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INTIMATE PARTNER VIOLENCE (IPV) COUNSELOR EDUCATION: EXPLORING OPINIONS, KNOWLEDGE AND PERCEIVED PREPAREDNESS TO COUNSEL IPV CLIENTS

by

ALVIS AYABA-APAWU

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2016

MAJOR: COUNSELING

Approved By:

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Advisor   Date

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DEDICATION

This work is dedicated to my wonderful family; Gladys, Danielle, Elnathan, Dr. Aaron Apawu, and also to Mr. Kellen Ayaba, Mrs. Habiba Ayaba and my siblings.

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Above all, "I abounded in good works because I had all that I needed through Grace".

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CHAPTER 1 INTRODUCTION

This chapter introduces the problem of study, the purpose of the study, research questions, hypotheses, and definition of research terminologies. The chapter also presents the basic assumptions and limitations of the study.

Intimate partner violence (IPV) is a global phenomenon that has serious physical, mental, and psychological effects (World Health Organization [WHO], 2014). IPV was first widely recognized as a major problem in the 1970s (Nicholls, Tonia, & Hamel, 2015). IPV has serious social and public health consequences and has gained increase attention among researchers and direct service professionals (Norris, 2014; Devries et al. 2013). IPV involves psychological, Physical, and sexual abuse by men and women toward romantic partners of the same or opposite sex (Capaldi eta al., 2012). The estimate of the global prevalence of violence by the World Health Organization shows that 35% of women have experienced physical or sexual violence by an intimate partner, non-partner or both (WHO, 2014). IPV is defined as an abuse perpetrated between romantic partners resulting in physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats (Norris, 2014; Bair-Merritt, 2010; Hindin et al., 2008; McLeod, Hays, & Chang, 2010). Sexual violence, which is a form of IPV can result in unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV (WHO, 2014). IPV is not only perpetuated among married couples but also among people in casual romantic relationships (Fincham et al., 2008; Kress, Protivnak, & Sadlak, 2008).

Traditionally, IPV has been seen through a feminist paradigm and understood to be the expression of men's power over women occurring in intimate heterosexual relationships, and supported by a patriarchal culture (Stith et al., 2012). Women's movement first drew attention to

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the problem of IPV and framed the problem in terms of male perpetration and female victimization (Hamel, 2009; Whitaker, 2007). As advocates for women began to organize shelters across the nation to provide safety and assistance for abused women, clinical information emerged that described patterns of severe physical and emotional abuse (Kelly, 2008). The initial research on IPV was therefore conducted with severely abused women from shelters (Hamel, 2009). The resulting assumption that IPV is primarily perpetuated by men against women was supported (Whitaker, 2007). This assumption was due to the prevailing patriarchal conception of IPV, a paradigm based on feminist sociopolitical ideology (Hamel, 2009). There is a growing body of literature that indicates that IPV can be perpetuated by men against women and women against men (Capaldi et al., 2012; Archer, 2000; Hamel, 2009; Kelly, 2008; Stuart, 2006; Whitaker, 2007). Ard and Makadon (2011) found that there was no difference in type of victimization between same sex and opposite sex IPV. In addition, there was no difference in physical and sexual abuse for male same sex and opposite sex victims. However, it is important to examine the reason for the use of violence in the dynamics of the relationship (Swan et al., 2008) to better understand the nature and type of IPV. Men and women endorse similar rates of IPV, however, statistics reflect that greater harm occurs in male to female violence (Houry et al. 2008; Straus, 2011).

IPV affect people regardless of racial or ethnic background, socio-economic status, religious beliefs or sexual orientation (WHO, 2014; McLeod et al., 2010). IPV is highly prevalent in United States (Stith et al., 2012; Fincham et al., 2008) and is progressively recognized as a public health problem affecting the lives of many Americans (Capaldi etal., 2012; McLeod et al., 2010). It is estimated that24 people per minute are victims of rape, physical violence, or stalked by an intimate partner in the United States, resulting in more than 12 million

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women and men over the course of a year (Center for Disease Control and Prevention [CDC], 2010). The CDC estimated the cost of IPV to the United States to be $5.8 billion per year in 2003 ($10.4 billion in 2012 dollars). The cost of providing health care to adult survivors of IPV ranges from $2.3 billion to $7.0 billion in the first year after the assault (Liebschutz, & Rothman, 2012; CDC, 2010). The annual health care cost for women who experience IPV are 42% higher than those for non-abused women (Liebschutz, & Rothman, 2012). Several studies have identified some factors contributing to IPV, including substance use, relationship control or domination, and stressful events (Weaver et al., 2015; Gormley & Lopez, 2010; Leonard, 2005; Lewis et al., 2005). Anger and hostility is often viewed as a factor that often contributes to IPV. However, according to Eckhardt et al. (1997), there is substantial inconsistency in findings related to anger, hostility, and IPV after reviewing two dozen studies examining anger and the perpetuation of marital violence. It is therefore prudent to investigate whether problems relating to anger arousal indeed relate to increased risk of male-to-female IPV perpetuation before making decisions in favor of, or against anger-focused interventions (Norlandera and Eckhardt (2005). Other factors such as childhood victimization, profound enmeshed attachment, disordered personality, and anxiety have also been noted (Capaldi et al., 2012; Coleman, 2003; Powell, 2008).

It is important to note that past victimizations, mental health symptoms, substance abuse, and poverty do not essentially result in IPV, but the interacting impact of these factors can result in IPV (Hill et al., 2012; Powell, 2008). Regardless of the progress made in past decades in IPV research, there is still a debate on how much risk for IPV occurrence is attributed to socio-demographic factors, education, income, ethnicity, or marital status (Campbell, 2004).

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Problem Statement

The consequences of IPV on individuals and the society at large are well documented in literature. Globally, as many as 38% of murders of women are committed by an intimate partner (WHO, 2014). "Nearly 1 in 4 women and 1 in 13 men experience intimate partner violence (IPV) at some time in their life" (Black, 2011). IPV victims suffer considerable negative health consequences due to the physical, sexual, and emotional abuse they experience (Black; 2011). Apart from the extensive monetary cost and homicides related to IPV, there is a consensus among many researchers regarding the physical, psychological, and sexual effects of IPV, as well as the numerous health problems such as depression, PTSD, body injuries, anxiety and suicide (WHO, 2014; Liebschutz, & Rothman, 2012; Bonomi et al., 2007; Bozorg-Omid, 2007; R. Campbell, Dworkin, & Cabral, 2009; Kaura & Lohman, 2007; Nilsson, 2008; Temple et al., 2007). Women who have been physically or sexually abused are 1.5 times more likely to have a sexually transmitted infection compared to women who have not experienced IPV (WHO, 2014).

There is an overlap between IPV and child abuse and other related problems (Geffner, Igelman, & Zellner, 2014; Moylan et al., 2010). A great number of children are exposed to violence between their parents resulting in problems of great magnitude that significantly impact their short term and long term development (Geffner, Igelman, & Zellner, 2014). Professionals who work with children who witness or experience IPV related abuse believe that IPV result in an increased risk for a multitude of psychological, behavioral, social and educational problems in children (Geffner, Igelman, & Zellner, 2014). Children living in homes with IPV are more likely than their peers to exhibit aggressive and antisocial behaviors, more likely to be anxious, fearful, and hyper-vigilant (Bair-Merritt, 2010). Bair-Merritt also noted that IPV exposure in school age children has also been linked to poor peer relations resulting from poor self-esteem and

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sensitization to hostility. Although IPV is a widespread problem in the society, there is still a lot to understand about the complex nature, causes, frequency of violence, severity, and the type of abuse experienced (Langhinrichsen-Rohling, 2005).

The physical, sexual and psychological consequences or IPV increases the likelihood that victims and survivors would seek counseling services. While some clients are likely to disclose a history of IPV when asked by health care professionals, others may be hesitant to disclose such information due to fear or shame (Connor et al., 2011).

Purpose of Study

Counselors frequently counsel IPV clients, and their ability to facilitate clients' safety and accurately assess the potential for further violence (Kress et al., 2008) is a required professional ability (Elbogen, 2002). The curriculum of counselor education training was rooted in a teaching–learning framework that include conditions for facilitating cognitive–developmental growth, theoretical training, skills and facilitating students' ability to counsel (Brendel, 2002). Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards require counselor education programs to train counselors to effectively manage family related issues including partner violence. This is embedded in section II.2.d; Social and Cultural Diversity studies that provide an understanding of the cultural context of relationships, issues, and trends in a multicultural society including: individual, couple, family, group, and community strategies for working with and advocating for diverse populations including multicultural competencies (CACREP, 2009). It is important to note that CACREP accredited counseling programs educate counseling students regarding family dynamics, domestic violence and its consequences. However, the intrinsic benefit of this study will

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enormously impact participants' opinions, knowledge and perceived preparedness to counsel IPV clients.

The results of a research study consisting of 500 members of American Mental Health Counselors Association (AMCHA) indicate that about 50% got training during graduate school on domestic violence (Bozorg-Omid; 2007). Out of the 50% who were trained in graduate school, 78% of them indicated that the training was inadequate. Another study by Nyame, Howard, Feder, & Trevillion, (2013) consisting of 131 mental health professionals revealed that only 15% of professionals routinely asked all clients about interpersonal violence. Despite the seriousness of IPV, many clients, especially women are reluctant to seek help and are not routinely asked about their experiences of relationship abuse as part of the assessment process (Stith et al., 2012; Bacchus, Mezey, & Bewley, 2003). This could partly be due to counselors becoming overwhelmed when clients present with multiple physical and psychological problems associated with IPV (McCauley et al., 1995), or not being competent to counsel clients with IPV. Most professionals also lack adequate knowledge of support services for in partner violent clients, (Nyame et al 2013). An increased understanding of the dynamics of IPV by counselors would facilitate effective and appropriate interventions when working with IPV clients (McLeod, Hays & Chang, 2010). Counselors are therefore encouraged to empower, promote autonomy and the ability of clients to make their own decisions requiring how they want to proceed in managing IPV in their relationships (McLeod, Hays & Chang, 2010; Kress et al., 2008). In light of the above assertions, the purpose of the research is to explore counseling students' opinions, knowledge and perceived preparedness to counsel IPV clients.

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Research Questions

Research Question 1: Is there significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education?

Research Question 2:Is there significant difference in the mean scores of students' IPV knowledge between the experimental group and the control group after IPV education?

Research Question 3: Is there significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education?

Research Hypotheses

Hypothesis 1: There is no significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education.

Hypothesis 2: There is no significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education.

Hypothesis 3: There is no significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education.

Definition of Terms

Intimate Partner Violence (IPV): refers to behaviors by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors (WHO, 2014). IPV in this study is defined as any violence perpetuated by one partner against the other that may result in physical, sexual, or psychological harm.

Counselors in training in this study refer to graduate students pursuing master's degree in Counseling at a Mid-west Urban University. Counseling students are educated to become responsible counselors and leaders. A student counselor graduating from a CACREP accredited program is expected to have not less than 48 credits hours of training. This study recruited

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students who were registered in the following courses; techniques of counseling, counseling practicum and counseling internship. Counseling students, counseling trainees, student counselors and counselors in training are used interchangeably.

Opinions refer to views, judgment, or appraisal formed in the mind about a particular matter according to the Merriam-Webster dictionary. Opinions in this study refer to views, appraisal or judgments that counseling students have regarding IPV.

Education has several definitions. The appropriate definition with regard to this study is from the Merriam Webster dictionary. It defines education as the knowledge and development resulting from an educational process. Education in this study refers to IPV discussions, presentation, or a lecture. Education or training is used interchangeably.

Knowledge from the Merriam Webster dictionary defines knowledge as information, understanding, or skill got from experience or education. This definition is appropriate and is adopted for the purpose of this study.

Perceived preparedness used in this study refers to how well students feel they are prepared to counsel IPV clients. It is assumed that the more IPV education students receive, the better they would be prepared to counsel IPV clients.

Assumptions

- The research Participants (both the treatment group and the control group) are assumed to accurately and honestly respond to the assessing instruments.
- Research Participants are believed to have the fundamental knowledge in counseling skills, theory, and techniques.
- The participants are assumed to have the mental and cognitive capability to comprehend the educational materials and to complete the questionnaires.

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- It is assumed that the research instrument would accurately measure the components that are relevant to this study.
- Participants (experimental group) are assumed to knowledgably use the internet to access IPV educational materials.

Limitations

- This study was limited to students who consented to participate and fully completed all required sessions.
- A non-randomized sampling method was used in this study; however, respondents were randomly assigned to the experimental group and the control group.
- This research was limited to counseling master's students at an urban university located in the Mid-western region of United States.

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CHAPTER 2 LITERATURE REVIEW

Introduction

This chapter outlines the types and patterns of IPV, etiology of IPV, and IPV interventions. Substance abuse and gender are also discussed in relation to IPV.

Intimate Partner Violence (IPV) emerged as a term to describe the different types of relationship violence among both heterosexual and homosexual partners (Daire, Carlson, Barden, & Jacobson, 2013). It is the act of intimidation, battery, sexual assault, and other abusive behavior perpetuated by one intimate partner against another (Cobia, Robinson, & Edwards, 2008). Abuse or violence often begins in a close mutual relationship, which over time become exclusive and result in the isolation of the victim by the abuser (Norris, 2014). Many individuals are affected by IPV in the society regardless of their sexual orientation, age, race, religion, nationality, economic status or educational background (WHO, 2014). The factors that are most likely to be associated with IPV include poverty, history of trauma, mental health symptoms, substance abuse and distress caused by multiple oppression (Hill et al., 2012). As many as 25-54% of women are affected by IPV in their adult lifetime (Bonomi et al., 2006), and one-third of female homicide victims that are reported in police records are killed by an intimate partner (National Coalition Against Domestic Violence [NCADV], 2007). Despite its numerous consequences, IPV is underreported. Only about one fourth of physical assaults, one fifth of rapes, and one half of stalking against women are reported to the police (NCADV, 2007). Because of the wide spectrum of IPV, most social scientists consider it imperative to specify the type of abuse when talking about IPV. The value of differentiating among the types of IPV will result in appropriate screening instruments and developmental processes that accurately describe the central dynamics of partner violence, it context and consequences (Kelly & Johnson, 2008).

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Types and Patterns of IPV

There are four types IPV; Physical violence, Sexual violence, Threats of physical or sexual violence, and Psychological or emotional violence (Center for Disease Control and prevention, 2010 ; Saltzman et al., 2002).

Physical violence is the intentional use of physical force with the potential of causing death, disability, injury, or harm. Physical violence includes scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of a weapon, and the use of restraints (one's body size or strength) against another person (CDC, 2010; Saltzman et al., 2002).

Sexual violence is divided into three categories (CDC, 2010; Saltzman et al., 2002). The first category involves the use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed. The second category involves an attempt or complete sexual act involving a person who is unable to understand the nature or condition of the act or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, influence of alcohol or other drugs, because of intimidation or pressure). The third category encompasses abusive sexual contact.

Threats of physical or sexual violence consist of the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. On the other hand, psychological or emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics (CDC, 2010; Saltzman et al., 2002).

Psychological or emotional abuse can include humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family,

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and denying the victim access to money or other basic resources (CDC, 2010; Saltzman et al., 2002) . In addition, stalking is often included among the types of IPV. Stalking generally refers to harassing or threatening behavior that an individual engages in repeatedly; such as following a person, appearing at a person's home or place of business, making harassing phone calls, and leaving written messages or objects (Tjaden & Thoennes, 1998). Research conducted by Krebs et al., (2011) indicates that there is a significant level of overlap among the forms of violence. In this case victims often experience more than one type of victimization by an intimate partner.

There are four patterns of relational violence. These are Coercive Controlling Violence (CCV), Violent Resistance (VR), Situational Couple Violence (SCV), and Separation-Instigated Violence (SIV). The patterns are determined based on gender mutuality, violence frequency, escalation, and reciprocity (Kelly and Johnson 2008). The CCV pattern refers to any IPV that comprises of power and control in a relationship resulting in wife beating or battering, spousal abuse, or domestic violence. This is similar to Patriarchal Terrorism used by Johnson (1995) which was later changed to Intimate Terrorism (Johnson, 2006). Coercive Controlling Violence is the type of intimate partner violence encountered mostly in agency settings such as law enforcement, the courts, shelters, and hospitals (Kelly & Johnson, 2008). Tactics such as intimidation, verbal or emotional abuse, isolation, blaming or denying are used by CCV perpetrators (Pence & Paymar, 1993). Abusers do not necessarily use all of these tactics, but they use a combination of the ones that they feel are most likely to work for them (Kelly & Johnson, 2008).

Violent Resistance is described as resistance, resistive or reactive violence, and as self-defense (Pence & Dasgupta 2006). The term violent resistance posits the reality that both women and men may, in attempt to stop the violence or to stand up for themselves, react violently to

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their partners who may have a pattern of CCV (Kelly & Johnson, 2008). VR does not lead to encounter with law enforcement compared to CCV because it is short-lived (Kelly & Johnson, 2008).

Situational Couple Violence (SCV), is the type of partner violence that does not have its basis in the dynamics of power and control (Johnson & Leone, 2005). This type of violence is also referred to as male-controlling interactive violence by Johnson and Leone (2005) and conflict motivated violence by Ellis and Stuckless (2006). SCV is the most common type of physical aggression among married couples and cohabiting partners, and is perpetrated by both men and women (Kelly & Johnson, 2008). The frequency of occurrence of SCV is lower per-couple and more often involve minor forms of violence (Johnson & Leone, 2005). Some verbally aggressive behaviors (cursing, yelling, and name calling) reported in SCV are similar to the emotional abuse of CCV. Jealousy may be a recurrent theme and accusations of infidelity may be expressed in SCV (Kelly & Johnson, 2008).The violence and emotional abuse of SCV does not come with chronic pattern of controlling, intimidating, or stalking behaviors (Leone, Johnson, Cohan, & Lloyd, 2004).

Separation Instigated Violence (SIV) describes violence that first occur in a relationship at separation (Kelly & Johnson, 2008). It has been referred by Johnston and Campbell (1993) as separation-engendered violence due to its non-continuity characteristic and occurs only in the context of a separation. SCV may continue through the separation process and CCV may continue or even escalate to homicidal level when the perpetrator feel his control is threatened by the separation (Kelly & Johnson, 2008). SIV is mainly of interest to those working with separating and divorcing families due to the violence that may occur as a result of the separation in the relationship (Johnston & Campbell, 1993) SIV is triggered by traumatic experiences

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during separation or divorce. The violence results in an unusual and serious loss of psychological control which is typically limited to one or two episodes at the beginning or during the separation period (Kelly & Johnson, 2008). The nature of SIV ranges from mild to severe and it is more likely to be perpetrated by the partner who is being left during a divorce of separate (Kelly & Johnson, 2008). An enhanced understanding of the multiple types and patterns of IPV and factors associated with their occurrence is needed to inform the development and implementation of effective prevention and interventions, resource allocation efforts, and evidence-based public health policy (Krebs et al., 2011).

Etiology and theoretical approach to IPV

Several IPV theories have been proposed over the years and offered differing explanatory framework for conceptualizing IPV (Bell & Naugle, 2008). Each of these theories has influenced IPV research, and many have found a degree of empirical support.

The traditional approach to viewing IPV is the Feminist Approach. In the 1880s, various states enacted laws specific to domestic violence, but those statutes were weakly enforced (Hamel, 2009). By the 1960s and 1970s, mediation as a form of intervention was used by the police in dealing with domestic disputes and physical violence (Young, 2005). However, there was an increasing number of battered cases in the 1980s and led to a growing battered women's movement. This resulted in media interest and high-profile public policies on domestic violence as well as a rapid change in interventions Kelly & Johnson (2008), prompting many states to enact legislation to make spousal assaults a crime (Hamel, 2009). The women's battered movement characterize a grass root response to the increasing battered cases (Martin, 1976). The movement was first made up of victims and their supporters, and later joined by academic feminists interested in the general advancement of women's rights (Hamel, 2009). Based on

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initial victims accounts of highly controlling husbands, feminists began to define spousal abuse as a gender issue and provided the movement with a theory both to explain the problem and to provide a blueprint for a change (Hamel, 2009). In light of these developments, IPV was explained to be the result of patriarchal conception of domination and control of husbands over their wives (R. E. Dobash & Dobash, 1979). From this perspective, research focused and viewed IPV as primarily a problem of men's violence against women caused by wider societal rules and patriarchal beliefs that encourage male dominance and female subordination (Bell & Naugle, 2008; R. E. Dobash & Dobash, 1979; Johnson, 1995; Yllo, 1993) rather than one potential factor interacting with others to cause IPV (Dutton, 2011). Thus, violence against women and the intentions associated with the violent event should be studied within the wider context of patriarchy (Dixon & Graham-Kevan, 2011). A common conclusion that arises from a gender-based research on the use of violence among women against male partners is understood as self-defense, retaliation or pre-emption for his aggression (Dixon & Graham-Kevan, 2011). IPV against women from the feminist perspective explain battering involving physical, sexual, and emotional abuse in the context of analysis of power and gendered relations (Pope & Ferraro, 2006). In his assessment of the feminist theory, Hamel asserted that in the event of a violent situation, perpetrators "mainly men are arrested and mandated to participate in batterer intervention programs, while the women are engaged in victim services and outreach programs" (Hamel, 2009). However, he believes that the feminist theories of IPV have not yet explained how patriarchal power translates into personal power in most relationships.

