sexual orientations can experience DV (Connections for Abused Women and their Children [CAWC], 2023). However, this issue occurs at increased rates for some groups compared to others (CAWC, 2023). For example, research suggests LGBTQIA+ individuals, people of color, and younger

individuals experience higher rates of DV than other groups (CAWC, 2023). Additionally, DV is also considered a gendered crime, as women experience higher rates of DV than men (Fanslow et al., 2023). DV can happen to men and women, but research suggests this issue's frequency, severity, and impact may affect people differently across genders (Fanslow et al., 2023). IPV is the most common type of violence against women across the world and is typically committed against them by their male partners (Fanslow et al., 2023). Around 1 in 4 women will experience IPV in their lifetime compared to 1 in 7 men (Huecker et al., 2023). Additionally, statistics show that women are more likely to experience sexual violence and be stalked than men, although all genders may experience violence, and numbers for men may be underrepresented (Huecker et al., 2023). Research indicates that around 1 in 5 women have either been raped or were the victim of an attempted rape, compared to 1-2% of men (Huecker et al., 2023). Finally, an estimated 1 in 6 women compared to 1 in 19 men have been stalked in their lives, and women are more likely to be stalked by their former or current partners than men as well, posited to be around 6 in 10 female victims compared to 4 in 10 male victims (Huecker et al., 2023).

Additionally, research indicates that DV has more severe implications and consequences for women than for men (Fanslow et al., 2023). Across the world, women are more likely to be seriously injured by their partners, fear for their lives, experience repeated victimization, and be plagued by more severe abuse (Fanslow et al., 2023). Furthermore, women are more likely to be killed as a result of DV (Fanslow et al., 2023). Around 40-70% of female homicide victims worldwide are killed by their former or current romantic partner (Fanslow et al., 2023). The rate of homicide committed due to IPV is six times greater for women than for male victims (Fanslow et al., 2023). Finally, DV is linked to poorer health outcomes for women than for men (Fanslow et al., 2023). Female victims may experience multiple overlapping kinds of IPV and

may struggle with more severe adverse psychological and physical effects (Fanslow et al., 2023).

The significance of DV victimization for men should not be understated or overlooked.

However, it is crucial to recognize the differences in victimization across genders, as the perpetration of violence against women is rooted in structural and societal inequality, sexism, and misogyny (Women's Aid, n.d.).

Mechanisms to Increase Cultural Relevance of DV Prevention Programs for Women

Cultural relevance is how consistent interventions are with a specific group's values, beliefs, and goals (Reese & Vera, 2007). Research indicates that culturally relevant approaches are key to effective prevention work. Cultural relevance is crucial to ethical practice and linked to retention rates, recruitment, intervention effectiveness, and program participation. Culturally relevant prevention methods incorporate evidence-based practices alongside the consideration of the target population throughout the development, implementation, and evaluation process. Finally, culturally responsive methods are essential in prevention research and practice as a mismatch in the values of an intervention and the targeted population can lead to cultural biases and may adversely influence how health behaviors are interpreted (Reese & Vera, 2007).

One mechanism to increase the cultural relevance of a prevention program is to involve the targeted community in developing, implementing, and evaluating interventions (Reese & Vera, 2007). According to Dryfoos (1990), Lerner (1995), and Reiss and Price (1996), it is necessary to involve target program community members in planning, implementing, and analyzing interventions to ensure the cultural relevance of prevention programs (Reese & Vera, 2007). By allowing the target group to be involved in the process, there is an opportunity for members of the identified community to gain an increased comprehension of the issue and enable them as agents of change in fixing their problems (Stringer, 1999, as cited in Reese &

Vera, 2007). Therefore, to improve the cultural relevance of a DV prevention program, it would be essential to involve different women who have experience with DV throughout the process. It would be appropriate to utilize this mechanism as it would not only increase the cultural relevance of the program but would also assist female victims of DV in understanding the problem and empower them to make changes in their lives to combat the issue. Furthermore, involving women who have been victimized in DV prevention programming will also contribute to the validity and competence of the program as it incorporates the experiences of actual victims who have been plagued by such violence.