The Duluth "Power and Control" wheel (Figure 1) illustrates the use of power by one partner to control and dominant the other. The Duluth "Power and Control" was developed by an educational battered women's group in a shelter to be used by Domestic Abuse Intervention

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Programs (DAIP) to educate men arrested for domestic violence and mandated by the courts to domestic violence programs (Gondolf, 2007). The author noted that the Duluth model could be characterized as a gender based cognitive behavioral approach to educating both men and women about the mechanism and complexity of IPV. The wheel shows eight tactics, or groups of behaviors identified by battered women as an ongoing component of their battering experiences. The tactics are coercion and threats, intimidation, emotional abuse, isolation, using children, male privilege, economic abuse, minimizing, denying and blaming (Pope & Ferraro, 2006). The acts of physical and sexual violence constitute the rim of the wheel which provide support and give strength to the broad range of tactics. The intent and effect of using these behaviors rest in the hub of the wheel; the creation of power and the creation of control. In this conceptual framework, battering is a complex interweaving of tactics that creates the batterer's power and control over a partner (Pope & Ferraro, 2006). Many people may engage in some of the behaviors found on the wheel at one time or another, but it is important to note that such unpleasant isolative behaviors are not battering (Pope & Ferraro, 2006). The author noted that they become battering only when a person is using it as a way to control a partner.

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Figure 1: The Duluth power and control wheel. The wheel shows eight tactics or behaviors used by batters to gain control over their partners in a relationship. Adopted from Domestic Abuse Intervention Project (DAIP), 202 East Superior Street, Duluth, MN 55802, 218-722-2781 .www.theduluthmodel.org

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Integrated Theories

Theories of IPV have strongly been influenced by either disciplinary biases of psychology, sociology, criminology ideologies or political agenda of feminist activists (Heise, 1998). Research on IPV suggests that violence between intimate partners has its etiology in a diversity of forces operating at different levels (DeMaris et al., 2003). An integrated approach to IPV conceptualize violence as a complex phenomenon grounded in an inter play among personal, situational, and socio-cultural factors (Heise, 1998). It is presumed that theories and models that examine only one partner's violence or factor at a time are likely to be biased (DeMaris et al., 2003). A body of literature has identified several factors that increase the likelihood of IPV. These factors include past history of abuse, poverty, socio-economic status, oppression, sexism, stressful events, and problems associated with mental health symptoms (Hill et al., 2012; Montalvo-Liendo, 2009; Jewkes,2002; Heise, 1998). However, having a past history of abuse, poverty, mental health symptoms, substance abuse, and past experiences of oppression do not necessarily cause intimate partner violence (Hill et al., 2012). Rather, the overlapping impact of each of these factors can increase the likelihood that IPV will occur (Coleman, 2003; Powell, 2008). Some researchers have highlighted the importance of adapting existing ecological models to the domain of IPV (Donald G Dutton & Corvo, 2006). An integrative and structural model of violence (ISMV) has also been proposed for the study of IPV (Winstok, 2007). ISMV consists of four levels of references. The first level assumes that interpersonal violence (attack) is a non-legitimate forceful tactic intentionally employed by one partner to cause physical and or psychological harm in an attempt to control a situation. The second level addresses the situation in which violence emerges. The third level focuses on the relationship between the parties and the fourth level refers to the socio-cultural context of the relationship. Dutton (2006) also

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proposed the Nested Ecological Model as the most appropriate etiology of IPV. The model incorporate social and psychological perspectives to provide a comprehensive guide of the potential causes of IPV from which functional theories about an individual's behavior can be hypothesized and tested (Dixon & Graham-Kevan, 2011). The authors emphasized that a multi-factor explanation of IPV will aid accurate assessment, understanding of its etiology, and function regardless of the perpetrator's gender. Such an integrative approach might facilitate our understanding of all forms of family violence, (Slep & O'leary, 2001). Recently Finkel et al., (2012) have also proposed an integrative approach called I^3 theory ("I-cubed theory"). According to the authors, the theory posits that all risk factors promote IPV perpetration through one or more of these three processes: instigation, impellance, and inhibition. Instigation refers to the exposure to discrete partner behaviors that normally trigger an urge to aggress. Impellance refers to dispositional or situational factors that psychologically prepare individuals to experience a strong urge to aggress when encountering an instigator. Due to variation of "impellance", people may sometimes be unaffected by an instigator and may experience no urge to aggress, or may be strongly affected by experiencing a powerful urge to aggress (Finkel et al., 2012). Inhibition, the final stage refers to dispositional or situational factors that increase the likelihood that people will override the urge to aggress. When the strength of inhibition exceed the strength of the urge to aggress, people behave nonviolently, and when the reverse occur, they behave violently" (Finkel et al., 2012).

Social Learning Theory

Social learning theory initially developed by Bandura (1976) is one of the most popular explanatory perspectives in IPV literature. In the social learning system new pattern of behavior can be acquired through direct experiences or by observing the behaviors of others (Bandura,

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1976; Bandura & McClelland, 1977). When applied to the family, social learning theory state that people model behaviors that they have been exposed to as children (Mihalic & Elliott, 1997, 2005). Observations of how parents and significant others behave in intimate relationships provide an initial learning behavioral alternatives which are appropriate or inappropriate (Mihalic & Elliott, 1997). Violence is learned through role models in the family either directly or indirectly, and is reinforced in childhood and continues in adulthood as a coping response to stress or a method of resolving conflict (Bandura, 1976). If the family of origin handled stressors and frustrations with anger and aggression, the child who has grown up in such an environment is at greater risk of exhibiting those same behaviors as an adult (Mihalic & Elliott, 1997). Victims and perpetrators of partner abuse are thought to have either witnessed abuse or directly experienced physical abuse as children, resulting in the development of tolerance or acceptance of violence within the family and intimate relationships (Lewis & Fremouw, 2001). Researchers and professionals have noted that many perpetrators had themselves been childhood victims of violence or observant (Renner & Slack, 2006). This pattern is known as the cycle of abuse or intergenerational transmission theory of violence (Mihalic & Elliott, 1997; Renner & Slack, 2006). A research conducted by Heyman and Slep (2002) support the general cycle of violence which hypothesizes that family of origin violence increases the risk for adulthood family violence. However, not all childhood victims of IPV (either through exposure or abused) have become perpetrators themselves (Widom, 1989). Whether or not violence continues into adulthood is thought to be dependent on the consequences associated with early episodes of violence in peer and dating relationships (Riggs, Caulfield, & Street, 2000). IPV is therefore believed to be maintained if it serves a purpose or has been appropriately reinforced (Mihalic & Elliott, 1997). Consequently, positive outcomes following partner abuse may increase a person's

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expectations that future violence will result in similar outcomes, and therefore lead to a continuous use of violence within the relationship (Riggs & O'Leary, 1989). Social learning theorists emphasize that direct reinforcement of violent behavior is not required to maintain the behavior (Bell & Naugle, 2008). Instead, simply witnessing negative consequence of violent behaviors may be sufficient in determining whether or not an individual will engage in future violent episodes (Riggs & O'Leary, 1989).

Attachment Theory

Attachment theory provides a great deal of conceptual framework for understanding IPV (Mauricio, Tein, & Lopez, 2007). Attachment and relational theory offer a more comprehensive conceptualization of the nature of abuse that stems from multiple, intersecting, and compounded psychological trauma (Coleman, 2003; Dutton, 2006; Hill et al., 2012). Attachment theory posits that the quality of infants and their primary caregivers interactions influence their attachment behaviors and result in the formation of internal working model of relationships which guides the structure of their relationship throughout their lifespan (Bowlby, 1969). When a care giver provides contact, reassurance, and comfort to an infant, it facilitates the child's development of emotional regulation, well-being, positive internal working model of self and others, and consequently a secured attachment (Godbout, Dutton, Lussier, & Sabourin, 2009). On the other hand, a disruption in the care giver infant bond is a the precursor to insecure attachment and corresponding negative models of self and others, thus promoting maladaptive relationship patterns that can continue to regulate relationship behaviors into adulthood (Mauricio et al., 2007). The internal working model of self influences one's perceptions about his or her self-worth, competence, and lovability, whereas the working model of other is responsible for expectations about the availability and trustworthiness of others (Mauricio et al., 2007). Changes

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occur throughout development in the content and structure of an individual's attachment relationships, shifting from asymmetric complimentary attachments such as the infant–caregiver relationship to more symmetric or reciprocal attachments such as adult romantic attachment relationships (Henderson et al., 2005). The transfer from complimentary to reciprocal attachment is gradual and consequently sexual partners tend to ascend to the top of the attachment hierarchy and assume the position as primary attachment figure during adulthood (Hazan & Zeifman, 1994). Based on the initial work of Bowlby, Hazan and Shaver (1987) formulated three types of attachment among adults; (a) secure attachment which is characterized by comfort in depending on others and close intimacy, (b) avoidant attachment, characterized by discomfort with closeness and trusting others, and (c) anxious or ambivalent attachment, characterized by clinginess and worrying about abandonment. In order to assess the individual differences in adult attachment orientations, Bartholomew incorporated Bowlby's conception of self and other representation in a two dimensional model of adult attachment (Henderson et al., 2005). The four attachment styles by Bartholomew & Horowitz (1991) consist of secure, dismissive (avoidant), preoccupied (anxious), and fearful (mixture of anxious and avoidant) attachment styles (Rapoza, 2008). Research on abused and traumatized children has identified another category of attachment behavior called disorganized or disoriented in children and unresolved trauma or loss in adults (Alexander, 2009). This attachment style is associated with major problems of affect regulation and has been implicated as an important contributor to re-victimization (Lyons-Ruth et al., 2003; Gidycz et al., 1993). Avoidant attachment is a reflection of one's negative model of others and it is marked by a pervasive discomfort with intimate closeness and a strong orientation toward self-reliant and counter dependent relationship behavior (Mauricio et al., 2007). Anxious attachment is a reflection of negative model toward one's self and it is

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represented by low self-esteem, pervasive fear of partner rejection, abandonment, and dependent relationship behaviors. Different patterns of IPV manifest as a result of the interacting attachment styles of both intimate partners (Bartholomew & Horowitz, 1991; Coleman, 2003). Anxious attachment is associated with both physical assault perpetration and victimization, but it is uncertain how this risk factor operates differently in males and females (Rapoza, 2008). Although individual level of anxious attachment has been implicated as a risk factor for IPV, the dynamics involved in the inter play of such factors within the relationship still need further exploration (Rapoza, 2008). Avoidant attached adults may be more distressed by fear of enmeshment, partner assertion, more disposed to use violence and other abusive strategies to control and intimidate their partners as a result of the negative model they may have of them (Mauricio et al., 2007). The risk factor between preoccupied attachment and victimization was found to be equal for men and women (Henderson, Bartholomew, & Dutton, 1997).

Cognitive Behavioral Theory

Cognitive Behavioral Theory (CBT) evolved from early root in behavior and cognitive theories in the late 1950s and early 1960s and has since being merged into CBT to produce a theoretical complex combination of therapeutic approach, (Hupp, Reitman, & Jewell, 2008). Cognitive-behavioral therapy (CBT) approaches are rooted in the fundamental principle that an individual's cognitions play a significant and primary role in the development and maintenance of emotional and behavioral responses to life situations (González-Prendes & Resko, 2012). In the context of IPV, CBT view aggressive behavior as a by-product of aggressive thoughts that are in turned "scripted" or learned in early development and used later in adulthood as a reactive response to stressors (Mitchell & Anglin, 2009). There are five cognitive steps (known as social information processing, SIP) developed by Dodge (1986) which are involved in the event of

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processing and responding to a situation. The five steps are; encoding an event, interpretation of that event, a search for response to the event, response decision made regarding the event and the decision is enacted. Reactive aggression theory conceptualize family violence as a process of three events focusing on an emotional and cognitive processes leading to behavioral response (Hyde-Nolan & Juliao, 2012). These three events occur when an individual experience an unpleasant situation: a) an aversive stimulus result in a negative emotional response, b) the negative emotional response then leads to an urge to hurt others or thoughts of hurting others and c) the urge to hurt results in aggressive behaviors (Hyde-Nolan & Juliao, 2012). Aggression can be understood through a cognitive susceptible model that focuses on a particular style of cognitive processing called "primal thinking". Primal thinking refers to how adverse childhood experiences produce the tendency to experience situations in an egocentric manner (Beck, 1999). Individuals with this mind set may over interpret situations in terms of their own self-interest (especially in regard to a preoccupation with perceived present and past injustices) and consequently result to the deliberate use of aggressive behaviors to protect one's interest (Norlander & Eckhardt, 2005). The tendency to use violence reinforces a set of implicit, automatic cognitive biases such as;

> overgeneralization (establishing inflexible rules and conclusions that apply to all situations), dichotomous thinking (viewing events or people in all-or-nothing abstractions), personalization (inferring the self to be critically affected by otherwise impersonal events), causal thinking (establishing inferences and conclusions in the absence of supporting evidence), and demandingness (absolutistic and inflexible demands that other people's act and event should occur in accordance with the individual's desires), (Norlander & Eckhardt, 2005 pg. 122).

The tendency to use aggressive behaviors when faced with situations of pain and anger facilitate our understanding of why family violence occur as well as our ability to confront and treat the

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cognitive distortions that underlies aggressive and abusive behaviors exhibited in IPV (Hyde-Nolan & Juliao, 2012).

Personality Theory

Personality disorders have also gained prominence in understanding the etiology of IPV (Mauricio et al., 2007). The main research approach that are often cited in literature are the Dutton's Borderline Personality Organization (BPO) and Assaultiveness theory, and the Holtzworth-Munroe and Stuart's Developmental Model of Batterer Subtypes (Dutton, 1995; Holtzworth-Munroe & Stuart, 1994). Dutton's BPO theory which is based on attachment theory posits that the tendency to carry out IPV in adulthood stems from an insecure attachment and shaming arising during early childhood or adolescence (Bell & Naugle, 2008). Individuals with insecure attachment style are characterized by having a desire for intimate social contact while also experiencing a fear of rejection and distrust of others, resulting in frequent dissatisfaction with intimate relationships (Bell & Naugle, 2008). The insecure attachment style with the combination of an individual’s tendency towards experiencing intense rapid anger leads to IPV perpetuation during instances in which the individual feel threatened by the partner (Dutton, 1995). Physical IPV perpetuation is a manifestation of personality disorder among men (Hines, 2008). One personality dysfunction that is related to the use of IPV in men, and may be for women as well, is borderline personality (BP), (Hines, 2008). Studies demonstrating the prevalence of personality dynamics of borderline and antisocial personality disorders among batterers provide additional support for the hypothesis that the presence of a personality disorder may be a risk factor for committing IPV (Mauricio et al., 2007). Personality disorders related to the need to control others (e.g. narcissistic and antisocial) and related to self-concept and identity (e.g., borderline) are particularly prominent among batterers (Hastings & Hamberger, 1988). A

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research study conducted by Murphy, Meyer, and O'Leary (1993) found that violent men, as compared to nonviolent men, consistently demonstrated higher scores on a measure of antisocial personality disorder after controlling for social desirability. Attachment theory provide a theoretical framework for understanding personality disorder origins, especially borderline and antisocial personality disorders (Mauricio et al., 2007). Based on Bowlby (1988) argument that the quality of one's early attachments determines internal representations of self and others, Mauricio al. (2007) noted that, the impact of the internal representation of self and others influences interpersonal functioning and impacts later psychological health. Early secure attachment in life contributes to healthy psychological development, whereas insecure attachment makes one vulnerable to psychopathology (Mauricio al., 2007). Personality disorder (PD) is one dimension consistently used to subtype batterers (Ross & Babcock, 2009). Holtzworth-Munroe and Stuart (1994) developed three types of batters with the following characteristics; family only, dysphonic borderline, and generally violent or antisocial. These types of batters are based on the severity and frequency of violence, generality of violence, and batterer's personality traits or disorder. The first type of batters, which is the family only batters display low levels of violence severity, low level of violence outside the relationship, no substance abuse, and low to moderate depression and anger proneness. Secondly, dysphonic or borderline batterers display moderate to high levels of violence severity, low to moderate violence outside the relationship, symptoms of borderline personality disorder, and higher level of depression and anger proneness. The third is generally violent or antisocial batterers characterized by a demonstration of moderate to high level of violence severity, high level of criminal behavior, violence outside the relationship, symptoms of antisocial personality disorder, and high level of substance abuse. The other two types of batterers that is based on physiology as

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outlined by Jacobson & Gottman, (1998) are the cobras and the pit bulls. The cobras constitute men who are able to calm themselves internally and focus their attention while striking swiftly at their wives with vicious verbal aggression and the pit bulls referring to men who exhibit anger in a slow manner but become increasingly aggressive. A comparison of women arrested for IPV and mandated into treatment with women from the general population found that, the odds of women arrested for IPV having BPD were 20.3 times greater than the women in the general population (Stuart et al., 2006). Borderline personality disorder is three times more common among women than among men (American Psychiatric Association, 1994). In light of this, Hines (2008) argued that borderline personality disorder is a good candidate for being associated with IPV in women. Although there is evidence among clinical samples that women with BPD may be at greater risk of using violence, it is unknown whether these results can be generalized to nonclinical samples (Hines, 2008).

Background and Situational Aggression Theory

Situational and background theory has received least attention (Bartholomew & Cobb, 2010). Riggs and O'Leary (1989) initially proposed background and situational aggression theory to give meaning to violence within courtship or courtship aggression. The model is base on social learning and conflict theory. The theory proposes that two major variables solely contribute to aggression in courtship (Riggs & O'Leary, 1996). The variables are background factors and situational factors. Background factors include interpersonal aggression, child abuse, and prior aggression that establishes an individual's aggressive partner of behaviors. Situational factors are characterized by relationship satisfaction, problem solving skills, intimacy level, stressors, and alcohol use and aggressive behaviors within relationships (Riggs & O'Leary, 1989). Background factors imply that violence in the family of origin contributes to one's

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definition and acceptance of violence as a response to conflict aggression and impulse (Riggs & O'Leary, 1996). Factors such as personality characteristics, psychopathology, and reduced emotional regulation increase the plausibility to use violence within an intimate relationship (Riggs & O'Leary, 1989, 1996). Riggs and O'Leary (1996) conducted a research based on the background and situational aggression theory and found that background factors such as witnessing violence, attitude towards the use of aggression, parental aggression, and prior use of violence are predictors of IPV. In addition, background factors accounted for about 60% of the variation in male to females partner violence incidents whereas situational factors appeared to account for a larger proportion of the variation in explaining courtship aggression (Riggs & O'Leary, 1996; White, Merrill, & Koss, 2001). Other researchers argue that partners in a mutually satisfying relationship characterized by mutual respect, construct communication and partner attribution will not be at risk of IPV regardless of their disposition towards violence (Bartholomew & Cobb, 2010). IPV does not occur randomly even in a "distressed relationship with entrenched pattern" rather, it occurs when the situational and interactional context trigger and sustain violent impulses by one partner or both (Bartholomew & Cobb, 2010). Family violence theorists perceive conflict as inherent in all relationships due to the different background and differing viewpoints of intimate partners, more so, the tactics used to resolve conflict may result in relationship violence (Straus, 1979).

Intergenerational Model of Violence

Intergenerational modal of violence, also known as intergenerational transmission, (IGT) of violence is focused on testing the mechanism linking aggression in the family of origin and aggression in subsequent romantic relationships from one generation to the another in order to explain IPV (Cuir et al., 2010). Earlier research studies that observed aggressive behaviors used

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by children shed light on violence as a socially learned behavior (Bandura, 1976; Bandura & McClelland, 1977) and demonstrated that there is a link between a history of witnessed inter-parental violence and violence enacted in subsequent generations of children (Kalmuss, 1984). IGT involves two types of modeling, the generalized modeling and specific modeling. Generalized modeling occurs when childhood family aggression communicate the acceptability of aggression between family members and thus increase the likelihood of any form of family aggression in the next generation (Kalmuss, 1984). This modeling type does not necessarily involve a direct relationship between aggression in the immediate first and second generational families. Specific modeling occurs when individuals reproduce the particular type of family aggression to which they were exposed. The intergenerational modeling of marital aggression appears to involve "specific" more than "generalized" modeling (Kalmuss, 1984).

Other theories that examine the mechanism underlying IGT of violence includes; emotional security, social learning models and the developmental-interactional model (Capaldi, Shortt, & Crosby, 2003; El-Sheikh et al., 2009). The developmental-interactional model of romantic-partner proposes that social learning processes in the family of origin contribute to the development of an interpersonal style conducive to aggression in subsequent romantic relationships (Capaldi et al., 2003). Aggression modeled between parents in a family system provide "scripts" for violent behaviors and teaches the appropriateness and consequences of such behaviors through direct and vicarious reinforcement of rewards and punishment (Bandura, 1973). Children who grow up in such an environment do not have the opportunity to learn positive conflict resolution methods such as negotiation, verbal reasoning, self-calming tactics, and active listening (Foshee, Bauman, & Linder, 1999). Experiencing violence as a child also increases the likelihood of violence in one's adult intimate relationship (Ehrensaft et al., 2003).

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Some researchers suggest that children do not need to directly witness parental aggression to suffer negative effects. Merely living in an aggressive parental conflict home puts a child at greater risk of being involved in an aggressive relationship later in life (Delsol & Margolin, 2004; Stith et al., 2000). One important question asked in the process of violence transmission is "through what developmental process does aggressive conflict between parents come to be associated with relationship conflict of their children in early adulthood" (Fite et al., 2008). The authors however suggested that social cognition is a likely mechanism in the trans-generational transmission of relationship conflict. The violence transmission process is complex and has many influences and contributors (Whiting et al., 2009).

All these theories (integrated theories, social leaning theories, attachment theories, etc) have contributed in one way or another in aiding our understanding of the etiology of IPV, yet these theories are limited in two primary ways. First and foremost, the current IPV theories fail to adequately capture and address the complexity of variables implicated in IPV episodes (Wathen & MacMillan, 2003;Whitaker et al., 2006). Secondly, while each of the current theories has found some level of support within the empirical literature, the extent to which these theories have successfully impacted IPV prevention and treatment programs have been limited (Wathen & MacMillan, 2003; Whitaker et al., 2006).

The Cycle Theory of Violence

The cycle theory of violence, which is mostly known as the "cycle of abuse" was theorized by Walker (1979) to explain the pattern of an abusive relationship. According to the author, a battered woman is not constantly being abused nor is the abusive event random, but occurs in a "definite battering cycle". A research analysis of 1,600 battering incidents indicated that the pattern of violence was consistent with patterns of the cycle of violence (Walker, 2006).

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The cycle consists of three distinct phases and each phase vary in both time and intensity for different couples (Walker, 1979). The cycle is made up of three phases. The first phase is the tension building phase which is characterized by increasing conflict and tension. The victim in this phase is exposed to verbal, emotional, and minor incidents of physical violence. The victim may minimize these incidents, place blame on themselves or external situations for the abusive behavior, may attempt to keep the batterer calm, and control the situation by modifying their own behaviors. The victims may also deny to themselves about being angry at the unjust psychological or physical harm they experience. The victim tries to please the batterer during this period and such behaviors could slow down or speed up the movement into the second phase (Walker, 2006). The second phase is the acute battering incident characterized by uncontrollable violence. This phase constitute the shortest part of the cycle but has the highest risk for physical or sexual damage (Walker, 1979). Victims isolate themselves after violent incidents in this phase and may wait several days to seek medical attention, or may minimize their injuries by refusing to acknowledge to themselves or others regarding the severity of the abuse (Walker, 2006). The third and final phase is called the loving-contrition or popularly known as the "honeymoon stage" where the batterer exhibit conciliatory behaviors, and may attempt to convince the victim of their intent to change (Walker, 1979). The batterer apologizes and engages in loving behavior in some relationship whiles in other relationships, there is a decrease or a temporary cessation in violence (Walker, 1979). The cycle of abuse is important because it explain how women become victimized, fall into learned helplessness behaviors, and why they do not attempt to escape an abusive and domineering relationships (Walker, 1977). It is prudent to understand the cycle of abuse in order to prevent or stop battering incidents (Walker, 1979). In contrary to this assertion, Dutton (1994) noted that the prevalence of violence in homosexual relationships also appears to

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go through similar abusive cycle making it harder to explain the notion that men dominate women through a distinct cycle of abuse.

Substance Abuse and IPV

Strong evidence exists that suggests that substance use is both a risk factor and an outcome associated with IPV (Weaver et al., 2015; Caetano et al., 2005; El-Bassel et al., 2003; El-Bassel et al., 2005; Fals-Stewart, Golden, & Schumacher, 2003). However, the effect of drugs used in violent events among intimate partners is even less well understood (Wilkinson & Hamerschlag, 2005). This may be partly due to the various combinations of substances use, the sequence of substance use among IPV victims and perpetrators (Moore, 2010), or the co-morbid substance use that differentially impact relationship violence compared to the use of individual substance (Smith et al., 2012). More so, the relation between specific substance use and IPV perpetration is complex (El-Bassel et al., 2005). The work by Moore and Stuart (2004) found a significant interraction of various drugs among men in a batterer intervention program. On the other hand, Murphy and his collegues examined drug interaction among men in alcohol treatment and found no evidence of drug interactions (Murphy, O'Farrell, Fals-Stewart, & Feehan, 2001). Another longitudinal study of victimization among women indicated a robust substance and alcohol use (Hequembourg, Mancuso, & Miller, 2006). Some researchers however, suggest that women may have the tendency to use substances to self-medicate for trauma symptoms such as anxiety, depression, and other mental health issues (Briere & Elliott, 1994; Gilbert et al., 2000). Relatively few studies have been conducted on the relationship between IPV and specific illicit drugs (El-Bassel et al., 2005). The majority of this research has examined cocaine and marijuana. A meta-analytic review by Moore et al. (2008), found that the drug most strongly linked with IPV was cocaine, followed by marijuana. Cocaine and marijuana

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use was also found to be associated with relationship violence perpetration (Chermack et al., 2001; Parrott et al., 2003; Smith et al., 2012). Fals-Stewart, Golden, and Schumacher (2003), found that IPV was three times more likely to occur on a day that the partner used cocaine compared to a day it is not used, even after controlling for antisocial personality and relationship discord. With regards to marijuana, Moore and Stuart (2004), noted that higher doses may suppress aggression whereas withdrawal may facilitate violence. Due to the frequent use of drugs combined with alcohol consumption, it becomes a challenge to disentangle the contribution of only drugs in violent events among intimate partners (Wilkinson & Hamerschlag, 2005). In light of this, Wilkinson and Hamerschlag proposed that future research studies exploring how substances influence violent events among intimate partners need to examine the role of alcohol only, alcohol with drugs, drugs only, different types of drugs, and drug withdrawal. A greater understanding of drug interactions and associations will potentially allow intervention and prevention efforts to focus more specifically on the substances most closely associated with relationship violence (Smith et al., 2012).

Alcohol use is widely accepted as the most common factor in IPV perpetration and victimization among both men and women (Foran & O'Leary, 2008; Leonard & Eiden, 2007; McKinney et al., 2010; Stuart et al., 2006; Stuart et al., 2008). The influence of alcohol in IPV has been observed among case control studies of partner homicides and among injured women seen in an emergency room (Leonard & Eiden, 2007). The likelihood of physical aggression occurring on days of alcohol consumption was found to be eight times higher for domestically violent men in a alcohol treatment program (Fals-Stewart, 2003). Although the relationship between drinking and IPV is well established, there is controversy as to whether the connection reflect a direct causal relationship or whether it is spurious or indirect (Leonard & Eiden, 2007).

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Researchers have identified the expectancy and the cognitive disruption hypotheses to explain the role that alcohol use play in violent events (Wilkinson & Hamerschlag, 2005). The expectancy hypothesis proposes that alcohol use act as a cue that physical violence is expected and this often results in the perpetrator excusing himself or herself from the responsibility of his or her behaviors. The cognitive disruption hypothesis focus on the psychopharmacologic effects of alcohol on decision making in intimate interactions (Wilkinson & Hamerschlag, 2005). Other several models have been proposed to account for the relationship between drug use and IPV. These theories include; the Proximal effects models (Pihl & Peterson, 1995; White, 1997), economic motivation models (Bean, 2001), Integrative models including bio-psychosocial theories (Leonard, 2001; Moore & Stuart, 2005), and the tripartite conceptual framework (Goldstein, 2003). The frequent models used to explain the relationship between drug use and IPV are the spurious model, the indirect effects model, and the proximal effects model (Leonard & Quigley, 1999). The spurious model state that the association between alcohol and aggression is due to other factors that co-vary with both alcohol and aggression rather than the presence of a causal link between alcohol and IPV (Foran & O'Leary, 2008). Secondly, the indirect effect model indicates that alcohol has a causal relationship with aggression that is mediated by other variables such as marital conflict and dissatisfaction. The proximal effect model state that alcohol intoxication facilitate aggression directly through psychopharmacological effects on cognitive functioning or expectancy effects related to intoxication (Foran & O'Leary, 2008). Alcohol intoxication leads to distorted perceptions of cues and lower inhibitions which can lead to aggression (MacDonald et al., 2000; Ito, Miller, & Pollock, 1996).

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Gender and IPV

IPV research has until very recently, almost exclusively been concerned with the physical and psychological abuse of women by their male partners, and has ignored marginalized alternative of the possibility of IPV perpetrated against men (Hamel, 2009). There are several controversies involving gender issues and the study of IPV. These controversies include gender symmetry of perpetration, utility of typologies, understanding bi-directionally violent couples, violence motivations and self-defense, and treatment effectiveness (Langhinrichsen-Rohling, 2010). These controversies raise the question of whether male violence against women should always be the primary and exclusive focus of empirical investigation and not studying intimate partner violence dyadically (Langhinrichsen-Rohling, 2005). The reluctance may be due to the fear of blaming the victim or increasing a victim's danger of IPV (Langhinrichsen-Rohling, 2005). However, Hamel (2009) noted that the reluctance to investigate gender issues and IPV in an objective and scientific manner has been due to the prevailing patriarchal conception of IPV, a paradigm based on radical feminist sociopolitical ideology. In contrary to the perspective that only women are victims of IPV, data shows that women perpetration of violence is frequent, and perhaps, more than that of men (Hamel, 2009). In light of this, the United States Congress passed legislation reauthorizing the Violence Against Women Act (originally enacted in 1996) in December 2005 to acknowledge that men can be victims of IPV (Young, 2006). A meta-analysis of IPV conducted by Archer (2000) indicates that women are more likely to engage in at least one act of physical aggression than men but male to female violence has more detrimental effects than female-to-male violence. The frequency of arrests of female perpetrators is dramatically increasing, particularly in light of the recent mandatory arrest laws (Barner & Carney, 2011; Mills, 2009a; Stuart et al., 2006). Additional studies that have examined mutually violent

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couples have found that women tend to suffer more ill effects than men in such relationship violence (Frieze, 2005). While men's use of violence is clearly damaging to women, the negative effects of partner violence perpetrated by women should not be minimized (Stuart et al., 2006). Women's use of violence against their male partners can also result in negative consequences such as physical injury, fear, anger, sadness, shame, depression, humiliation, stress, and even death (Hines & Malley-Morrison, 2001).

It is prudent as a researcher to consider factors that may account for the differences in gender related IPV research results. Three major factors are outlined in literature to be associated with this disparity. These are the failure of existing measures or instruments, the disparity in the sample used for research studies, and the nature of IPV assessment methods. The use of measures such as the Conflict Tactics Scales (CTS 1 and CTS2) to assess the context, motives, causes, and consequences of IPV may have limitations that affect research results. (Dutton, 1994; Frieze, 2005). Secondly, the use of community samples for a research study may result in different results as compared to sample from the shelter or clinical sample (Johnson 1995; 2005; 2006). Dixon and Graham-Kevan (2011) noted that research supporting a gender perspective work with samples from the shelters and from the accident and emergency departments. Research using samples of this nature would unsurprisingly find high rate of male to female violence (Dutton, 2011). Finally, most research studies incorporate self-reported assessment method that relies heavily on the integrity of the respondents (Chan, 2011). Men and women often exhibit different styles of disclosure (Chan, 2011) and these differences of individual reports of violence consequently influence research findings and conclusions (Caetano et al., 2009; Dobash & Dobash, 2004). According to Reed, Raj, Miller, and Silverman (2010), IPV should be viewed as a non-gendered phenomenon that affects the health and well-being of men

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or boys and women or girls similarly. The authors emphasized that the etiology and the nature of IPV behaviors are similar regardless of the perpetrator's gender. Thus, a non-gender research perspective encourages the examination of the use of violence among intimate partners, and incorporates a variety of theoretical standpoints that guide researchers and practitioners to understand why both men and women engage in IPV (Dixon & Graham-Kevan, 2011). In addition, theories that account for confirming and disconfirming IPV findings need to be developed in honesty and be rigorously tested to advance the field of IPV research (Langhinrichsen-Rohling, 2005).

IPV Intervention Approaches

Several intervention programs and approaches have been identified in literature in working with both victims and perpetrators of IPV. Services to IPV victims were part of a broader social system in the 1900's until 1967 when agencies began to provide shelters for victims of IPV (Lemon, 2009). The initial perspective of IPV intervention programs took a victim-centered approach. However, there has been a shift since the 1980s towards more perpetrator-centered interventions with a criminal justice perspective dominating the intervention response to IPV (Goodman & Epstein, 2005). Male batterer programs in the US have become the primary means of intervention of domestic violence cases brought to the criminal courts (Gondolf, 2011). Intervention approaches used in batter treatment programs include psychodynamic approach, cognitive-behavioral approach, couples counseling, and culturally-oriented approach (Gondolf, 2011). The most dominant interventions outlined in literature for male batter programs are the Duluth model and CBT.

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The Duluth Model of Intervention

The Duluth Domestic Abuse Intervention Project (DAIP) commonly known as the Duluth model, began in 1981 and was the primary intervention for interpersonal violence in all fifty U.S states within ten years of its founding (Pence & Paymar, 1993). It began as a psycho-educational treatment approach for perpetrators of IPV with a multi institutional team of emergency responders, police departments, prosecutors, courts, several women's shelters and human service agencies (Pence & Paymar, 1993). The Duluth Model can be characterized as a gender based cognitive behavioral approach to educating men arrested for domestic violence and mandated by the court to domestic violence programs (Gondolf, 2007). In this educational approach, group facilitators use consciousness-raising to challenge perpetrators beliefs about power, control, and dominance over their spouse (Barner & Carney, 2011). The Duluth approach also constitute counseling which is embedded in a larger system of intervention including arrests for domestic violence, sanctions against non compliance to court orders, support and safety planning for victims, and referral to other agencies (Gondolf, 2007). The hallmark development of the Duluth model was the "power and Control Wheel" which suggest that relationship violence is rooted in "patriarchal societal learning rather than a constellation of cognitive or emotional triggers" (Pence & Paymar, 1993). The curriculum focused on exposing the behaviors associated with abuse and violence in what is referred to as the "Power and Control Wheel" (Gondolf, 2007). The concept of the Duluth intervention logically attempts to challenge the denial or minimization associated with abusive behavior that is particularly prevalent among court-ordered men. In addition, perpetrators are taught to develop alternative skills to avoid abuse or violence and to promote cognitive restructuring of the attitudes and beliefs that reinforce violent behavior (Gondolf, 2007). The model is implemented in various ways lasting 8

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to 36 weeks, and it is the common treatment of choice in most states in the U.S. (Stover, Meadows, & Kaufman, 2009). Group facilitators offer learning tools to perpetrators as a means of replacing exiting behaviors and assuage the issues of power and control at the center of violent actions (Barner & Carney, 2011). In contrast, Dutton and Corvo (2007) indicated that the design of the Duluth model is not therapeutic yet make claims it initiate psycho therapeutic behavioral changes in IPV perpetrators. However, from a therapeutic point of view, the Duluth wheels serves to counter denial and help individuals take responsibility for their behavior (Gondolf, 2007). In addition the Duluth power and control wheel may help to expose abusive behaviors or forms such as physical violence, enforced isolation and economic dependency that perpetrators may use against their partners (Stuart, 2005). The equality wheel presented below is the opposite of the power and control wheel depicted in page.18. The equality wheel indicates behaviors that perpetrators need to engage in to facilitate egalitarian relationship (Pence & Paymar, 1993).

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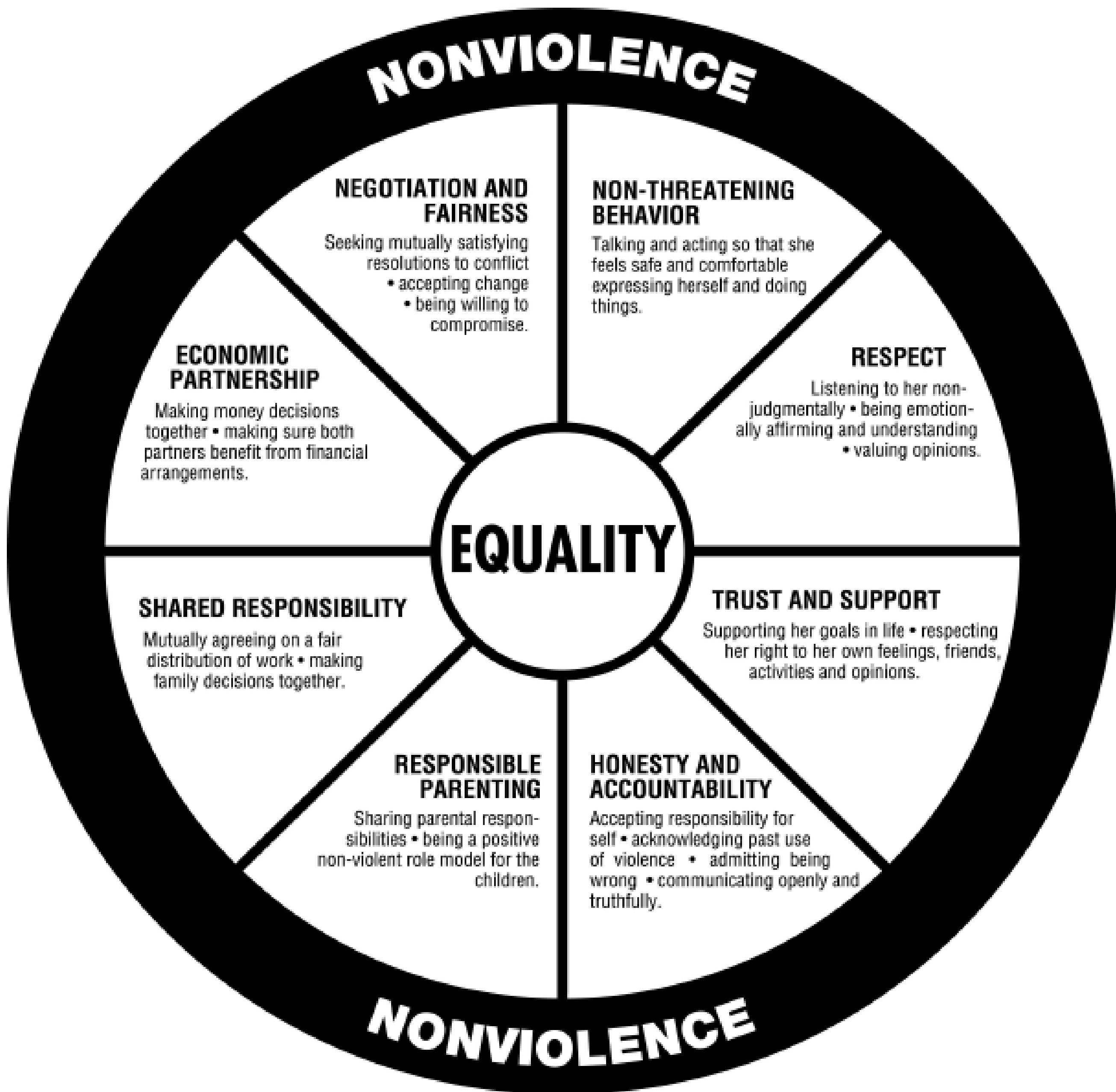

Figure 2: The Duluth wheel of Equality. Adopted from Domestic Abuse Intervention Project (DAIP), 202 East Superior Street, Duluth, MN 55802, 218-722-2781 .www.theduluthmodel.org

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Cognitive Behavioral Theory

Another alternative intervention for batter program beside the Duluth model is Cognitive Behavioral Therapy, (CBT). CBT is similar to the Duluth model. Distinguishing between the two models is becoming increasingly difficult (Stover et al., 2009). The main difference between CBT and the Duluth model of intervention is the view of perpetrators' attitudes; whether these attitudes are necessarily predisposed to violence or whether they are socially reinforced (Barner & Carney, 2011). A meta analysis review of Batter Intervention programs (BIP_S) by Babcock, Green, and Robie, (2004) and Dunford (2000) report no significant difference between the Duluth model and CBT based interventions. No research has demonstrated clearly and consistent superior effectiveness for one batter intervention approach over another (Dutton & Sonkin, 2013). Cognitive behavioral batterers' intervention was developed primarily by psychologists and it tend to make violence the primary focus of treatment (Babcock et al., 2004). The pros and cons of violence is pointed out along with providing skills training such as anger management, conflict resolution skills, assertiveness, and relaxation techniques to promote alternatives to the use of violent behaviors (Stover et al., 2009).

Circles of Peace

Circles of Peace (CP) is a form of batter intervention which provides an alternative to the traditional BIP interventions (Stith et al., 2012). The CP intervention is a systemic intervention developed by Mills (2009b). This intervention involves a conference between victims, offenders, and sometimes includes supportive family members and friends. The facilitator is called a circle keeper. The circle keeper is usually a community member trained to work with both the perpetrator (called ''the applicant''), and the victim (called "the participant"). A CP uses an intake assessment and safety screening to ensure the safety of victims if they choose to

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participate. The program also uses an ‘‘Initial Social Compact’’. The initial social compact is a document signed by the offender promising not to be violent but to rather participate in any treatment that may be necessary and helpful. Another technique is the ‘‘talking piece’’. The talking piece is an object identified by the family that must be held by the speaker when talking. The rules and guidelines of CP include no violence, no blaming, and a focus on acknowledgment, understanding, responsibility, and healing.

Motivational Interviewing

Motivational interviewing (MI) is an effective evidence based approach to overcoming the ambivalence that prevent many people from making the desired changes in their lives (Miller & Rollnick, 2002). The MI approach is a client centered directive therapeutic style that enhances readiness to change by helping clients to explore and resolve ambivalence (Hettema, Steele, & Miller, 2005). The MI therapist creates an atmosphere that encourages clients to resolve these ambivalence and develop confidence in their ability to change (Musser & Murphy, 2009). MI emphasizes autonomy and choice, reinforce ‘‘change talk’’ from clients, focuses on reflections and questions related to change (Musser & Murphy, 2009). Motivational interviewing is an effective form of intervention with IPV offenders due to the resultant increase in engagement as well as attendance at group treatment programs (Miller & Rollnick, 2002). Some MI methods of working with groups includes paraphrasing clients’ verbalizations, double sided reflection of ambivalence about change, amplifying reflection or reframing of resistant statements, summary of change relevant to the content (abusive behaviors), evocative questions, and affirmation (Musser & Murphy, 2009). Taft and his collegues investigated the effectiveness of motivational enhancement techniques and found significant effect on group attendance for participants in the

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experimental group compared to those in the control group (Taft, Murphy, Elliott, & Morrel 2001).

Other interventions for batter groups include but not limited to family system theories which focus on analyzing family dynamics and communication patterns, Trauma based approaches and culturally focused programs that pay attention to historical and contemporary experiences of particular cultural groups (Saunders, 2008).