Another mechanism to increase the cultural relevance of a DV prevention program would be cultivating specific cultural knowledge to prevent cultural bias and ensure the best outcomes (Reese & Vera, 2007). Prevention efforts must be culturally relevant and informed by knowledge of the target community to form positive professional relationships with community members and establish programs valued by the community. As many mental health professionals are outsiders to the community in which they practice, dedicating time to familiarize themselves with a specific community is an essential aspect of successful preventative work. Making valuable contributions and spending time in the community before, throughout, and after implementing interventions can provide further insight into specific cultural knowledge. Such contributions allow professionals a glimpse of cultural and community norms and illustrate a sense of dedication to the community itself, ultimately furthering the success of the implemented interventions (Reese & Vera, 2007).

This mechanism may be appropriate to improve prevention programming for DV as it prioritizes understanding more about women who have been victimized. For example, mental health professionals doing prevention work for IPV must consider variables such as sexism,

racism, and poverty as they impact women's perspectives regarding their autonomy and capacity to control their environments (Hage, 2000, as cited in Reese & Vera, 2007). As a result of feelings of disempowerment in their relationship or from their community and society as a whole, women may experience increased rates of IPV (Reese & Vera, 2007). However, this may not be true when considering other cultural groups affected by DV. Therefore, mental health professionals must foster cultural familiarity with the communities targeted by the prevention programming to ensure a higher chance of culturally relevant and effective interventions (Reese & Vera, 2007).

Core Ethical Considerations in DV Prevention Programming

One ethical consideration that must be considered when doing prevention programming for individuals experiencing DV is stakeholder collaboration. Stakeholder collaboration is an essential consideration when doing prevention programming for individuals experiencing DV, as the counselor must work with multiple concerned parties. For instance, relevant stakeholders may include clients, family members, the community and its organizations and members, members of an interdisciplinary treatment team, and more. There are a variety of ethical codes related to working with stakeholders. For example, according to the ACA, a counselor must request a release from clients to inform other mental health professionals the client is working with and develop a positive collaborative relationship, as dictated in Code A.3 of the Code of Ethics (2014). Code B.3.b. of the ACA's Code of Ethics also references collaboration with stakeholders, stating that when a counselor collaborates as part of an interdisciplinary or treatment team as part of services to the client, the client must be aware of the team's existence, composition, what information is discussed and the purpose in disclosing it. Code B.5.b. also refers to the counselor's duty to collaborate with stakeholders. The code states that counselors

are responsible for appropriately building collaborative relationships with the parents or guardians of minor or incapacitated clients unable to provide consent to ensure the best service and treatment outcomes for clients (ACA, 2014).

Ethical codes D.1.b., D.1.c., and D.1.d. discuss a counselor's responsibilities when collaborating with stakeholders further, specifically about ethical obligations when working with colleagues from other disciplines to serve clients (ACA, 2014). These codes posit that counselors must form and maintain collaborative relationships with professionals from different disciplines to ensure the best treatment for clients, which must remain the primary objective. Furthermore, it states that counselors must contribute and work with other health professionals in an interdisciplinary team as part of the decision-making process that impacts the client's well-being. Finally, these ethical codes require professional counselors to work with fellow members of an interdisciplinary team to establish the professional and ethical obligations of the team and its participants. The code states that the counselor and the team should first try to address any ethical concerns that arise within the interdisciplinary team. However, if resolution efforts are unsuccessful, the counselor is responsible for seeking other methods to address their concerns, which are congruent with the client's well-being (ACA, 2014).

An additional ethical consideration in DV prevention programming is informed consent. Ethical code A.2.a. of the ACA Code of Ethics states that clients have the right to choose whether to enter or exit a counseling relationship and must be effectively informed about the counselor and the counseling process (ACA, 2014). This code posits that counselors have an ethical responsibility to review, verbally and in writing, the rights and responsibilities of both parties in the counseling relationship. Finally, code A.2.a. specifies that informed consent should be an ongoing aspect of the counseling process and that mental health professionals should

effectively document informed consent conversations as the counseling relationship progresses (ACA, 2014).