IPV Interventions for women

There is disparity in IPV literature regarding the interventions for women involved in IPV. Most practitioners argue that women are usually arrested for defensive actions used in the face of assaults perpetrated by their partner against them whiles others believe that these higher arrest rates more accurately reflect the true prevalence of physical aggression perpetrated by women (Henning, Renauer, & Holdford, 2006). In light of this, women are view as victims or offenders respectively. Regardless of this discrepancy, it is important to consider whether women's needs for treatment differ from that of men, or whether the effective mode of interventions for men's intervention programs need to be evaluated before used for women's intervention programs (Stith et al., 2012). Women treatment needs have been addressed through the examination of women's motivation to use violence (Stith et al., 2012). Findings in literature suggest that women's use of violence depicts owing to problems with emotional regulation and for reasons of self defense or retaliation (Stith et al., 2012). Interventions for IPV victims typically focus on advocacy and counseling to assist victims to leave their abusive partners, and are evaluated for services provided by domestic violence shelters (Stover et al., 2009). Other interventions includes medical services, (e.g. prenatal clinics and community involvement service) police social service outreach and advocacy (Stover et al., 2009). Several police social

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service outreach programs have been developed in various communities involving follow up home visits made by police officers and social workers to IPV reported homes to provide victims with information on services available to them (Stover et al., 2009).

Conclusion

Many theories provide an insight to IPV. However, there is still much to be understood in terms of how the factors of IPV influence victimization among intimate partners. There is inconsistency in literature with regards to the incidence of partner violence and gender, and identifying effective gender base interventions of helping IPV victims and survivors. On the hand, there is unanimous view regarding the effects of IPV on individuals and the society at large. There is thereford the need for more concise IPV future research to facilitate effective therapeutic interventions for both IPV survivors and perpetrators.

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CHAPTER 3 METHODOLOGY

Introduction

This chapter focuses on the method used to assess opinions, IPV knowledge, and the perceived preparedness of counseling students to counsel IPV clients. The chapter outlines the research design, research questions and hypotheses, the setting of the research study, the nature of the research participants, research instrument, treatment procedures, and method of analysis.

Participants of this study were recruited from a Counselor Education Master's program. Participants were registered for the techniques of counseling, counseling practicum, and counseling internship courses. All respondents attended a pre-study information meeting where the study procedures and the duration of the study were discussed. Participants also completed a consent form, demographic questionnaire, and the pre-test instrument. The counseling students were randomly assigned to the experimental group and the control group using "pick from the bowl" technique (details of this technique is discussed in subsequent section). The IPV educational materials were emailed to only participants in the experimental group in three different sections within two weeks. The post-test was then completed by both the experimental group and the control group after the two weeks period. The pretest was used to compare the control and experimental groups to establish equivalency. The post-test on the other hand was used to determine any differences among the experimental and the control groups with regards to students' opinions on IPV, student's IPV knowledge and their perceived preparedness to counsel IPV clients.

Research Design

This study used the same research design for hypothesis 1, 2 and 3. A pretest-posttest design was used to test hypothesis 1 as illustrated in Table 1 below. The control group completed

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the pre-test and post-test without receiving IPV training as illustrated below. The pre-test and the demographic questionnaire were administered to both groups. The IPV educational materials were emailed to the experimental group within two weeks. The post-test was then administered to both the control and the experimental groups. Below are the pretest-posttest design for hypotheses 1, 2 and 3.

Pretest-Posttest design for Hypothesis 1

Hypothesis 1: There is no significant difference in the perceived preparedness between the experimental group and the control group after IPV education.

Table 1

Convenience Sampling	Research group	Pre-test	Experiment (IPV Education)	Post-test
Random Assignment	Experimental group	O_1	X	O_2

Table 2

Convenience Sampling	Research group	Pre-test	Post-test
Random Assignment	Control group	O_1	O_2

The one group pretest-posttest experimental design was also used to test hypothesis 2 and 3 as illustrated below. The control group was administered the pre-test and post-test without the IPV education as illustrated below.

Pretest-Posttest design for Hypothesis 2

Hypothesis 2: There is no significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education.

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Table 3

Convenience Sampling	Research group	Pre-test	Experiment (IPV Education)	Post-test
Random Assignment	Experimental group	O_1	X	O_2

Table 4

Convenience Sampling	Research group	Pre-test	Post-test
Random Assignment	Control group	O_1	O_2

Pretest-Posttest design for Hypothesis 3

Hypothesis 3: There is no significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education.

Table 5

Convenience Sampling	Research	Pre-test	Experiment (IPV education)	Post-test
Random Assignment	Experimental group	O_1	X	O_2

Table 6

Convenience Sampling	Research group	Pre-test	Post-test
Random Assignment	Control group	O_1	O_2

Issues of Validity

Several factors can affect the internal and external validity of a research study (Campbell, Stanley, & Gage, 1963). Such factors may include history, maturation, testing, instrumentation, regression, selection, interaction of testing and treatment, and the multiple treatment interference

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(Campbell et al., 1963). Maturation, testing, history, and instrumentation will be discussed in this study as they may affect the internal validity of the study.

Maturation

This refer to the process within which the respondent operates as a function of the passage of time including growing older, growing hungrier or growing tired (Campbell et al., 1963). Maturation may also cover biological or psychological processes which may also vary within the passage of time (Campbell et al., 1963). All these factors may affect the internal validity of the study.

Testing

One way that testing may affect the internal validity of the research is when the test is taken the second time (Campbell et al., 1963). There is a chance that respondents would perform better on the post- test due to the initial exposure to the pre-test. Such improvement in the post-test may therefore be contributed to participants' learning rather than the research experiment. This study will attempt to reduce this testing threat by administering the post-test two weeks after the pre-test. Participants were also encouraged to independently and honestly respond to the questionnaire.

History

History refers to the specific events that occur between the first and second measurement in addition to the experimental variable (Campbell et al., 1963). It is possible that any external events or activities that happens between the pre-test and post-test (besides the intended experiment to measure opinions and the perceived level of preparedness of students) would have an impact on the outcome of the study. It will be difficult to control for such external historic

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effect in this study. However, the short period between the pretest and post test in this study will possibly reduce the amount of external historic events during the study.

Instrumentation

Instrumentation is a threat to internal validity resulting from changes in the calibration of a measuring instrument, changes in the observers or scores used which may lead to changes in the obtained measurement of a study (Campbell et al., 1963). This study used a standard objective scale to obtain research data in order to consequently reduce instrumentation threat to internal validity. However, due to the self-reporting nature of the "PREMIS", there is the possibility of a "social desirability" threat to external validity. The nature, internal and external validity of the instrumentation is discussed in detail in subsequent section.

Independent and Dependant Variables

Independent Variable

IPV Education

The independent variable in this study is the Intimate Partner Violence (IPV) education (See Appendix). The IPV educational materials were emailed to participants in the experimental group in three different sections within two weeks. The objectives of the IPV education are outlined as follows;

Session 1:

- Respondents will be able to define IPV and identify the different types of IPV.
- Respondents will be able to identify the various risk factors of IPV.
- Respondents will be able to illustrate the effects of IPV on individuals, children, the society, and the economy as a whole.
- Respondents will be able to recognize and encounter myths and misconceptions regarding IPV.

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- Respondents will be able to identify abusive behaviors that abusers are likely to use against their victims, e.g. Isolation, stalking, control, etc.
- Respondents will be able to identify factors that may prevent IPV victims from leaving an abusive relationship.
- Respondents will learn about the cycle of abuse, and
- Respondents will be encouraged to reflect on personal reactions to IPV situations.

Session 2

- Respondents will be able to screen for signs of IPV among clients.
- Respondents will be knowledgeable about IPV screening instruments.
- Respondents will be introduced to various therapeutic interventions for working with IPV victims and survivors.
- Respondents will be knowledgeable regarding documenting IPV incident in clients chart.
- Respondents will learn about the counselors' role in assisting IPV victims and survivors.

Session 3

- Respondents will be able to assess IPV client readiness to change using Prochaska's Trans-theoretical stage model of change.
- Respondent will be able to assess IPV clients' safety and help create a safety plan for them.
- Respondents will be able to outline IPV resources in Detroit and neighboring cities to facilitate treatment and change.
- Respondents will consider "confidentiality" and IPV related issues.
- Respondents will be knowledgeable regarding what to expect after an abuse is reported by the client.

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- Respondents will be informed about IPV and domestic violence (DV) laws in Michigan State.

Dependent variable

The three main dependent variables in this study are opinions, IPV knowledge (perceived and actual), and perceived preparedness. Opinions used in this study refer to views, appraisal or judgments that counseling students have regarding IPV. Knowledge used in this study refers to facts or information acquired by a person through experience or education. The perceived preparedness in this study refers to how prepared students feel they are regarding counseling IPV clients. In this study, Perceived preparedness is measured using the Perceived Preparation scale from the background section of the PREMIS instrument.

Research Questions and Hypotheses

Research Question 1: Is there significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education?

Hypothesis 1: There is no significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education.

Null Hypothesis (H_o): $\mu_t = \mu_c$

Alternative Hypothesis (H_a): $\mu_t \neq \mu_c$

Where t = treatment group (experimental group) and c = control group

Research Question 2: Is there significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education?

Hypothesis 2: There is no significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education.

Null Hypothesis (H_o): $\mu_t = \mu_c$

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Alternative Hypothesis (H_a): $\mu_t \neq \mu_c$

Research Question 3: Is there significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education?

Hypothesis 3: There is no significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education.

Null Hypothesis (H_o): $\mu_t = \mu_c$

Alternative Hypothesis (H_a): $\mu_t \neq \mu_c$

Research Setting

The research per-study meeting was held at a university located in a large urban metropolitan area. The university consists of about 13 schools and colleges and offer more than 370 major subject areas with over 33,000 graduate and undergraduate students. The pretest-posttest was administered in this location because of it easy accessibility. Furthermore, participants' familiarity to the environment consequently reduced stressful events during the research process.

Characteristics of Research Participants

The participants were recruited from the Counselor Education Master's Program at an Urban University. The criteria for being part of this study was that counseling student should be registered for techniques of counseling, counseling practicum and counseling internship courses. The reason for this criterion is to ensure that participants had the knowledge and skills in counseling theories and counseling ethics to facilitate their comprehension of research materials. There were more female than male participants in this study. The gender disparity is consistent and reflective of the general population trend of the counseling program.

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Sample Size

A substantial sample size for this study was determined before the collection of data. the Three factors that affect the sample size in a study are the alpha level, effect size, and power (Hair Jr, et al., 2010).

Alpha (α) level refers to the probability of making a Type I error (rejecting the null hypothesis when the null hypothesis is true) while Beta (β) refer to the probability of making a type II error or the probability of a false negative. An alpha level of $\alpha = 0.05$ is used in this study. This alpha level is a standard level in social sciences research (Stevens, 2009).

Effect size is the estimate of the degree to which the phenomena being studied exist in the population (Cohen, 1992). Effect size help researchers to determine whether the observed relationship (differences or correlation) among the studied phenomenon is meaningful (Hair Jr et al., 2010). All other things being equal, the larger an effect size, the bigger the impact of the experimental variable, and the more important the discovery of its contribution (Fritz, Morris, & Richler, 2012). Effect size can be calculated using Cohen's *d*, Chi-square, or f- test. The Cohen's *d* is defined as the difference between the means, ($M_1 - M_2$) divided by standard deviation of either groups (when variances of the two groups are homogeneous). Cohen's *d* is used to calculate the effect size in this study; 0.2 represents a small effect, 0.5 is a moderate effect, and 0.8 is a large effect size, (Cohen, 1988).

Power (1-β) refers to the probability that the test will accurately reject the null hypothesis when the null hypothesis is false, find a hypothesized relationship or differences among phenomenon when it exist (Hair Jr et al., 2010). According Hair et al (2010), as the power increases, the probability of rejecting the null hypothesis when the null hypothesis is false also increases. A power size of 0.70 is used in determining the sample size as indicated below. With

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regards to the chosen alpha level, effect size, power, and u = 1; (u = K-1, where K = 2 groups), the ideal sample size for this study is n = 13 per group with reference to table 8.4.4 in the Statistical analysis for behavioral sciences, 2nd edition by Cohen (1988).

Selection Method

The present work used convenience sampling method to access the overall participants of the study. Participants were randomly assigned to both the experimental group and the control group. The research participants were provided with a written informed consent highlighting that participation in the study was completely voluntary, hence participants could choose to quit the study any time without any cost to them. The risks and benefits of participating in the study were also explained in the consent form. A pre-study meeting was held to randomly assign participants to the control group and experimental group using "pick from the bowl" technique. Pick from the bowl is a technique where codes (A1…A20 and B1…B20) were written on pieces of paper and mixed up in a bowl. Students who picked a code between A1 to A20 were assigned to the experimental group and students who picked B1 to B 20 were assigned to the control group. In all, thirty participants were recruited for this study.

Research Procedure

Participants were informed regarding the nature of the research process (type of research, respondents' right of voluntary participation, length of study, IPV education, and consent forms). Participants were then randomly assigned to the control and experimental groups. The respondent profile and the pre-test were administered to voluntary students for both groups.

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IPV Education Procedure

The IPV educational materials (see appendix) were emailed to participants in the experimental group in three different sections within two weeks. The IPV education constituted power point, self-reflective exercises and reflective questions.

Instrumentation

IPV has received attention from various disciplines (Medical, Counselor Education, Psychology, Social Work, etc.) because of the well documented health consequences in literature. However, many health care professionals seem inadequate with regards to screening for IPV, counseling IPV clients, or referring IPV victims to appropriate recourses (Connor et al., 2011). "This crisis of confidence among health care professionals has necessitated the creation of standardized IPV education programs, along with self-administered survey tools and well-defined educational outcome measures" (Connor et al., 2011; Pg 1013). One of such comprehensive survey tools recently created is the PREMIS. The PREMIS, a self-reporting instrument was created by Short and his colleagues to measure physicians' preparedness to manage IPV patients (Short et al, 2006). The draft of the tool was evaluated using psychometric techniques in a group of 166 physicians in 2002, revised and retested in a group of 67 physicians on three occasions in 2003 and 2004 (Short, Alpert, Harris Jr, & Surprenant, 2006). The final developed tool was found to have a good stability of psychometric properties of Cronbach's $\alpha \geq 0.65$ and internal correlation. In 2007 and 2008, psychometric properties of the PREMIS was adapted, tested, and evaluated on a group of 117 Medical students, 52 Nursing students, 56 Social work students and 61 Dentistry students during their last semester of college (Connor et al., 2011). Three scales of the PREMIS (Background, IPV knowledge, and opinions) presented a Cronbach's $\alpha \geq 0.70$, demonstrating acceptable reliability. The adapted instrument also showed

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good stability of psychometric properties among the student population and a good correlation within several measures (Connor et al., 2011). However, there is no current data on the test-retest reliability of the PREMIS instrument. In light of this, the modified PREMIS was tested for reliability consistency before (pre-test) and after use (post-test).

The PREMIS tool was adopted and modified for this study to assess counseling students' opinions, IPV knowledge and their perceived preparedness to counsel IPV clients. The PREMIS was modified to fit the counseling field and to facilitate participants understanding of the questionnaire.

Respondent Profile

The respondents profile consisted of nine demographic questions; gender, age, highest educational level, ethnicity, respondents' field of study, employment status, job settings, and a question regarding licensure. The respondent profile was created for the purpose of this study to be consistent with the counseling arena. Participants completed the respondent profile in addition to the pre-test questionnaire during the introductory meeting.

Physician Readiness to Manage Intimate Partner Violence (PREMIS)

The PREMIS instrument consists of five sections; Respondent profile, Background (Perceived Preparation scale, and Perceived Knowledge scale), Intimate Partner Violence (IPV) Knowledge scale, Opinions scale, and Practice issues scale. The respondent profile consists of ten questions ranging from demographic questions to physician practice related questions. The respondent section of the PREMIS is excluded from this study because it was created purposely for physicians and it is not consistent with participants of this study. The Background of the PREMIS consists of three major sections. The first section asked respondents about their previous IPV training hours. The second section consisted of the Perceived Preparation scale

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which consisted of 11 items inquiring about how prepared respondents feel they are with respect to working with IPV clients. Responses and scores vary from 1 (not prepared) to 7 (well prepared). The background section has a mean score of 4.14, ±1.49 (SD) across all 11 items and a high internal consistency at $\alpha = 0.959$ (Short, Alpert, Harris Jr, & Surprenant, 2006). All the questions on the background section are applicable to this study. However, minor changes were made to the terminology in order to be consistent with the counseling field (the word physician was replaced with counselor and patients with clients). The third part of the background section is the Perceived Knowledge scale consisting of 16 items inquiring how much respondents feel they know about IPV. Responses on this scale ranged from 1 (nothing) to 7 (very much) with a mean score of 3.00 (*SD* = 0.82) and high internal consistency $\alpha = 0.963$ among items. The IPV Knowledge scale measures respondents' knowledge regarding IPV. It consists of 7 multiple choice items and 11 true or false questions which were based on findings from IPV literature. The Opinion scale of the PREMIS consists of 32 items inquiring about respondents' views and opinions regarding IPV. A six good-fit scale with 31 items were identified with $\alpha \geq 0.65$ (Short et al., 2006). The opinions of counseling students in this study were measured using the Opinions scale of the PREMIS. The four point Likert type scale consists of 32 items ranging from strongly disagree to strongly agree. However, question 15, (I comply with the joint commission standards that require assessment for IPV) of this section was excluded from this study because it is not consistent with participants of this study. The final section of the PREMIS tool is the practice issues scale consisting of 13 items specifically relating to physician's actual practice. The current study does not intend to solicit practice related information; hence, this section was also excluded from this study. Also, items in the practice issue scale are specific to physician practice and not consistent with the participants of this study.

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External reliability and validity studies of the PREMIS

An initial instrument was revised base on repeated testing to arrive at the PREMIS. The PREMIS instrument demonstrate good internal consistency reliability with Cronbach's $\alpha \geq 0.65$, (Short et al., 2006). The authors noted that the developed scales were closely connected with theoretical constructs and predictive of self-reported behaviors. In addition, the scales had stable results in the population studied for a period of 12 months (in absence of outside IPV education or other interventions). Connor and his colleagues adapted and modified the PREMIS in 2007 and 2008 to evaluate a group of 117 Medical students, 52 Nursing students, 56 Social work students, and 61 Dentistry students during their last semester of college. The three adapted scales (Background, IPV knowledge and Opinions) presented a Cronbach's $\alpha \geq 0.70$, demonstrating acceptable reliability and consistency among the scales (Connor et al., 2011).

Data Collection

The research participants (both the control group and the experimental group) were asked to complete the respondent profile. Participants also completed the modified PREMIS as part of the pre-test batteries during the introductory meeting. Respondents were assigned codes in order to easily identify and eliminate incomplete responses from the data analysis. The IPV educational materials were emailed to participants in the experimental in three different sections within two weeks after the introductory meeting. Both the experimental group and control then completed the modified PREMIS again as part of the post-test batteries.

Data Analysis

The data was checked for leverage and influence before analyses. The data was analyzed using Statistical Package for the Social Sciences software (SPSS, version 22). The Statistical analysis of the data included descriptive statistics, the use of repeated measures Analysis of

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Variance (ANOVA), Kruskal-Wallis and the Mann-Whitey nonparametric tests. The assumption of normal distribution, homogeneity of variance, and independence of the date were tested as part of the data analysis procedures. The effect size and reliability were also checked. The results of the data are presented in table and chart format. The statistical analysis for each hypothesis is outlined below.

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Table 7

Statistical analysis for Hypotheses

Research Questions and Hypotheses	Variable and instrument	Statistical analyses method
Research Question 1: Is there significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education? Hypothesis 1: There is no significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education.	Respondents profile Independent variable: IPV Education Dependent variable: Perceived preparedness Instrument: modified PREMIS	Descriptive statistics Repeated Measures ANOVA
Research Question 2: Is there significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education? Hypothesis 2: There is no significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education.	Independent Variable: IPV Education Dependent Variable: IPV knowledge Instrument: modified PREMIS	Kruskal-Wallis and Mann-Whitney nonparametric tests
Research Question 3: Is there significant difference in the mean scores of students' opinion between the experimental group and the control group after IPV education? Hypothesis 3: There is no significant difference in the mean scores of students' opinion between the experimental group and the control group after IPV education.	Independent Variable: IPV education Dependent Variable: Student's opinions instrument: modified PREMIS	Repeated Measures ANOVA

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CHAPTER 4 RESULTS

Introduction

This chapter presents the findings of the study. Results are depicted using descriptive statistics, tables and charts. Repeated measures ANOVA, Kruskal-Wallis and Mann-Whitney nonparametric tests were used to analyze the data. Statistical Significance level is set at 0.05.

The research study explored the opinions, knowledge, and the perceived preparedness of counselors' in training to counsel IPV clients. The study was set out to find whether there is a significant difference in the mean scores between the experimental group and the control group after IPV education in the areas of students' opinions, knowledge and their perceived preparedness to counsel IPV clients.

Research Question 1: Is there significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education?

Research Question 2: Is there significant difference in the mean scores of students' IPV knowledge between the experimental group and the control group after IPV education?

Research Question 3: Is there significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education?

Descriptive Statistics

Gender

The frequency statistics for the gender of the participants show that 93.3% of the respondents were female and 6.7% were male. The table 8 below shows the frequency statistics of respondents.

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Table 8

Frequency distribution of Gender				
	Frequency	Percent	Valid Percent	Cumulative Percent
Female	28	93.3	93.3	93.3
Male	2	6.7	6.7	100.0
Total	30	100.0	100.0	

Age

The age of participants range from 24 to 57 with a mean age of 33.32. Table 9 shows the mean, range, sum and standard deviation of respondents ages.

Table 9

Descriptive Statistics of Age					
	N	Minimum	Maximum	Mean	Std. Deviation
AGE	30	24	57	33.60	8.61
Total	30				

Race

Forty percent of the respondents identified themselves as Black or African Americans, 50% identified themselves as White/Caucasians, 3.3% identified themselves as Asian American and 6.7% identified themselves as Hispanic/Latino. The table below illustrates the descriptive statistics of respondents' ethnicity.

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Table 10

Frequency distribution of Race

	Frequency	Percent	Valid Percent	Cumulative Percent
Black / African American	12	40.0	40.0	40.0
White / Caucasian	15	50.0	50.0	90.0
Asian American	1	3.3	3.3	93.3
Hispanic/ Latino	2	6.7	6.7	100.0
Total	30	100.0	100.0	

Educational Level

Eighty percent of respondents have a minimum of Bachelors Degree while 20% of the respondents indicated that they already have a master's degree. All participants are students in the Counseling master's program. The table below shows the distribution of participants' educational level.

Table 11

Frequency distribution of participants Educational Level

	Frequency	Percent	Valid Percent	Cumulative Percent
Bachelor Degree	24	80.0	80.0	80.0
Master Degree	6	20.0	20.0	100.0
Total	30	100.0	100.0	

Area of Specialty

There are various areas of concentration in the Counseling program. The statistical distribution as shown in the table below indicates that 70% of the respondents majored in community counseling, 6.7% in school counseling and 23.3% majored in community and Art therapy combined.

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Table 12

Frequency distribution of students' area of concentration

	Frequency	Percent	Valid Percent	Cumulative Percent
Community counseling	21	70.0	70.0	70.0
School counseling	2	6.7	6.7	76.7
Community & Art therapy	7	23.3	23.3	100.0
Total	30	100.0	100.0	

Employment

63.3% of the respondents indicated being full-time employed, 30% are employed part-time and 6.7% indicated not employed. The table below illustrates the statistical distribution of participants' employment status.

Table 13

Frequency distribution of employment status

	Frequency	Percent	Valid Percent	Cumulative Percent
Full Time	19	63.3	63.3	63.3
Part – Time	9	30.0	30.0	93.3
Not Working	2	6.7	6.7	100.0
Total	30	100.0	100.0	

Counseling Licensure

All thirty participants (equivalent group) reported that they do not hold any counseling professional licensure.

Testing for Assumptions

Normal Distribution

Normal distribution refers to how data rely on the normally distributed populations. The Kolmogorv-Smirnov and Shapiro-Wilk test suggest that the data from the Perceived Preparation

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scale and the Opinion scale of the PREMIS questionnaire met the assumption of normal distribution ($p > 0.05$). The table below shows the test for normality.

Table 14

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Perceived preparation Pre-test	0.207	30	0.002	0.931	30	0.053
Perceived preparation Post-test	0.089	30	0.200*	0.979	30	0.811
Opinion pre-test	0.110	30	0.200*	0.943	30	0.108
Opinion post-test	0.094	30	0.200*	0.979	30	0.797

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

- See Appendix for the expected and observed distribution for the data.

Previous IPV or Domestic Violence (DV) Training

Participants were asked to report their previous hours of IPV or DV training. The results of the pre-test indicated that the minimum previous hours of IPV/DV training was 0, and the maximum was 10. 53.3% reported no previous training and 10% reported having 10 hours of training. The table below shows the frequency distribution of previous IPV/DV training hours.

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Table15

Frequency distribution of IPV/DV training pre-test

Hours	Frequency	Percent	Valid Percent	Cumulative Percent
0	16	53.3	53.3	53.3
1	2	6.7	6.7	60.0
2	2	6.7	6.7	66.7
3	2	6.7	6.7	73.3
5	1	3.3	3.3	76.7
6	2	6.7	6.7	83.3
7	1	3.3	3.3	86.7
9	1	3.3	3.3	90.0
10	3	10.0	10.0	100.0
Total	30	100.0	100.0	

The participants were asked again to report their hours of IPV/DV training as part of the post-test batteries. The results below indicate a reduction in the percentage of participants who reported no previous IPV/DV training from 53.6% to 28.6%. The effect size of the IPV training was Cohen's d = 0.74 base on the post-test means and standard deviations. The table below shows the statistical distribution of the hours of participants' IPV/DV hours of training.

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Table 16

Frequency distribution of IPV Post-test

Hours	Frequency	Percent	Valid Percent	Cumulative Percent
0	9	30.0	30.0	30.0
1	1	3.3	3.3	33.3
2	6	20.0	20.0	53.3
3	3	10.0	10.0	63.3
4	2	6.7	6.7	70.0
5	1	3.3	3.3	73.3
6	2	6.7	6.7	80.0
7	2	6.7	6.7	86.7
10	1	3.3	3.3	90.0
11	1	3.3	3.3	93.3
12	2	6.7	6.7	100.0
Total	30	100.0	100.0	

The results of participants' mean scores before and after IPV training are depicted in the table and graph below;

Table 17

Descriptive Statistics for IPV/DV training

	Group	Mean	Std. Deviation	N
IPV/DV training Pre-test	Group B	2.20	3.36	15
	Group A	2.80	3.84	15
	Total	2.50	3.56	30
IPV/DV training post test	Group B	2.20	3.36	15
	Group A	4.87	3.80	15
	Total	3.53	3.78	30

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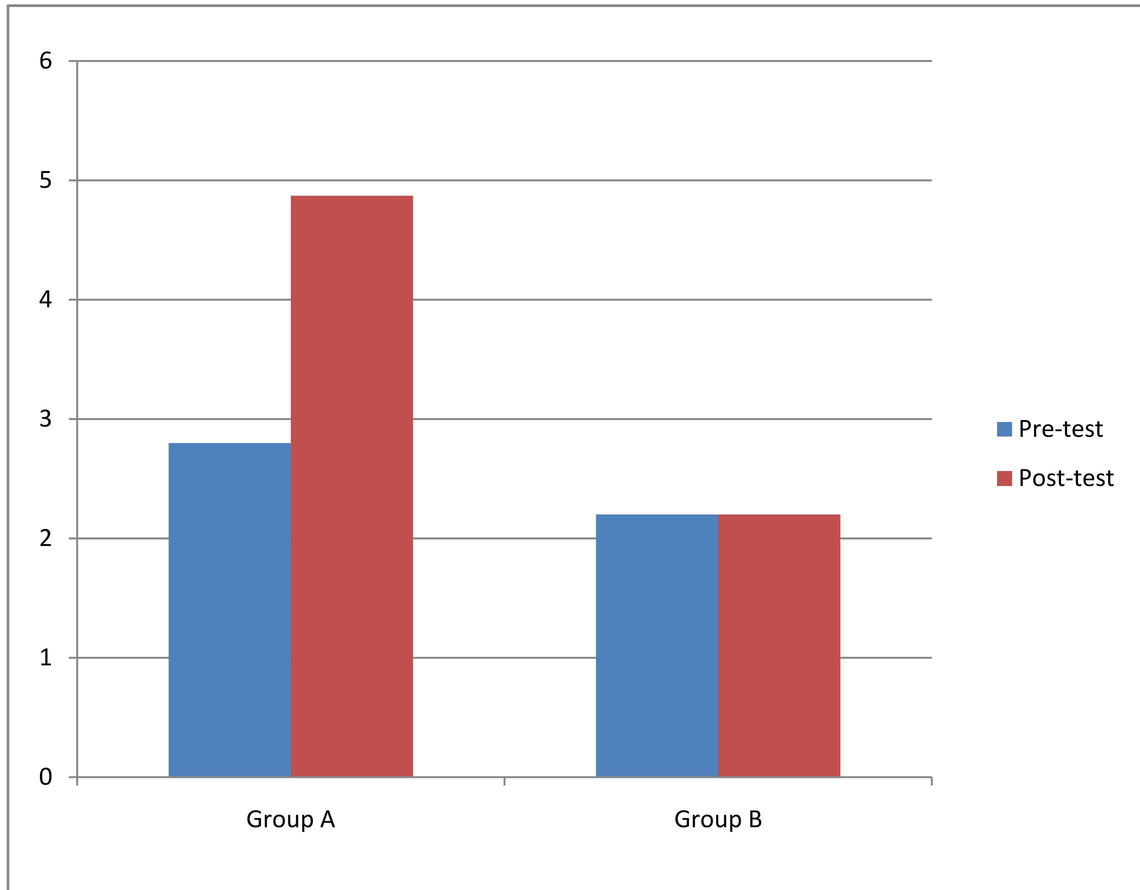

Figure 3: ***Graphical representation for IPV/DV training mean scores of group A and B***

Perceived preparedness

Perceived preparedness was measured with the Perceived Preparation scale consisting of 12 items. A pretest-posttest reliability test was done to test the reliability and consistency of the scale. The Cronbach's alpha for the pre-test was 0.94, and the post-test was 0.97. The results indicate a high consistency and reliability of the scale.

Hypothesis 1

Null Hypothesis 1: There is no significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education.

$$\mu 1_{\text{mean scores of experimental group (A)}} = \mu 2_{\text{mean scores of control group (B)}}$$

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Alternative Hypothesis 1: There is significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education.

$$\mu1_{\text{mean scores of experimental group (A)}} \neq \mu2_{\text{mean scores of control group (B)}}$$

Hypothesis 1 was tested with repeated measures ANOVA. Participants' were put into two groups: Group A was the experimental group and group B was the control group. A repeated measure ANOVA was performed to compare the mean scores of the experimental group and the control group after IPV education. The outcome variable for both the pre-test and post-test were found to be normally distributed. The equality of covariance matrices was not significant, the assumption of Mauchly's test of sphericity and equally of variance assumption were met. The results of repeated measures ANOVA showed that the mean (*M*) and standard deviation (*SD*) scores for the experimental group before the IPV education were 3.18 and 1.38 respectively, whereas the scores after the IPV education were M = 4.93, SD = 1.00. From the pre-test, the participants in the control group had M = 3.11 and SD = 1.56, whereas from the post-test they had M = 3.26, SD = 1.49. The mean differences between the experimental group and the control group was statistically significant, $F (1, 28) = 25.60$, $p < 0.001$, partial $\eta^2 = 0.48$ and statistical power was adequate at 0.99. The effect size was Cohen's d = 1.30 based on the post-test means and standard deviations. The mean scores of Group A and B are showed in the table and graph below.

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Table 18

Descriptive Statistics for perceived preparedness

	Group	Mean	Std. Deviation	N
Perceived preparedness Pre-test	Group B	3.11	1.56	15
	Group A	3.18	1.38	15
	Total	3.15	1.45	30
Perceived preparedness Post-test	Group B	3.26	1.49	15
	Group A	4.93	1.00	15
	Total	4.09	1.51	30

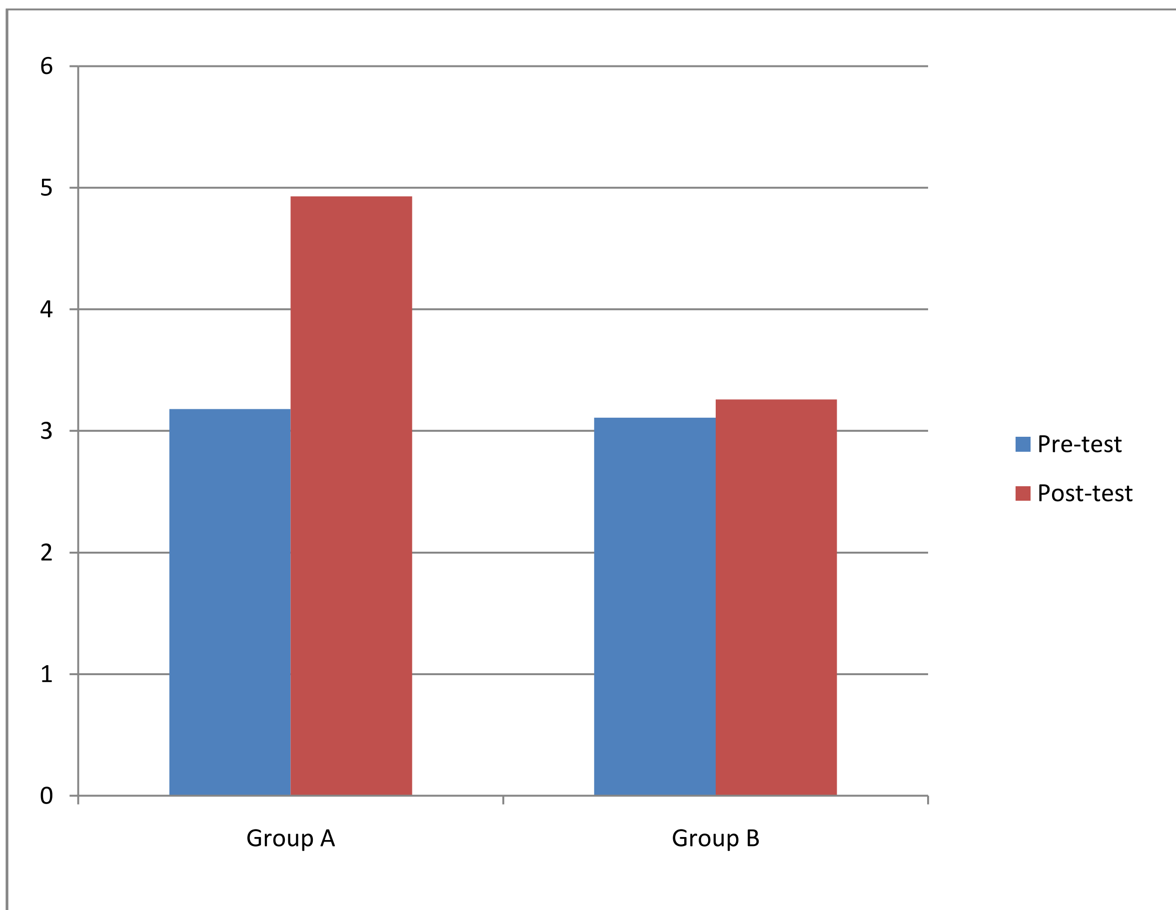

Figure 4: ***Graphical representation for perceived preparedness mean scores of group A and B***

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IPV knowledge

The Cronbach's alpha for the reliability test of 33 items on the IPV Knowledge scale for pre-test was 0.87 and 0.88 for the post-test. The results indicate a high consistency and reliability of the scale.

Hypothesis 2

Null Hypothesis 2: There is no significant difference in the mean scores of IPV knowledge between the experimental group and the control group after IPV education.

$$\mu 1_{\text{mean scores of experimental group (A)}} = \mu 2_{\text{mean scores of control group (B)}}$$

Alternative Hypothesis 2: There is significant difference in the mean scores of IPV knowledge between the experimental group and the control group after IPV education.

$$\mu 1_{\text{mean scores of experimental group (A)}} \neq \mu 2_{\text{mean scores of control group (B)}}$$

The outcome variable for both the pre-test and post-test of IPV knowledge was slightly skewed. The skewness of the pre-test was -0.93 and kurtosis was 0.18, while the skewness of the pos-test was -0.86 and kurtosis was 0.13. Though the assumption of Mauchly's test of sphericity and the equality of covariance matrices was not significant, the equally of variance assumption based on the Levene's test was rejected. As a result, the Kruskal-Wallis test was performed as an alternative to the one way ANOVA test to find out whether the ranked mean scores between the post-test group and the pre-test group are statistically significant. The Mann-Whitney hypothesis test summary was performed as a follow up test to support the results of the Kruskal-Wallis test. The pre-test result of the Kruskal-Wallis was not significant; χ^2 (1, N=30) = 0.92, p = 0.34; indicating no significant difference between the ranked mean scores of the experimental group and the control group before the IPV education. The post-test on the other hand was significant;

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χ^2 (1, N=30) = 10.51, p = 0.001. The rank mean scores of Group A and B are showed in the table and graph below.

Table 19

Descriptive statistics for IPV knowledge for group A and B

	Groups	N	Mean Rank
IPV Knowledge Pre-test	Group B	15	13.97
	Group A	15	17.03
	Total	30	
IPV Knowledge post-test	Group B	15	10.30
	Group A	15	20.70
	Total	30	

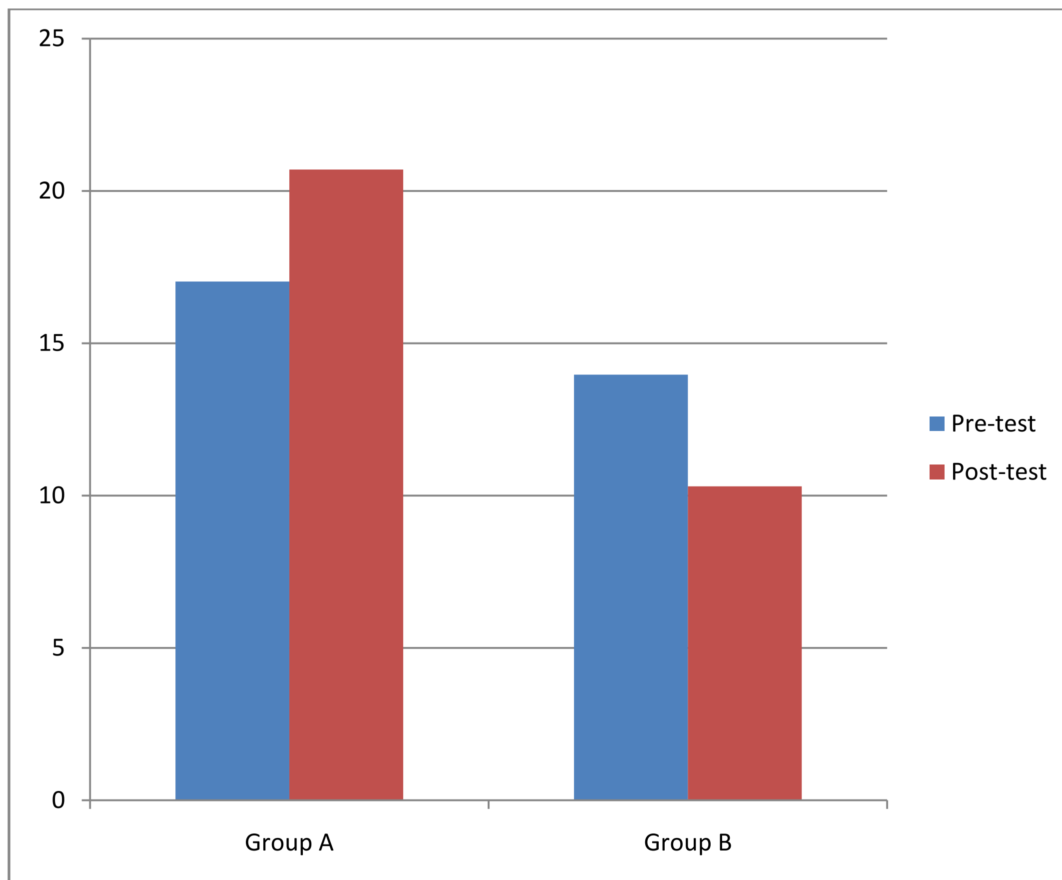

Figure 5: ***Graphical representation for IPV Knowledge ranked means of group A and B***

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The Mann-Whitney test was performed to support the results of the Kruskal-Wallis test presented above. The table below indicates the results of the Mann-Whitney test.

Table 20

Descriptive Statistics of the pretest-posttest scores of IPV knowledge

	N	Mean	Std. Deviation	Minimum	Maximum
IPV Knowledge pre-test	30	19.60	6.53	5.00	28.00
IPV Knowledge post-test	30	22.30	6.29	7.00	32.00

Table 21

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of IPVKN_pretest is the same across categories of GROUP.	Independent-Samples Mann-Whitney U Test	.345[1]	Retain the null hypothesis.
2	The distribution of IPVKN_posttest is the same across categories of GROUP.	Independent-Samples Mann-Whitney U Test	.001[1]	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is .05.

[1] Exact significance is displayed for this test.

The Cohen's *d* is 0.42 based on the Mann-Whitney mean and standard deviation scores for IPV knowledge above.

Opinions

The Cronbach's alpha for the reliability test of 31 items on the Opinion scale was 0.72 for pre-test and 0.74 for post-test. The results indicate a high consistency and reliability of the scale.

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Hypothesis 3

Null Hypothesis 3: There is no significant difference in the mean scores of students' opinion between the experimental group and the control group after IPV education.

$$\mu 1_{\text{mean scores of experimental group (A)}} = \mu 2_{\text{mean scores of control group (B)}}$$

Alternative Hypothesis 3: There is significant difference in the mean scores of students' opinion between the experimental group and the control group after IPV education.

$$\mu 1_{\text{mean scores of experimental group (A)}} \neq \mu 2_{\text{mean scores of control group (B)}}$$

A repeated measure ANOVA was performed to compare the mean scores of the experimental group and the control groups after IPV education. The outcome variable for both the pre-test and post-test were found to be normally distributed.The equality of covariance matrices was not significant, the assumption of Mauchly's test of sphericity and equal variance assumptions were met. The results of a repeated measures ANOVA for opinion showed that before the IPV education, the mean and standard deviation scores for the experimental group were 3.97 and 0.48 respectively, whereas after the IPV education, the scores were $M = 4.47$, $SD = 0.56$. The participants in the control group had $M = 3.99$ and $SD = 0.70$ for pre-test and $M = 4.07$, $SD = 0.58$ for post-test. The mean differences between the experimental group and the control group was statistically significant; $F(1, 28) = 9.80$, $p = 0.004$, $\eta^2 = 0.26$, and statistical power of 0.86. The effect size was Cohen's $d = 0.70$ base on the post test means and standard deviations. The mean scores of Group A and B are showed in the table and graph below.