Another code relevant to informed consent is A.2.b, which requires that counselors clearly explain all aspects of provided services, including information such as the counselor's credentials and experience, the purpose and goals of counseling, the services' risks and limitations, the technology's role, and more. Counselors must ensure that clients understand all diagnoses, treatments, assessments, procedures, costs, rights, and limitations to confidentiality. Code A.2.c. states that informed consent must be given with developmental and cultural sensitivity, using clear language, and appropriate services must be arranged when there is a language barrier between the client and counselor. This code states that counselors must consider a client's cultural background with informed consent and make changes when necessary. Finally, Code A.2.d., referencing clients who cannot give consent, requires counselors to include clients in the decision-making process as appropriate and seek the assent of clients to services for minors, incapacitated adults, and others who cannot give voluntary consent. This ethical code requires mental health professionals to understand the balance between clients' autonomy and their capacity for consent or assent for services and familial rights and duties to protect their loved ones and make the best choices for their care (ACA, 2014).

Confidentiality is another important ethical principle when programming community DV prevention efforts. Confidentiality may be particularly critical when dealing with DV, as it could be vital to the safety and well-being of clients, further stressing the importance of maintaining client privacy to ensure safety. The ACA has many ethical codes regarding confidentiality. For instance, ethical codes B.1.a. and B.1.c. require counselors to protect potential, current, and former clients' confidential information. These codes state that mental health professionals must

initially and consistently inform clients of the limitations of confidentiality and identify potential breaches. It also maintains that counselors must only disclose confidential information when given appropriate consent, ethical justification, or legal cause. Furthermore, code B.1.a. discusses the multicultural and diversity considerations of confidentiality. It states that counselors should be aware of and pay attention to the differences in cultural meanings of confidentiality. It also requires that mental health professionals respect these cultural differences and continuously involve the client in making decisions concerning the appropriate disclosure of confidential information (ACA, 2014).

Ethical codes B.2.d., B.2.e., B.3.e., B.5.c., B.6.g., and B.7.b. refer to the disclosure of confidential information (ACA, 2014). They state that counselors should only break confidentiality when required and in an appropriate manner. For example, B.2.d. states that when counselors are ordered by the court to disclose confidential information without the client's consent, they must attempt to obtain written informed consent from the client, try to get the disclosure prohibited, or attempt to limit the disclosure as much as possible to protect the therapeutic relationship and the client. B.2.e. also requires counselors to disclose only necessary information when breaking confidentiality in appropriate circumstances and incorporate clients into the decision-making process concerning disclosure to ensure they are informed and involved. Finally, codes B.3.e. and 3.6.b. require mental health professionals to take precautions to ensure confidentiality when sending confidential information and secure their records by keeping them in a safe medium that cannot be accessed by unauthorized individuals (ACA, 2014), further keeping the documents and information of clients private.

The ACA's 2014 Code of Ethics discusses the responsibility of counselors to protect and ensure confidentiality for minor and incapacitated clients in codes B.5.a., B.5.b., and B.5.c.

(ACA, 2014). They state that counselors must protect the privacy of the information provided by minor clients and adults who are unable to effectively provide voluntary informed consent, as determined by local, state, and federal laws and ethical standards. When working with minors, counselors must inform the child's parents or guardians about the counseling process and relationship and respect the family's cultural diversity, rights, and duties. Mental health professionals must also collaborate with caretakers to ensure the best outcomes for the client. Furthermore, these ethical codes state that counselors must seek additional consent from an appropriate third party to disclose confidential information in the case of a client unable to give consent, even if they have already obtained the client's permission. In these situations, counselors are expected to inform the client to an appropriate degree based on the level of comprehension and take additional measures to protect client privacy (ACA, 2014).

Ethical codes B.6.g. and B.7.b. offer instructions on navigating the disclosure of confidential information with relevant third parties and stakeholders (ACA, 2014). Code B.6.g. states that counselors must get consent in writing from clients to disclose or send records to legitimate third parties unless there is an exception to confidentiality. It requires counselors to ensure the recipients of a client's records comprehend their classified nature. B.7.b. requires mental health professionals to protect client confidentiality when seeking consultation from colleagues. It requires counselors to refrain from disclosing any information that could lead to the identification of a client without their consent. Code B.3.c. mandates that counselors discuss confidential information with clients in environments where privacy can be reasonably protected (ACA, 2014).