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Table 22

Descriptive Statistics of opinion mean scores for group A and B

	Groups	Mean	Std. Deviation	N
Opinion Pre-test	Group B	3.99	0.70	15
	Group A	3.97	0.48	15
	Total	3.99	0.59	30
Opinion Post-test	Group B	4.07	0.58	15
	Group A	4.47	0.56	15
	Total	4.27	0.60	30

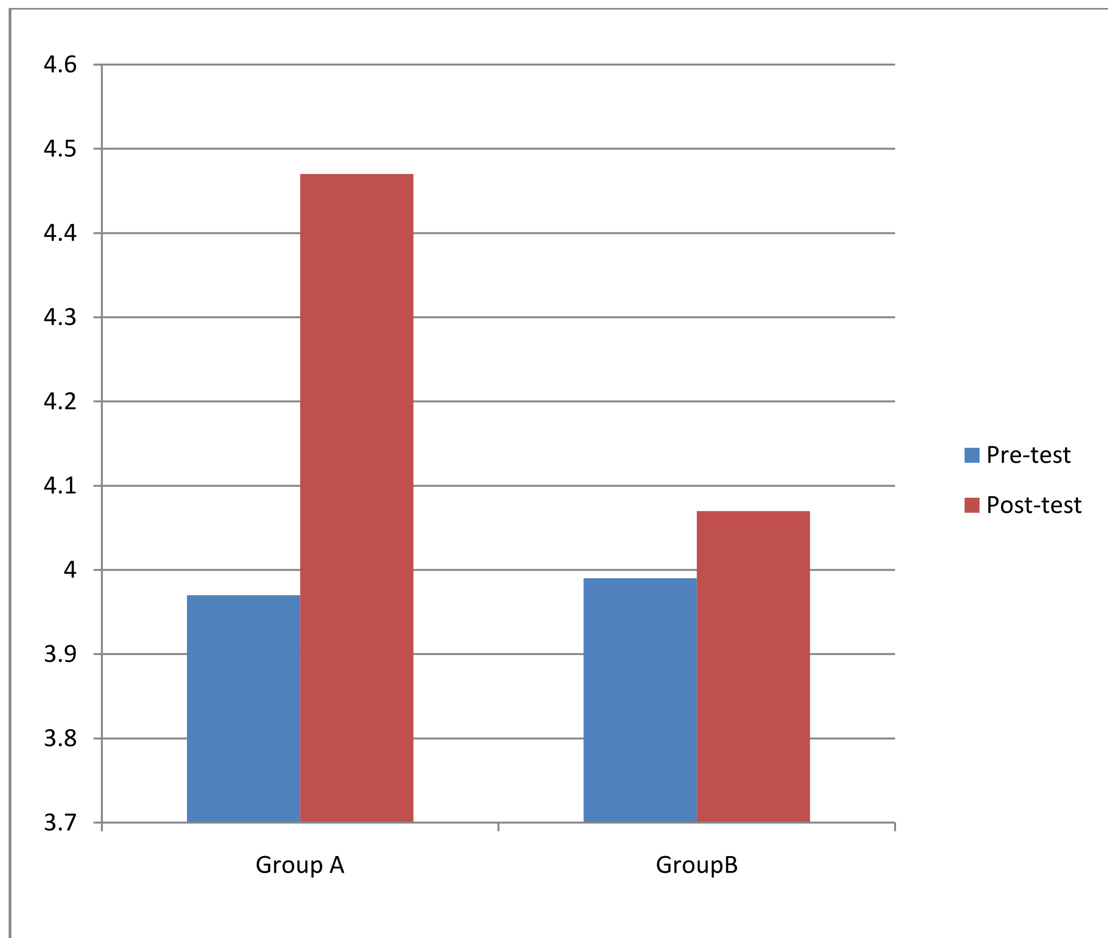

Figure 6: ***Graphical representation for opinions mean scores of group A and B***

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Supplementary Results

Perceived IPV knowladge

Below are the Kolmogorov-Smirnov and Shapiro-Wilk test of normality for perceive IPV knowledge. The table and graphs below illustrate the results of the test of normality.

Table 23

Tests of Normality for Perceived Knowledge

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Perceived knowledge pre-test	0.203	30	0.003	0.871	30	0.002
Perceived knowledge post-test	0.123	30	0.200*	0.953	30	0.201

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

- See the diagram for the expected and observed values in Appendix

Reliability Test

The Cronbach's alpha for the reliability test of 16 items on the Perceived IPV Knowledge scale was 0.96 for pre-test and 0.98 for post-test. The results indicate a high consistency and reliability of the scale. The assumption of Mauchly's test of sphericity and the equality of variance assumptions were met. A repeated measure ANOVA was then performed to compare the mean scores of the experimental group and the control groups after IPV education. The results for Perceived knowledge showed that the mean and standard deviation (*SD)* scores for the experimental group was 3.01 and 1.34 respectively before the IPV education and $M = 5.32$, $SD = 0.94$ after the IPV education. The participants in the control group had $M = 3.14$, $SD = 1.49$ for pre-test and $M = 3.33$, $SD = 1.55$ for post-test. The mean differences between the experimental group and the control group was statistically significant, $F(1, 28) = 50.98$, $p < 0.001$, partial $\eta^2 = 0.65$ and 1.00 for statistical power. The effect size was Cohen's $d = 1.49$ based on the post-test

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means and standard deviations. The mean scores of Group A and B are showed in the table and graph below.

Table 24

Descriptive Statistics for perceived knowledge

	Groups	Mean	Std. Deviation	N
Perceived Knowledge Pre-test	Group B	3.14	1.49	15
	Group A	3.01	1.34	15
	Total	3.07	1.39	30
Perceived Knowledge Post-test	Group B	3.33	1.55	15
	Group A	5.23	0.94	15
	Total	4.28	1.59	30

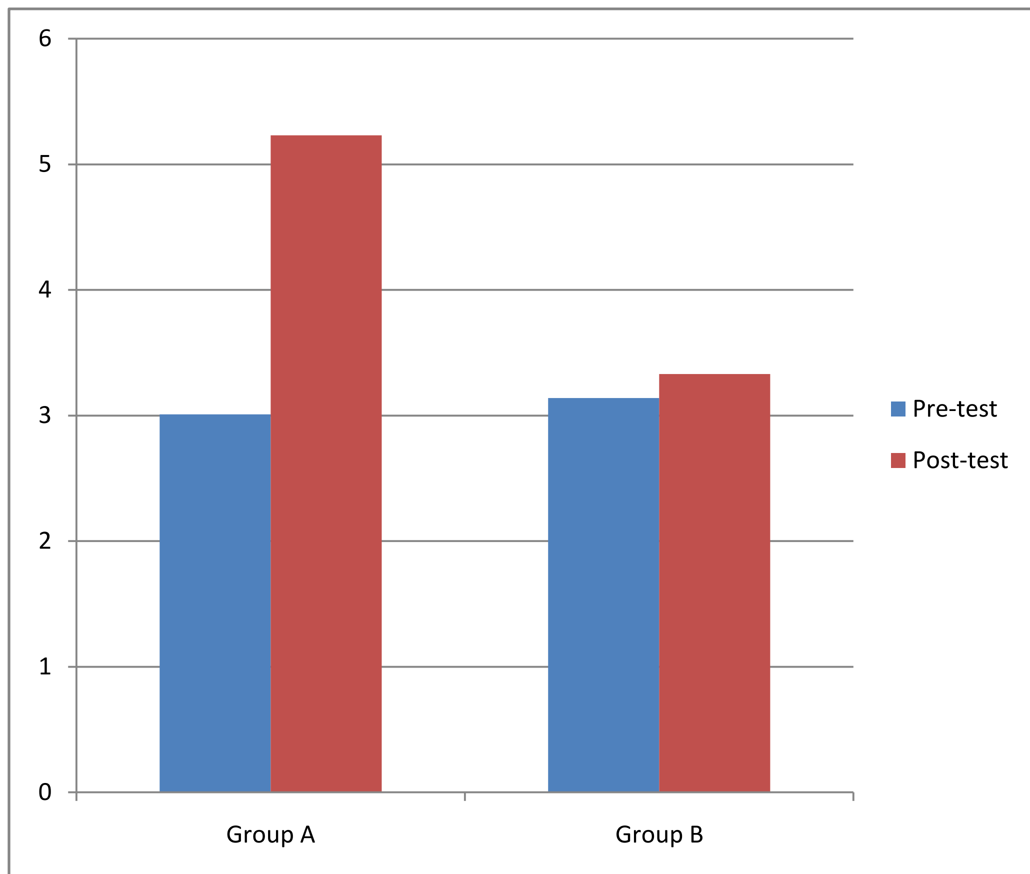

Figure 7: ***Graphical representation for Perceived knowledge mean scores of group A and B***

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Pearson Correlation

The Pearson correlation coefficient (*r*) was used to examine the strength of association among the variables of interest. The table below shows the results of the Pearson correlation among IPV knowledge, Perceived knowledge, perceived preparation and opinion. The strongest positive linear relationship existed between perceived knowledge and perceived preparation indicated by Pearson coefficient (*r*) = 0.96.

Table 25

Results of Pearson Correlation among variables of study

		IPV Knowledge post-test	Perceived Knowledge post-test	Perceived preparation Post-test	Opinion post-test
IPV Knowledge post-test	Pearson Correlation	1	0.75**	0.76**	0.63**
	Sig. (2-tailed)		0.00	0.00	0.00
	N	30	30	30	30
Perceived Knowledge post-test	Pearson Correlation	0.75**	1	0.96**	0.67**
	Sig. (2-tailed)	0.00		0.00	0.00
	N	30	30	30	30
Perceived preparation Post-test	Pearson Correlation	0.76**	0.96**	1	0.67**
	Sig. (2-tailed)	0.00	0.00		0.00
	N	30	30	30	30
Opinion post-test	Pearson Correlation	0.63**	0.67**	0.67**	1
	Sig. (2-tailed)	0.00	0.00	0.00	
	N	30	30	30	30

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

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CHAPTER 5 DISCUSSION

Introduction

Violence in an intimate relationship comes in different forms and can be complicated with serious effects on individual lives including children. The cost of intimate partner violence (IPV) on the economy is well documented in literature. IPV can result in psychological abuse, sexual assault, physical injuries, isolation, deprivation, intimidation and threats (Norris, 2014; Bair-Merritt, 2010). The differences in the type of IPV victimization were found to be the same regardless of gender (Makadon, 2011). As stated earlier, Nearly 1 in 4 women and 1 in 13 men experience intimate partner violence (IPV) at some time in their life (Black, 2011).

Addressing IPV is part of the nature of the counseling profession. Counselors are most likely to encounter victims, survivors and perpetrators of IPV at some point in their career. A recent study by Nyame et al. (2013) reported that mental health professionals experience difficulties in assessing and managing interpersonal violence and lack adequate knowledge of support service for victims and survivors. The lack of knowledge and expertise about how to address IPV can prevent Counselors from screening and responding to victims and survivors, (Rose et al., 2011). In light of this, the purpose of this study was to explore counseling students' opinions, knowledge and their perceived preparedness to counsel IPV clients.

Characteristics of research participants

The research participants were recruited from a Counselor Education master's program at a Midwestern Urban University. Forty participants were initially recruited for this research, however, ten participants were eliminated from the study due to incomplete participation in the research process. The statistical analyses were computed with responses from thirty participants. Fifteen participants were assigned to the experimental group and fifteen to the control group.

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The participants of this study were 28 females and 2 males. This result is consisted with the 2014 Bureau of Labor Statistics which reported that 524 of 737 employed counselors in 2014 were women. The age of participants ranged from 24 to 57 with 33.32 as the mean age. The age ranged revealed the diverse nature of the respondents.

Fifty percent (15) identified themselves as White/Caucasians, 40% (12) of the respondents identified themselves as Black or African Americans, 3.3% (1) identified as Asian American and 6.7% (2) identified themselves as Hispanic/Latino. Twenty-one respondents majored in community counseling, two people majored in school counseling and seven people majored in community and Art therapy combined. All thirty participants reported that they do not hold any counseling professional licensure.

Participants were asked to report their previous IPV or DV training hours as part of the pre-test and post-test batteries. Sixteen participants (53.3%) indicated that they had no previous IPV/DV training for pre-test. This was reduced to 9 (30%) participants for post-test, indicating a 23.3% reduction among participants who reported no previous IPV/DV training. The Cohen's *d* was 0.74 indicating a large effect size of the IPV education.

Hypothesis 1. Hypothesis 1 was derived from the research question "Is there significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education". The null hypothesis was "There is no significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education" while the alternate hypothesis was "There is significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education".

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Hypothesis 1 was tested with a pretest-posttest one treatment group design as elaborated in previous sections. The results indicated that there was a significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education as demonstrated. The mean difference between the experimental group and the control group was statistically significant, $F(1, 28) = 25.60$, $p < 0.001$, $\eta^2 = 0.48$. The Cohen's d was 1.30, suggesting that the IPV education had a large effect on the perceived preparedness of students in the experimental group. The power of this analysis was 0.99 indicating the probability that the test accurately rejected the null hypothesis when the null hypothesis is false was high. The null hypothesis was then rejected while the alternate hypothesis was retained base on the results of the study.

Demonstrating competency in counseling IPV clients cannot be over emphasized. Counselors frequently counsel IPV clients and as such, their ability to facilitate clients' safety and accurately assess the potential for further violence is crucial (Kress et al., 2008). However, the study by Nyame et al. (2013) revealed that mental health professionals face difficulties in assessing and managing partner violence. Previous studies in literature illustrates that counselors' competency is positively influenced by the level of their academic preparation (Kolb, 2011; Nyame et al, 2013; Bozorg-Omid, 2007). The results of a repeated ANOVA suggest that participants in the experimental group increased their perceived preparedness after the IPV education. In other words, students in the experimental group felt more prepared to counsel IPV clients after the IPV education than those in the control group. The result of this study support previous findings that the more informed counselors are regarding IPV, the more competent they will be in counseling IPV clients (Kolb, 2011).

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Hypothesis 2: Hypothesis 2 was derived from the research question "Is there significant difference in the median scores of students' IPV knowledge between the experimental group and the control group after IPV education? The null hypothesis was "There is no significant difference in the mean scores of students' IPV knowledge between the experimental group and the control group after IPV education", and the alternate hypothesis was "There is significant difference in the mean scores of students' IPV knowledge between the experimental group and the control group after IPV education".

The hypothesis was tested with a pretest–posttest one treatment group design as elaborated in previous sections. The results indicated that there was a significant difference in the ranked mean scores of students' IPV knowledge between the experimental group and the control group after IPV education. The difference between the ranked mean for the pre-test was not statistically significant; χ^2 (1, n = 30) = 0.92, p = 0.34, whereas the difference between the ranked mean for the post-test was statistically significant; χ^2 (1, n = 30) = 10.51, p = 0.001. The Mann-Whitney U hypothesis test summary was performed to support the results of the Kruskal-Wallis test above. The Mann-Whitney U was 89.50, and p = 0.35, indicating no significant differences in the mean scores between the two groups before IPV education. The post-test U = 34.50 and p = 0.001, indicating a significant difference between the groups after IPV education. The Cohen's *d* was 0.42 based on the Mann-Whitney mean and standard deviation scores. The result of the Cohen's *d* suggested that there was a moderate effect of the IPV education on participants' IPV knowledge.

Counselors are professionally required to provide their clients with the best possible care. These includes linking clients to appropriate resources, assisting clients to make important decisions regarding managing abusive relationships and using appropriate counseling techniques

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and strategies specific to IPV clients. The level of the counselor's IPV knowledge is vital in accomplishing these responsibilities. The research study conducted by (Rose et al., 2011) revealed that the lack of resources and knowledge about support services can inhibit effective pathways of care for IPV clients. In another study by Kolb (2011), counselors working with domestic violence victims and survivors reported that their training and practical knowledge equipped them in make decisions regarding the safety and emotional well being of their clients. In light of this, mental health professionals should be educated and trained on how to appropriately identify and support IPV clients (Nyeme et al., 2013). There is a consensus in literature with regards to how education or academic preparation improves practitioners' knowledge and the effects it has on counseling IPV clients (Kolb, 2011; Trevillion et al., 2012a; Nyame et al., 2013, Bozorg-Omid, 2007). The finding of the present study suggest that IPV education significantly improves counselors' knowledge and understanding of working with IPV clients, thus putting them in a better position to effectively counsel and support them. This assertion is congruent with findings in literature and support the ideology that, educating counselors and mental health workers would facilitate appropriate care and support for IPV clients as a result of an increase in IPV knowledge.

Hypothesis 3. Hypothesis 3 was also tested with a pretest-posttest one treatment group design as explained in previous sections. The results indicated that there was a significant difference in the mean scores of students' opinion between the experimental group and the control group after IPV education. The mean differences between the experimental group and the control group was statistically significant; $F(1, 28) = 9.80$, $p = 0.004$, $\eta^2 = 0.26$. The Cohen's d was 0.70, suggesting that the IPV education had a large effect on the opinions of students in the experimental group. The power of this analysis was 0.86 indicating the probability that the test

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accurately rejected the null hypothesis when the null hypothesis is false was high. The null hypothesis was rejected while the alternate hypothesis was retained based on the results of the study.

IPV and domestic violence education has been demonstrated in literature as a strong factor influencing the opinions of counselors and mental health professionals (Postmus et al., 2011; Bozorg-Omid, 2007; Black, Weisz, & Bennett, 2010). Counselors and mental health professionals who are more informed have a positive opinion and attitude regarding working with clients (Kolb, 2011; Nyame et al., 2013). A study by Postmus et al., (2011) reported that education or training decreased students' blaming attitudes and beliefs supportive of myths, and increased their screening behavior among survivors of violence. Education was also found to be positively associated with professional competency. A positive opinion is crucial in working with IPV clients because the decisions clients make and the decisions counselors make on behalf of clients can be a "matter of live or death" (Kolb, 2011). The results of the present study imply that the counseling students' in the experimental group improved their opinions regarding IPV clients after the IPV education. This result is consisted with previous findings (Black, Weisz, & Bennett, 2010; Postmus et al., 2011). Whiles the improvement of students' opinion in this study does not suggest an increase in the level of their professional skills, a positive opinion on IPV may facilitate competency and overall professional skills.

Supplementary results

Perceived IPV Knowledge was also tested with a pretest-posttest one treatment group design.The repeated measures ANOVA for Perceived IPV Knowledge showed that there was a significant difference in the mean scores between the experimental group and the control group. The mean differences between the experimental group and the control group was statistically

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significant; F (1, 28) = 50.98, $p < 0.001$, $\eta^2 = 0.65$. The power of this analysis was 1.00. The result implys that participants' in the experimental group improved with regards to how they feel about counseling IPV clients than those in the control group. An improvement in how students feel about working with IPV clients is crucial in facilitating a successful treatment process.

There was a strong positive linear correlation among the variables of interest; perceived preparedness, IPV knowledge, opinions and perceived knowledge as illustrated in the Pearson correlation table in previous sections. The strength of the correlation ranged from 0.63 to 0.96. The strongest correlation existed between perceived knowledge and perceived preparation; r = 0.96. This relationship imply that the more students thought of themselves as being knowledgeable regarding counseling IPV clients, the more prepared they viewed themselves to be. It is interesting but not surprising to realize that IPV education influenced the strong positive correlation among the variables of interest in this study.

Limitation of the study

The initial estimated sample size for this research was twenty-six (26); n = 13 for each group. Thirty (30) participants were used for this study indicating that the sample size was met. However, larger sample size is recommended for future studies in order to draw a more conclusive inference of the study. In addition, the gender composition of the sample for this study was skewed towards female participants. There were 28 females out of 30 participants. This composition may not be a representation for all counselor education programs, thus the findings of this study is limited to similar demographics. The PREMIS as stated earlier, is a self-reporting instrument that may create a "social desirability" threat. This means that there is the tendency of participants to answer the questions on the scales in a manner that seems to be favorable.

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Suggestions for Future Research

Despite the limitations of this study, the results demonstrate interesting opportunities for future studies regarding intimate partner violence. There is tons of literature on domestic violence, however, there is limited current and specific IPV studies in the Counselor Education field. As stated earlier, it is no longer considered scientifically or ethically acceptable to generalized IPV without specifying the type of abuse. Differentiating among the types of IPV will facilitate accurate description of partner violence and the development of appropriate screening instruments and interventions (Kelly & Johnson, 2008).

Though the sample composition (28 females out of 30 participants) is consistent with the counselor education program, the use of a larger sample size with the possibility of an even gender composition from several Universities is recommended for future studies. This would cater for any biases resulting from a skewed sample size. Research sample from a non-randomized sampling may not be a representative of the entire population. It is therefore recommended that both random sampling and random assignment should be used in the future to eliminate any systematic biases. It is also recommended that the IPV education or training should be done in an interactive manner in order to promote full participation, understanding of the educational materials and to decrease incomplete participation.

Conclusion

The consequences of IPV are well documented in literature. The increasing number of IPV incidence means that counselors will inevitably encounter IPV victims and survivors in their work. Providing an effective and supportive counseling service to IPV clients is a critical component of the counseling profession. It is crucial for counselors working with IPV clients to be knowledgeable, prepared and competent to facilitate recovery and prevent re-victimization.

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However, the literature shows that mental health professionals does not routinely asked all clients about IPV, experience difficulties in addressing IPV, and lack the knowledge of supportive services for IPV clients. The lack of knowledge of support services and incompetency will inhibit effective counseling services to IPV clients. On this basis, the present research was designed to explore counseling students' opinions, knowledge and their perceived level of preparedness to counsel IPV clients. The results showed that the opinions, knowledge, and the perceived preparedness of students in the experimental group improved significantly in contrast to students in the control group. In addition, the opinion of students, their knowledge and their perceived level of preparedness were highly correlated. The results of this study demonstrate the need to deliberately prepare counseling students and mental health professionals in order to effectively counsel IPV clients. While this study undoubtedly, provides valuable information and serves as the basis for future research, large sample size is recommended. In addition, dynamic training or educational methods should be used as well as random sampling and selection.

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APPENDIX A: NORMALITY PLOTS

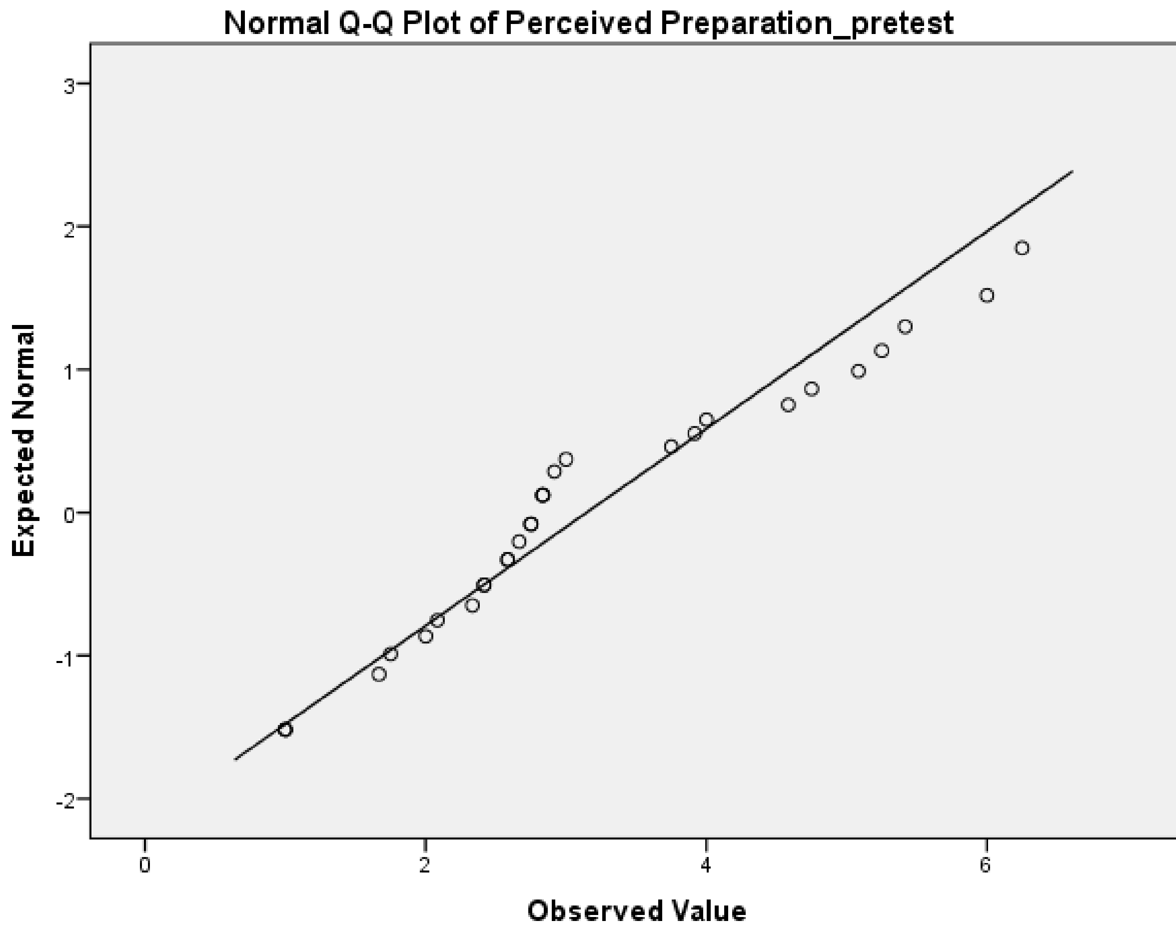

Figure 8 : ***Expected and Observed Value for Perceived Preparation pre-test***

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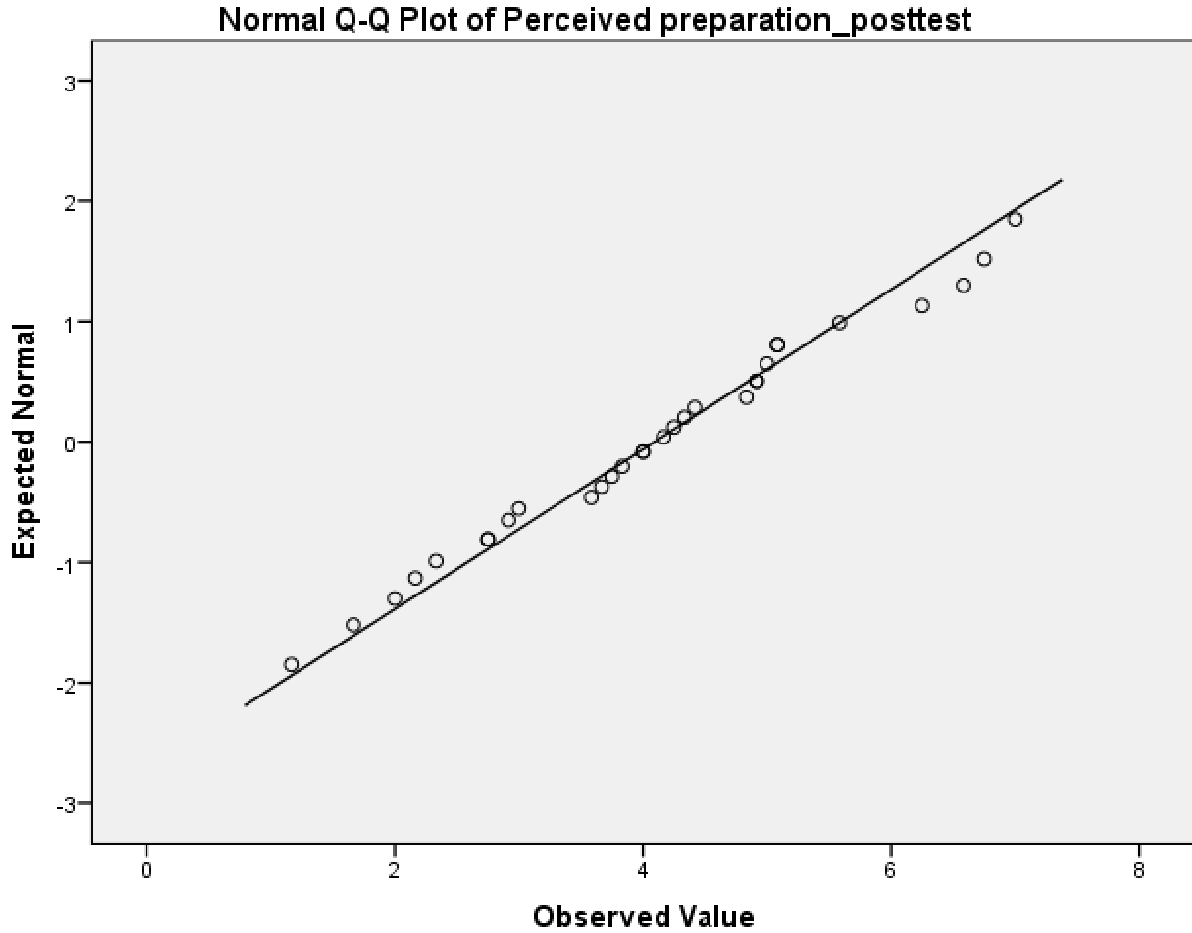

Figure 9: ***Expected and Observed Value for Perceived Preparedness post-test***

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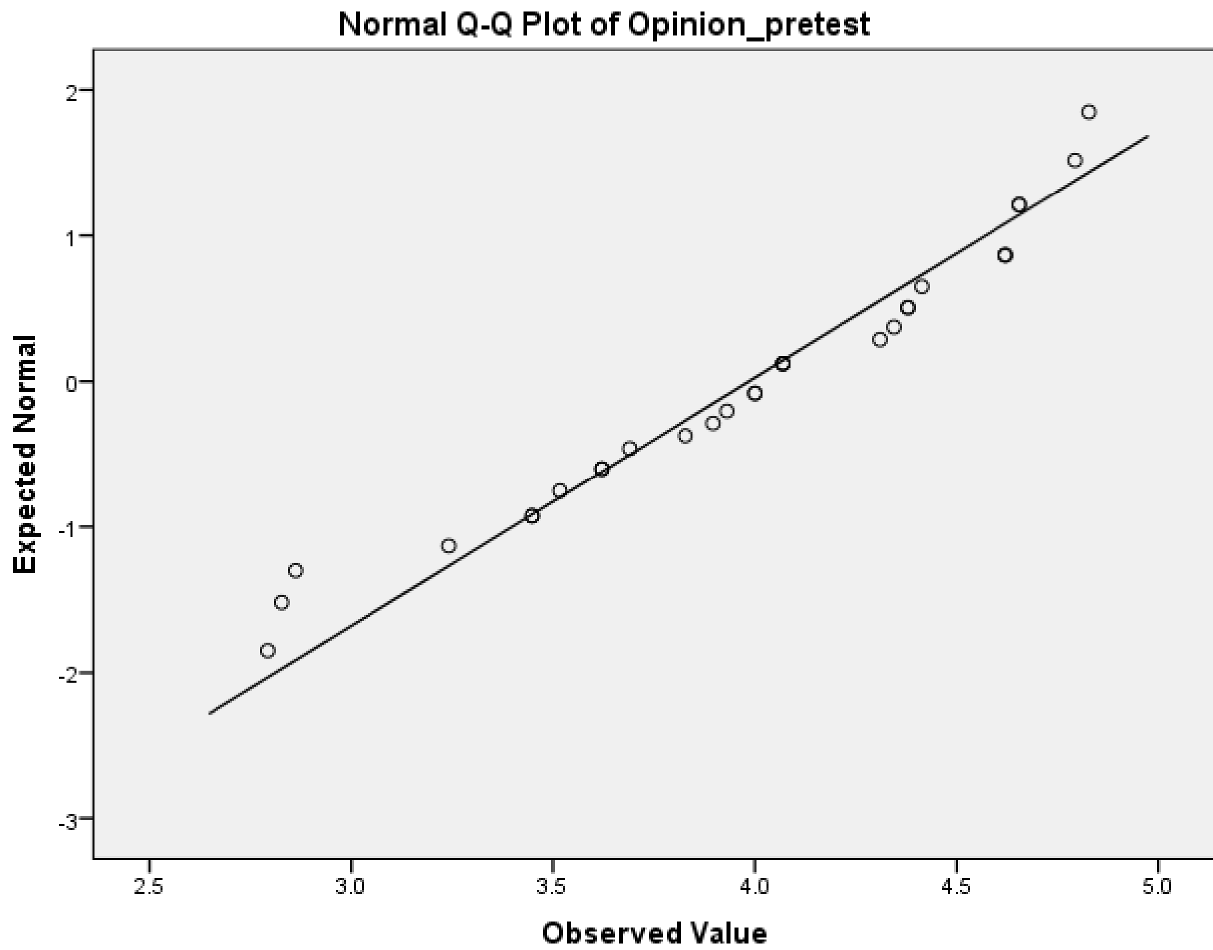

Figure 10: ***Expected and Observed Value for Opinions pre-test***

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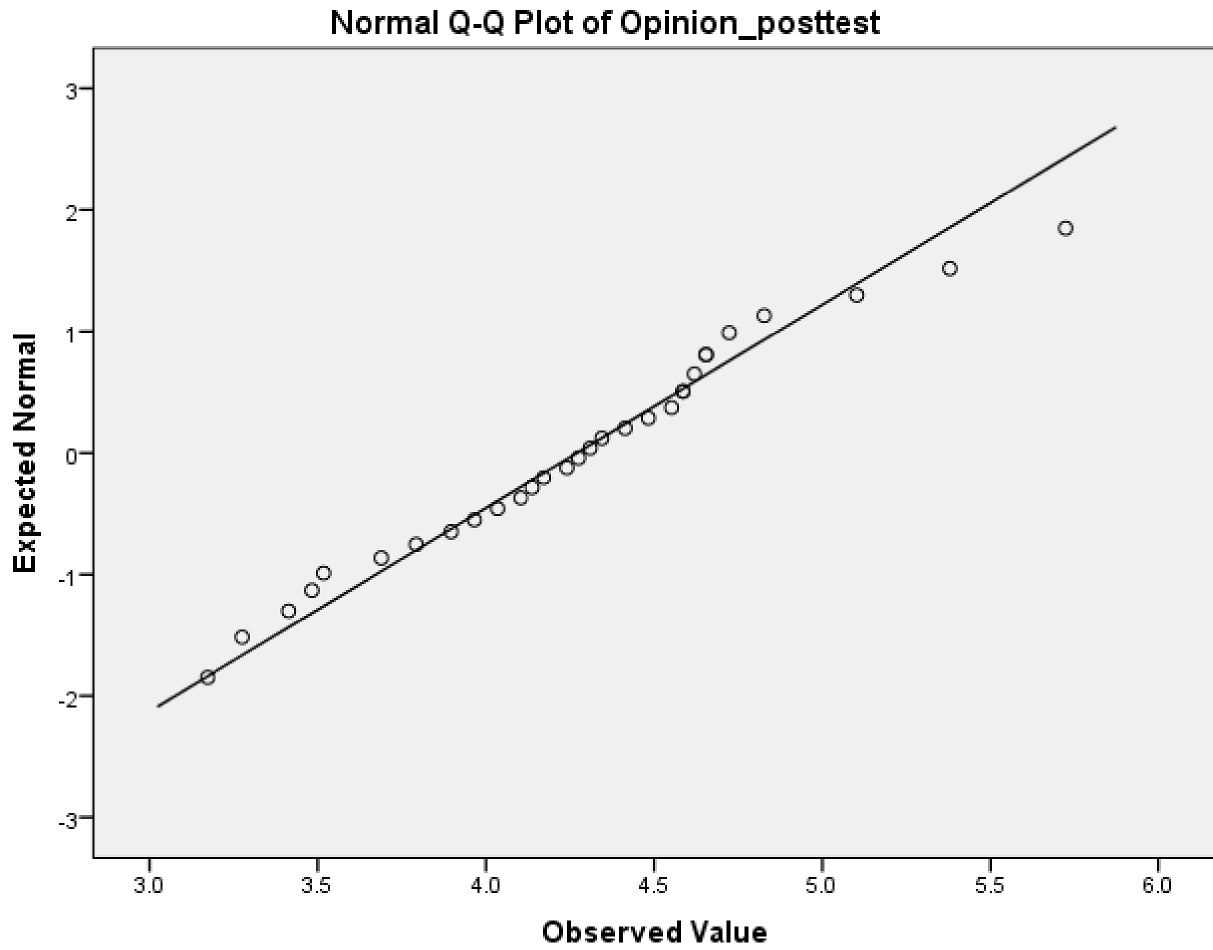

Figure 11: ***Expected and Observed Value for Opinions post-test***

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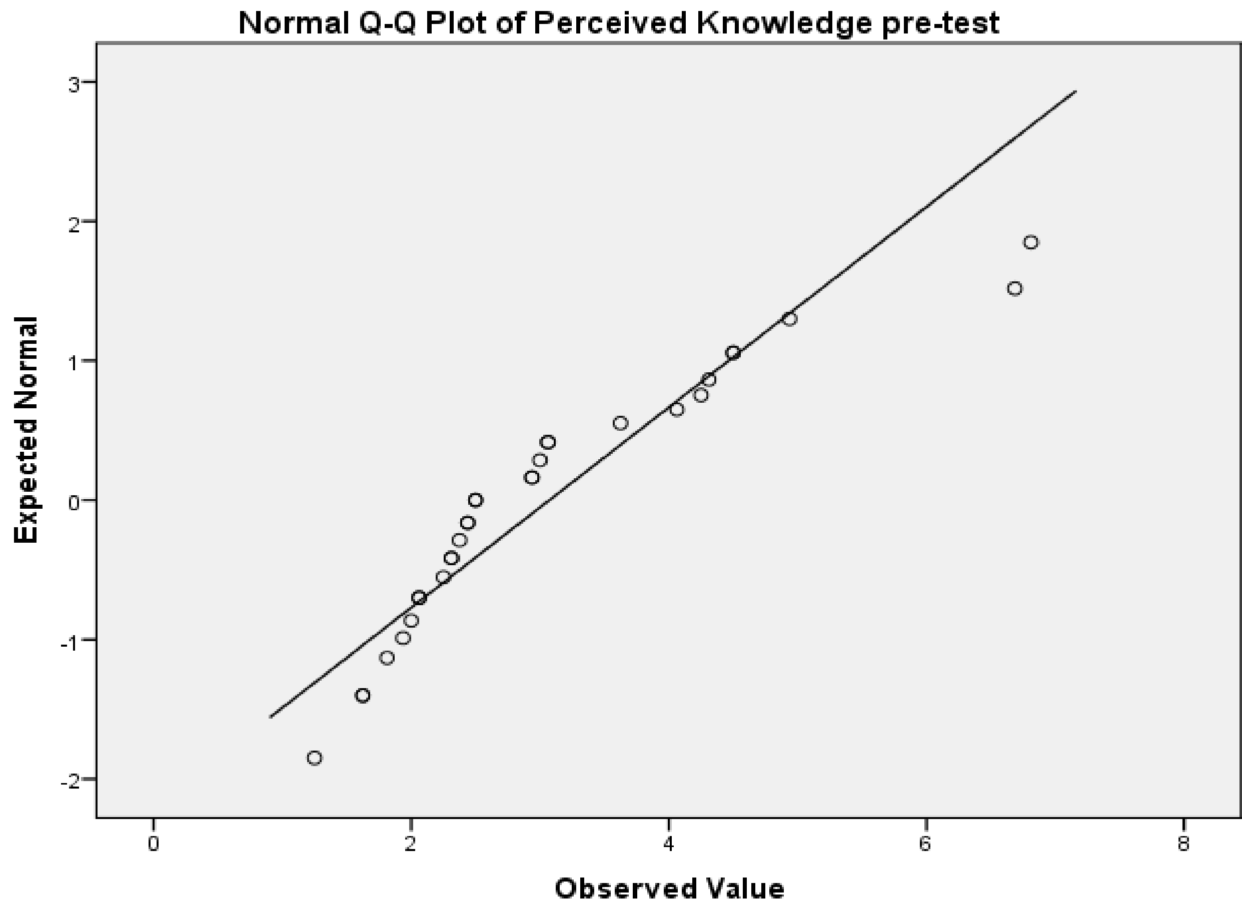

Figure 12: ***Expected and Observed Value for perceived knowledge pre-test***

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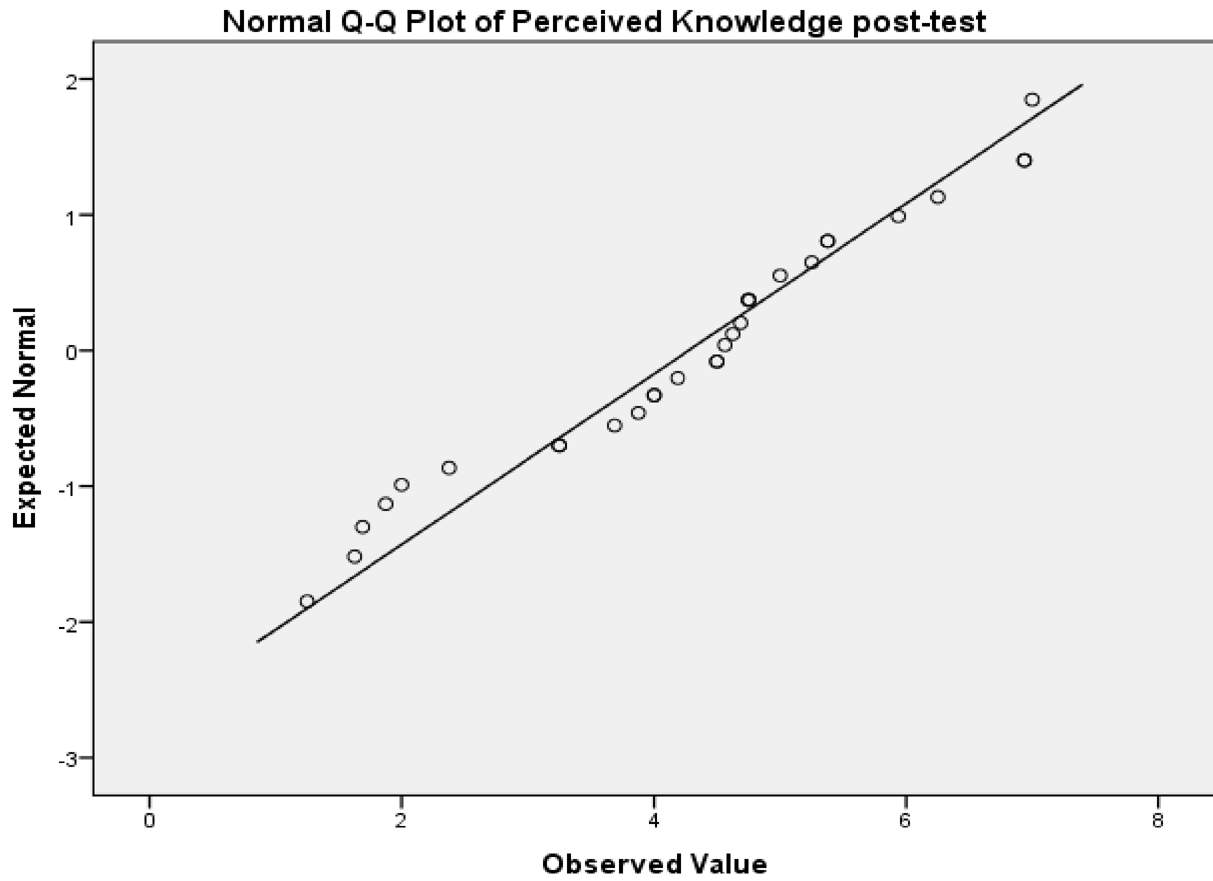

Figure 13: ***Expected and Observed Value for perceived knowledge post-test***

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APPENDIX B: CONSENT AND PERMISSION FORMS

WAYNE STATE UNIVERSITY

IRB Administration Office
87 East Canfield, Second Floor
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
http://irb.wayne.edu

CONCURRENCE OF EXEMPTION

To: Alvis Ayaba-Apawu
Theoretical & Behavior Foundations

From: Dr. Deborah Ellis C. Zolondek/BB.
for Chairperson, Behavioral Institutional Review Board (B3)

Date: March 20, 2015

RE: IRB #: 032815B3X

Protocol Title: Intimate Partner Violence (IPV) Counselor Education: Exploring Opinions and Perceived Level of Preparedness to Counsel IPV Clients

Sponsor:

Protocol #: 1503013836

The above-referenced protocol has been reviewed and found to qualify for **Exemption** according to paragraph #2 of the Department of Health and Human Services Code of Federal Regulations [45 CFR 46.101(b)].