PART 5: ADVOCACY

Domestic Violence in Florence, Alabama

The counseling profession has long valued advocacy and being agents of change (Toporek et al., 2009). Mental health professionals are ethically obligated to align the environment with healthy human development as much as possible (Toporek et al., 2009). Therefore, professional counselors must cultivate advocacy competence, which refers to their capacity to understand and conduct advocacy efforts practically and ethically (Toporek et al., 2009). Two integral aspects of ethical practice in counseling are multiculturalism and social justice. The Multicultural and Social Justice Counseling Competencies (MSJCC) provide mental health professionals with guidelines to incorporate multicultural and social justice tenets into research, theory, and practice (“*Multicultural and Social*,” 2015). This framework examines the role that a counselor's self-awareness, the client's worldview, the therapeutic relationship, and counseling and advocacy interventions play in multicultural and social justice competence. The counseling and advocacy techniques section of the MSJCC applies the socioecological perspective to examine social justice advocacy across multiple levels (“*Multicultural and Social*,” 2015).

Barriers to Addressing DV

While healthcare services, the justice system, and community organizations can be powerful resources in helping survivors of DV, research indicates that there are a variety of obstacles across various socio-ecological levels that may impede help-seeking or attainment for DV victims (Robinson et al., 2021). Understanding various barriers impacting DV survivors can assist in developing interventions geared toward IPV and improving agencies dedicated to helping victims. Some of the obstacles identified by multiple studies include factors such as systemic failures, feared consequences of disclosing DV, lack of awareness related to available

community services, accessibility issues, and a lack of resources (Robinson et al., 2021). Victims identified multiple barriers to getting help for DV, including language barriers, a lack of accessible resources, a lack of disability accommodations, no childcare, mental health stigmatization, a lack of concern from formal systems, discrimination, lack of trust in helping organizations, and more (Robinson et al., 2021).

Researchers posit that gender roles and consequential stigmatization from disclosing victimization can result in survivors' reluctance to seek help for DV as well (Robinson et al., 2021). Thus, this is an example of a barrier on the community level as it describes oppressive societal spoken or unspoken norms, beliefs, or rules ("Multicultural and Social," 2015). Furthermore, people experiencing DV may not seek help due to their lack of knowledge regarding available services (Robinson et al., 2021). Survivors of DV might not ever obtain assistance with this issue as the relevant programs and formal organizations offering services in their community are unknown, especially resources for marginalized groups such as ethnic minorities or the LGBTQIA+ community (Robinson et al., 2021). Therefore, this is an example of an institutional barrier related to the community organizations and social institutions within a society ("Multicultural and Social," 2015). Finally, factors such as immigrant status, no access to transportation, poverty, housing insecurity, fears about child services removing children from the home, and low education rates are barriers impeding DV victims from obtaining the necessary assistance from formal services (Robinson et al., 2021). Individuals who are not legal citizens of their country of residence may be hesitant to report victimization or seek help due to fears of deportation or incarceration (Robinson et al., 2021). Immigration laws are an example of an obstacle to help-seeking on the public policy level as they relate to local, state, and federal laws or rules ("Multicultural and Social," 2015).

Advocacy Actions to Address DV

According to the MSJCC, counselors are ethically responsible for intervening with and for clients at various levels, including the intrapersonal, interpersonal, institutional, community, public policy, and internal domains (“Multicultural and Social,” 2015). Advocating on the institutional level includes addressing inequity in social institutions such as community agencies, churches, businesses, schools, etc. Competent mental health professionals at this level examine the level of support from social institutions with clients, help clients find supportive people within social institutions who can assist in combating inequities facing marginalized victims, and work with different organizations to address the role of power, privilege, and oppression in impacting clients and their issues. Professional counselors must support their clients by engaging in social advocacy to remove barriers and inequities within social institutions while simultaneously managing individual counseling duties. Finally, the MSJCC posits that any research must incorporate multicultural and social justice to draw attention to social institutions' inequities and benefits over marginalized and privileged clients (“Multicultural and Social,” 2015).

Intervening at the community level requires counselors to examine the empowering and oppressive rules, values, and norms interwoven within society and address any obstacles to the growth of people, communities, and groups (“Multicultural and Social,” 2015). At this level, counselors should collaborate with clients to examine how societal values, norms, and rules impede and encourage client development and progress. Mental health professionals must research to determine how much societal factors impact clients. They should engage in social advocacy to combat obstacles that hinder client growth due to societal and communal norms, beliefs, and regulations. Finally, counselors should work to shape the norms, beliefs, and rules of

privileged clients with the experiences of marginalized clients (“Multicultural and Social,” 2015).

Public policy interventions address barriers to client development by working to enact change in local, state, and federal policies or laws (“Multicultural and Social,” 2015).

Multicultural and social justice competence at the public policy level can be ensured by involving clients in conversations about how they impact and are impacted by local, state, and federal legislation and policies. Furthermore, counselors must gather relevant data examining how local, state, and federal legislation and policies impede or encourage client development. Mental health professionals have ethical obligations to advocate for equitable treatment in all laws and procedures, eliminating the imbalance between privileged and marginalized clients. Finally, the MSJCC posits that counselors must find ways to work with clients to shape legislation and procedures to promote multiculturalism and social justice (“Multicultural and Social,” 2015).

There are numerous ways that mental health professionals can advocate for victims of DV at the institutional, community, and public policy levels. For instance, working with those affected by DV to help them gain access to community resources or services (Sullivan, 2018). To effectively advocate for clients suffering from DV, counselors must be in contact with people associated with different organizations that are in control of necessary resources. Additionally, counselors can advocate for DV survivors by assisting them in increasing social support and connection within their community, which is crucial to their well-being. It may be important for people who have experienced DV to establish strong bonds and networks within their communities. Furthermore, advocates can work to foster communities that hold perpetrators

accountable, prioritize justice, and ensure that every community member has access to opportunities and resources (Sullivan, 2018).

Mental health professionals must dedicate advocacy efforts to enact change in the criminal justice, healthcare, and welfare systems (Sullivan, 2018). Counselors are also responsible as advocates for being aware of all relevant laws and practices concerning DV. Finally, collaboration with lawmakers and policymakers can encourage the creation and implementation of local, state, and federal guidelines to reduce DV and protect victims (Sullivan, 2018). These advocacy efforts would be effective in helping clients access necessary resources, make connections within their communities to relevant organizations or agencies that can help, and work to change different legislation and rules related to DV perpetration and victimization.

REFERENCES

- Access Continuing Education, Inc. (n.d.). *Domestic violence/intimate partner violence: Applying best practice guidelines*. Retrieved March 11, 2025, from <https://www.accesscontinuingeducation.com/ACE4000LP-11/c5/index.htm>.
- Alabama Public Health. (2022). *Violence*. <https://www.alabamapublichealth.gov/healthrankings/violence.html>.
- American Counseling Association. (2014). *2014 ACA code of ethics*. <https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf>.
- American Psychiatric Association. (2023) *Domestic violence*. Retrieved March 3, 2025, from

<https://www.psychiatry.org/patients-families/domestic-violence>.

Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *The American Journal of Emergency Medicine*, 38(12), 2753-2755. <https://doi.org/10.1016/j.ajem.2020.04.077>.

Centers for Disease Control and Prevention. (2024a, February 8). *Preventing intimate partner violence*. <https://www.cdc.gov/intimate-partner-violence/prevention/index.html>.

Centers for Disease Control and Prevention. (2024b, February 8). *Risk and protective factors*. <https://www.cdc.gov/intimate-partner-violence/risk-factors/index.html>.

Centers for Disease Control and Prevention. (2024c, April 9). *About violence prevention*. https://www.cdc.gov/violence-prevention/about/?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html.

Chawla, S. A., Solomon, J., & Sarnquist, C. (2024). A review of evidence-based dating violence prevention programs with behavioral change outcomes for adolescents and young adults. *Trauma, Violence, & Abuse*, 25(4), 3315-3331. <https://doi.org/10.1177/15248380241246779>.

Community Preventive Services Task Force [CPSTF]. (n.d.). Violence prevention: Primary prevention interventions to reduce the perpetration of intimate partner violence and sexual violence among youth. *The Community Guide*. Retrieved March 28, 2025, from <https://www.thecommunityguide.org/findings/violence-prevention-primary-prevention-interventions-reduce-perpetration-intimate-partner-violence-sexual-violence-among-youth.html>.

Connections for Abused Women and their Children. (2023). *Who is most affected by domestic*

violence? Retrieved April 1, 2025, from <https://www.cawc.org/news/who-is-most-affected-by-domestic-violence/>.

Fanslow, J. L., Mellar, B. M., Gulliver, P. J., & McIntosh, T. K. D. (2023). Evidence of gender asymmetry in intimate partner violence experience at the population-level. *Journal of Interpersonal Violence, 38*(15-16), 9159-9188.
<https://doi.org/10.1177/08862605231163646>.

Guy-Evans, O. (2020, November 9). *Bronfenbrenner's ecological systems theory*. Simply Psychology. <https://www.simplypsychology.org/bronfenbrenner.html>.

Hudnall, M., Lewis, D., & Parton, J. (n.d.). *2020-23 statewide crimes*. Retrieved March 3, 2025, from <https://crime.alabama.gov/Data/TwentyTwentyStatewideCrime>.

Huecker, M. R., King, K. C., Jordan, G. A., & Smock, W. (2023). Domestic violence. *StatsPearls Publishing* [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK499891/>.

Mineo, L. (2022, June 29). 'Shadow pandemic' of domestic violence. *The Harvard Gazette*. <https://news.harvard.edu/gazette/story/2022/06/shadow-pandemic-of-domestic-violence/>.

Multicultural and Social Justice Counseling Competencies. (2015).
<https://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=20>.

National Cancer Institute. (2005). *Theory at a glance: A guide for health promotion practice*. Washington, DC: U.S. Department of Health and Human Services: National Institutes of Health. <https://cancercontrol.cancer.gov/sites/default/files/2020-06/theory.pdf>.

National Domestic Violence Hotline. (n.d.). *Domestic violence statistics*. Retrieved March 4,

2025, from [https://www.thehotline.org/stakeholders/domestic-violence-statistics/#:~:text=1%20in%204%20women%20\(24.3,intimate%20partner%20in%20their%20lifetime.](https://www.thehotline.org/stakeholders/domestic-violence-statistics/#:~:text=1%20in%204%20women%20(24.3,intimate%20partner%20in%20their%20lifetime.)

Ohio Domestic Violence Network. (n.d.). *Risk and protective factors tip sheet*. Retrieved March 12, 2025, from <https://www.odvn.org/wp-content/uploads/2020/05/Risk-and-Protective-Factors-Tip-Sheet.pdf>.

Reese, L. E., & Vera, E. M. (2007). Culturally relevant prevention: The scientific and practical considerations of community-based programs. *The Counseling Psychologist, 35*(6), 763-778.

Rezaee, S., Bagherzadeh, R., Mahnoush, R., Fotovat, L., & Vahedparast, H. (2024). The effect of life skills training on reducing domestic violence and improving treatment adherence in women with diabetes experiencing intimate partner violence: A randomized clinical trial based on the theory of self-efficacy. *BMC Public Health, 24*, 3390. <https://doi.org/10.1186/s12889-024-20913-y>.

Robinson, S. R., Ravi, K., & Voth Schrag, R. J. (2021). A systematic review of barriers to formal help seeking for adult survivors of IPV in the United States, 2005-2019. *Trauma, Violence, and Abuse, 22*(5), 1279-1295. <https://doi.org/10.1177/1524838020916254>.

Schwarzer, R., & Luszczynska, A. (n.d.). *Perceived self-efficacy*. Retrieved March 29, 2025, from <https://cancercontrol.cancer.gov/sites/default/files/2020-06/self-efficacy.pdf>.

Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). *Risk and protective factors*. Retrieved March 10, 2025, from https://waldenu.instructure.com/courses/156576/pages/week-3-learning-resources?module_item_id=6238722.

Sullivan, C. M. (2018). Understanding how domestic violence support services promote survivor well-being: A conceptual model. *Journal of Family Violence*, 33(2), 123-131.

<https://doi.org/10.1007/s10896-017-9931-6>.

Social cognitive programs for violence. (2008). In C. M. Renzetti, J. L. Edleson (Eds.) *Encyclopedia of interpersonal violence*, (2), 677-678. SAGE Publications, Inc., <https://doi.org/10.4135/9781412963923>.

Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). *Promoting systemic change through ACA advocacy competencies*. *Journal of Counseling & Development*, 87, 260-268.

Williams, A. D. (2024). Understanding family violence from a therapeutic lens. *The Family Journal: Counseling and Therapy for Couples and Families*, 32(1), 152-159. <https://doi.org/10.1177/10664807231198875>.

Woman's Aid. (n.d.). *Domestic abuse is a gendered crime*. Retrieved April 1, 2025, from <https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/>

World Population Review. (2024). *Domestic violence by state 2024*. Retrieved March 4, 2025, from <https://worldpopulationreview.com/state-rankings/domestic-violence-by-state>.

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