- Social/Behavioral/Education Exempt Protocol Summary Form (received in the IRB Office 3/5/2015)
- Protocol (received in the IRB Office 3/5/2015)
- Research Information Sheet (dated 3/5/2015)
- IPV Education/Training Materials: Session One, Session Two, and Session Three
- Data Collection Tools: Respondent Profile, Physician Readiness to Manage Intimate Partner Violence, IPV Knowledge, and Opinions

This proposal has not been evaluated for scientific merit, except to weigh the risk to the human subjects in relation to the potential benefits.

° Exempt protocols do not require annual review by the IRB.

° All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.

° Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (http://irb.wayne.edu/policies-human-research.php).

NOTE: Forms should be downloaded from the IRB Administration Office website http://irb.wayne.edu at each use.

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Exploring opinions and perceived level of preparedness to counsel IPV clients

Research Information Sheet

Title of Study: Intimate Partner Violence (IPV) Counselor Education: Exploring opinions, knowledge and perceived level of preparedness to counsel IPV clients.

Principal Investigator (PI): Alvis Ayaba-Apawu, M. A, LPC, Doctoral candidate
Theoretical and Behavioral Foundations,
College of Education
313-577-1613

Purpose

You are being asked to be in a research study of exploring opinions and perceived level of preparedness to counsel IPV clients because you are enrolled in the counselor education program and taking CED 7040 (Techniques of Counseling), CED 7150 (Counseling Practicum), or CED 7020 (Counseling Internship). This study is being conducted at Wayne State University. The estimated number of study participants to be enrolled at Wayne State University is about 30 students. **Please read this form and ask any questions you may have before agreeing to be in the study.**

In this research study, the opinions and the perceived level of preparedness of participants to counsel IPV clients will be explored.

Study Procedures

If you agree to take part in this research study, you will be asked to;

1. Fill out questionnaires at the beginning of the study and at the end of the study. The questionnaire takes approximately 30 minute to complete. The questionnaire consists of a profile section, and the PREMIS tool. The PREMIS tool consists of the background scale, IPV knowledge scale and the opinions scale. The questionnaire ask for your program of study, general questions regarding your program of study, questions about how much you feel you are prepared to counsel IPV clients and your opinions and knowledge regarding IPV.

2. Take IPV education for three weeks through Blackboard if you are randomly selected as part of the experimental group. The IPV education is in power point format and will be available to you weekly for three weeks. It will take approximately 30 minutes to complete the IPV education for each week.

Benefits

As a participant in this research study, there may be no direct benefit for you. The possible benefits to you for taking part in this research study are the intrinsic benefits including being informed about IPV, learning how to counsel IPV clients, and having awareness of available resources in Detroit to refer IPV clients. In addition, the findings of the study will benefit other counseling students in the future as well as the counselor education program as a whole.

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Risks
There are no known risks at this time to participation in this study. However, in the event of needing counseling or psychological services for feeling sad or anxious as a result of reflecting on IPV questions and related issues, you can contact the Counseling and Psychological Services (CAPS) at 313-577-3398 and after hours at 313-577-9982. CAPS is located at Gullen Mall, room 552, student center building, Wayne State University, Detroit Michigan, 48202.

Study Costs
Participation in this study will be of no cost to you.

Compensation
You will not be paid for taking part in this study.

Confidentiality
You will be identified in the research records by a code name or number. There will be no list that links your identity with this code.

Voluntary Participation/Withdrawal
Taking part in this study is voluntary. You have the right to choose not to take part in this study. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to receive.

Questions
If you have any questions about this study now or in the future, you may contact Alvis Ayaba-Apawu or one of her research team members at the following phone number 313-577-1760. If you have questions or concerns about your rights as a research participant, the Chair of the Institutional Review Board can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Participation
By completing the questionnaires you are agreeing to participate in this study.

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PERMISSION LETTER FOR THE PREMIS INSTRUMENT

-----Original Message-----
From: Alvis Talata Ayaba-Apawu [mailto:em6356@wayne.edu]
Sent: Tuesday, January 28, 2014 1:37 PM
To: John M. Harris
Subject: permission to use PREMIS instrument

Hello Dr. Harris,

I am a PhD student in the Counselor Education and Supervision program in Wayne state University, Michigan. I am currently working on my dissertation with the interest of accessing the perspectives of counseling students on intimate partner violence (IPV). I intend to do a pre-test and a post-test after conducting IPV in-class training to possibly increase their knowledge on IPV.

While doing literature review, I came across the instrument that you and your colleagues developed; Provider readiness to manage intimate partner violence. I believe this instrument will be very helpful for my study. Can I kindly use your instrument for my dissertation?

Sincerely,
Alvis Ayaba-Apawu.

----- Original Message -----
From: "Skip Harris" <jharrisjrmd@outlook.com>
To: "Alvis Talata Ayaba-Apawu" <em6356@wayne.edu>
Cc: "Lynn Short, PhD" <LMShort@comcast.net>
Sent: Thursday, January 30, 2014 10:43:43 AM
Subject: RE: permission to use instrument

Dear Alvis,

You are free to use the PREMIS tool for your work. If you have a chance, please let us know how it goes.
I've attached a current version and some additional information.

Best of luck,
John M. Harris Jr., MD, MBA

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PERMISSION LETTER FOR THE DULUTH POWER AND CONTROL WHEELS

-----Original Message-----
From: Alvis Talata Ayaba-Apawu [em6356@wayne.edu]
Sent: Thursday, February 06, 2014 10:43 PM
To: Karin Sollom
Subject: Permission to use wheels

Hello Karin Sollom,

I am a PhD. counseling student in Wayne State University in Detroit, MI. I am currently writing my dissertation on the topic; Intimate Partner Violence (IPV) Counselor Education: Exploring opinions, knowledge and perceived preparedness to counsel IPV clients. The power and control wheel as well as the equality wheel will be so helpful in my study in explaining IPV and I am kindly asking for your permission to these diagrams.
Thank you,
Alvis Ayaba-Apawu.

-----Original Message-----
From:Karin Sollom <ksollom@theduluthmodel.org>
Sent:Fri 2/7/2014 10:30 AM
To: Alvis Talata Ayaba-Apawu;
Re: Permission to use wheels

Dear Alvis,

Thank you for your request. You have permission to use the Power and Control Wheel and Equality Wheel in your dissertation. Please do credit each use of the wheels to the Duluth Domestic Abuse Intervention Project, as indicated below.

The Power and Control Wheel was developed in Duluth by battered women who were attending education groups sponsored by the local women's shelter. The wheel is used in our Creating a Process of Change for Men Who Batter curriculum, and in groups of women who are battered, to name and inspire dialogue about tactics of abuse. While we recognize that there are women who use violence against men, and that there are men and women in same-sex relationships who use violence, this wheel is meant specifically to illustrate men's abusive behaviors toward women. The Equality Wheel was developed for use with the same groups.
Please let us know if you have questions about other DAIP training materials or programming.

Sincerely,
Karin Sollom

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APPENDIX C: INSTRUMENTS

Respondent Profile

Respondent code:...............

Please take a moment to answer these demographic questions. These answers *will not be used to identify / track any individual*, but will be used in a collective manner for data analysis.

1. Gender: Female................ Male...................... Other......................

2. Age: ....

3. Highest educational degree: ....

4. Please put a check/ mark one of the following Race/Ethnicity that applies to you:

Black/African-American..................... Asian-American.........................

White/Caucasian................................ Hispanic/Latino.......................

Native American................................

Other: (please indicate)...

5. Please indicate your major field of study

....

6. Are you currently working: Full-time........... Part-time............. Currently not working............

7. Please indicate your job settings? (Choose all that apply)

Community Agency...................... College Counseling Center...........................

Private Practice............................ Hospice/in-patient.............................

School.. Out-patient.............................

Other (specify)...

8. Do you hold any professional Counseling Licensure? Yes.................. No.................

9. If "Yes" please indicate (...)

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THE MODIFIED PREMIS INSTRUMENT

PHYSICIAN READINESS TO MANAGE INTIMATE PARTNER VIOLENCE

Background

1. Estimated total number of hours of previous IPV/DV training: ______

2. Please circle the number which best describes how prepared you feel to perform the following:
(1 = Not prepared; 2 = Minimally; 3 = Slightly; 4 = Moderately; 5 = Fairly well; 6 = Well; 7 = Quite well prepared)

	Not Prepared						Quite well Prepared
a. Ask appropriate questions about IPV	1	2	3	4	5	6	7
b. Appropriately respond to disclosures of abuse	1	2	3	4	5	6	7
c. Identify IPV indicators based on client's history	1	2	3	4	5	6	7
d. Assess an IPV victim's readiness to change	1	2	3	4	5	6	7
e. Help an IPV victim assess his/her danger of lethality	1	2	3	4	5	6	7
f. Conduct a safety assessment for the victim's children	1	2	3	4	5	6	7
g. Help an IPV victim create a safety plan	1	2	3	4	5	6	7
h. Document IPV history and findings in client's chart	1	2	3	4	5	6	7
i. Make appropriate referrals for IPV	1	2	3	4	5	6	7
j. Fulfill state reporting requirements for:							
-IPV	1	2	3	4	5	6	7
-Child abuse	1	2	3	4	5	6	7
-Elder abuse	1	2	3	4	5	6	7

3. How much do you feel you now know about:
(1 = Nothing; 2 = Very Little; 3 = A little; 4 = A moderate amount; 5 = A fair amount; 6 = Quite a bit; 7 = Very Much)

	Nothing						*very* much
a. Your legal reporting requirements for:							
- IPV	1	2	3	4	5	6	7
- Child abuse	1	2	3	4	5	6	7
- Elder abuse	1	2	3	4	5	6	7
b. Signs or symptoms of IPV	1	2	3	4	5	6	7
c. How to document IPV in client's chart	1	2	3	4	5	6	7
d. Referral sources for IPV victims	1	2	3	4	5	6	7
e. Perpetrators of IPV	1	2	3	4	5	6	7
f. Relationship between IPV and pregnancy	1	2	3	4	5	6	7
g. Recognizing the childhood effects of witnessing IPV	1	2	3	4	5	6	7
h. What questions to ask to identify IPV	1	2	3	4	5	6	7
i. Why a victim might not disclose IPV	1	2	3	4	5	6	7
j. Your role in detecting IPV	1	2	3	4	5	6	7
k. What to say and not say in IPV situations with a client	1	2	3	4	5	6	7
l. Determining danger for a client experiencing IPV	1	2	3	4	5	6	7
m. Developing a safety plan with an IPV victim	1	2	3	4	5	6	7
n. The stages an IPV victim experiences in understanding and changing his/her situation	1	2	3	4	5	6	7

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Pg.2 This survey has been adapted from the PREMIS tool published by Short et al., (2006).

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1 = Precontemplation 2 = Contemplation 3 = Preparation
4 = Action 5 = Maintenance 6 = Termination

[ ] Begins making plans for leaving the abusive partner
[ ] Denies there's a problem
[ ] Begins thinking the abuse is not their own fault
[ ] Continues changing behaviors
[ ] Obtains order(s) for protection

8. Circle **T** for "true", **F** for "false", or **DK** if you "don't know" the answer to the following:

a. Alcohol consumption is the greatest single predictor of the likelihood of IPV. T F DK
b. There are good reasons for not leaving an abusive relationship. T F DK
c. Reasons for concern about IPV should not be included in a client's chart if s/he does not disclose the violence. T F DK
d. When asking clients about IPV, counselors should use the words "abused" or "battered." T F DK
e. Being supportive of a client's choice to remain in a violent relationship would condone the abuse. T F DK
f. Victims of IPV are able to make appropriate choices about how to handle their situation. T F DK
g. Health care providers should not pressure clients to acknowledge that they are living in an abusive relationship. T F DK
h. Victims of IPV are at greater risk of injury when they leave the relationship. T F DK
i. Strangulation injuries are rare in cases of IPV. T F DK
j. Allowing partners or friends to be present during a client's history and intake assessment ensures safety for an IPV victim. T F DK
k. Even if a child is not in immediate danger, counselors in all states are mandated to report an instance of a child witnessing IPV to Child Protective Services. T F DK

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Opinions

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Statements	*Strongly Disagree*	*Disagree*			*Agree*	*Strongly Agree*	
1. If an IPV victim does not acknowledge the abuse, there is very little that I can do to help.	1	2	3	4	5	6	7
2. I ask all new clients about abuse in their relationships.	1	2	3	4	5	6	7
3. My workplace/environment encourages me to respond to IPV.	1	2	3	4	5	6	7
4. I can make appropriate referrals to services within the Community for IPV victims.	1	2	3	4	5	6	7
5. I am capable of identifying IPV without asking my clients about it.	1	2	3	4	5	6	7
6. I do not have sufficient training to assist individuals in addressing situations of IPV.	1	2	3	4	5	6	7

 This survey has been adapted from the PREMIS tool published by Short et al., (2006).

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Statements	Strongly Disagree	Disagree			Agree		Strongly Agree
7. Clients who abuse alcohol or other drugs are likely to have a history of IPV.	1	2	3	4	5	6	7
8. I feel comfortable discussing IPV with my clients.	1	2	3	4	5	6	7
9. I don't have the necessary skills to discuss abuse with an IPV victim who is:							
a) Female.	1	2	3	4	5	6	7
b) Male.	1	2	3	4	5	6	7
c) From a different cultural/ethnic background.	1	2	3	4	5	6	7
10. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for the violence.	1	2	3	4	5	6	7
11. I am aware of legal requirements in this state regarding reporting of suspected cases of:							
a) IPV.	1	2	3	4	5	6	7
b) Child abuse.	1	2	3	4	5	6	7
c) Elder abuse.	1	2	3	4	5	6	7
12. I am able to gather the necessary information to identify IPV as the underlying cause of client's illnesses (e.g., depression, anxiety).	1	2	3	4	5	6	7
13. If a client refuses to discuss the abuse, counselors can only counsel clients regarding other symptoms.	1	2	3	4	5	6	7
14. Victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
15. Health care providers have a responsibility to ask all clients about IPV.	1	2	3	4	5	6	7
16. My work place/environment allows me adequate time to respond to victims of IPV.	1	2	3	4	5	6	7
17. I have contacts of services within the community to establish referrals for IPV victims.	1	2	3	4	5	6	7
18. Alcohol abuse is a leading cause of IPV.	1	2	3	4	5	6	7
19. Screening for IPV as part of an intake assessment is likely to offend those who are screened.	1	2	3	4	5	6	7
20. There is adequate private space at my work place for me to provide care for victims of IPV.	1	2	3	4	5	6	7
21. I am able to gather the necessary information to identify IPV as the underlying cause of client's illness (e.g. depression, anxiety).	1	2	3	4	5	6	7
22. Women who choose to step out of traditional roles are a major cause of IPV.	1	2	3	4	5	6	7
23. Health care providers do not have the knowledge to assist clients in addressing IPV.	1	2	3	4	5	6	7
24. I can match therapeutic interventions to an IPV client's readiness to change.	1	2	3	4	5	6	7
25. Use of alcohol or other drugs is related to IPV victimization.	1	2	3	4	5	6	7
26. I can recognize victims of IPV by the way they behave	1	2	3	4	5	6	7

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Pg.5 This survey has been adapted from the PREMIS tool published by Short et al. (2006).

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APPENDIX D: IPV EDUCATIONAL MATERIAL

Wayne State University
Theoretical and Behavioral Foundations Department
Research Proposal: Intimate Partner Violence (IPV) Counselor Education: Exploring opinions, knowledge and perceived level of preparedness to counsel IPV clients.

IPV Education/Training

By

Alvis Ayaba-Apawu, M.A, LPC, PhD. Candidate

Committee members:
Dr. John Pietrofesa, Chairperson
Dr. JoAnne Holbert
Dr. Tami Wright
Dr. Antonio Gonzolez -Prendes

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What is Intimate Partner Violence (IPV)?

IPV involves psychological, Physical and sexual abuse by men and women toward romantic partners of the same or opposite sex (Capaldi, Knoble, Shortt, & Kim, 2012). IPV consist of Physical violence, sexual violence, threats of physical or sexual violence, emotional/psychological violence and stalking. IPV may occur among cohabitating or non cohabitating romantic or sexual partners and among opposite or same sex couples (CDC,2010). IPV affects people regardless of racial or ethnic background, socio-economic status, religious beliefs or sexual orientation. Nearly 1 in 4 women and 1 in 13 men experience IPV at some time in their life" (Black, 2011).

What is the difference between Domestic Violence (DV) and IPV ?

Domestic violence is used in many countries to refer to intimate partner violence but the term encompasses child or elder abuse, or abuse by any member of a household. IPV is specifically used to refer to abuse that occur between intimate partners regardless of their sexual orientation.

WHO: http://www.who.int/reproductivehealth/topics/violence/vaw_series/en/ retrieved on 1/15/2015

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Consequences of IPV

Consequences of IPV

- It is estimated that about 24 people per minute are victims of rape, physical violence, or stalked by an intimate partner in the United States resulting to more than 12 million women and men over the course of a year (CDC 2010).
- The CDC estimated the cost of IPV to the United States to be $5.8 billion per year in 2003 ($10.4 billion in 2012 dollars). The cost of providing health care to adult survivors of IPV ranges from $2.3 billion to $7.0 billion in the first year after the assault (CDC,2010; Liebschutz, & Rothman, 2012). The annual health care costs for women who experience IPV are 42% higher than those for non abused women. Sexual violence, which is a form of IPV can result in unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV (WHO, 2013).

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Consequences of IPV cont.

- The psychological impact of IPV include but not limited to; Depression, anxiety, low self-esteem, Inability to trust, fear of intimacy, antisocial behavior, suicidal behavior , symptoms of post-traumatic stress disorder, emotional detachment, sleep disturbances, etc.
- IPV results in an increased risk for multitude of psychological, behavioral, social and educational problems in children (Geffner, Igelman, & Zellner, 2014 .Pg1-2). Children living in homes with IPV are more likely than their peers to exhibit aggressive and antisocial behaviors, more likely to be anxious, fearful, and hyper-vigilant (Bair-Merritt, 2010). In addition, IPV exposure in school age children has also been linked with poor peer relations which could be due to poor self-esteem and sensitization to hostility.

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Factors contributing to IPV

Factors contributing to IPV

- **Individual Factors**: Alcohol and drug use, depression, anger and hostility, antisocial personality traits, borderline personality traits, Past history abuse, low income and aggressive or delinquent behavior as a youth.
- **Relationship Factors**: Dominance and control of the relationship by one partner over the other, belief in strict gender roles, unhealthy family relationships and interactions.
- **Community/societal factors:** Poverty and associated factors e.g. overcrowding, Low social capital, traditional gender norms, weak community and legal sanctions against IPV (e.g., mandatory reporting, unwillingness of neighbors to intervene in situations where they witness violence).

- CDC: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html; retrieved on 01/15/2015

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IPV Education/Training: session 1

Myths and Misconception regarding IPV

Myths and Misconception regarding IPV

- ***"Domestic violence/IPV is not a problem in my community."***

  In 2011, the Michigan State Police reported victims of domestic violence/IPV in all 83 Michigan counties. Michigan State Police records from 2011 also show that a woman is 15 times more likely to be killed by a partner or former partner (Mendel & Debnar, 2013)

- ***" Domestic violence/IPV is a personal problem between spouses, or partners, and I shouldn't get involved."***

  Intervention from family and friends can be very effective in helping someone escape an abusive relationship. Victims of violence lose a total of nearly 8 million days of paid work (the equivalent of more than 32,000 full-time jobs) as a result of the violence *(CDC, 2003).*

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Myths and Misconception regarding IPV cont.

- ***" Domestic violence/IPV is caused by alcohol and drug abuse, stress, and mental illness."***

  Alcohol use, drug use, and stress do not *cause* domestic violence/IPV, though they may coincide with it or increase the rate of occurrence of IPV.

- ***" Domestic violence/IPV happens only to poor women and women of color."*** IPV affects people regardless of racial or ethnic background, socio-economic status, religious beliefs or sexual orientation (Black, 2011).

- ***" if it were that bad, she/he would just leave."***

  There are many reasons why victims may not leave:

  Economic and emotional dependency , lack of work experience, lack of support from family or friends, lack of information regarding resources, may still love the abuser or believe they will change(most common reason), hesitation to separate children from the abuser, or fear of the abuser.

Source: (Mendel .S., & Debnar. S., 2013)

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Myths and Misconception regarding IPV cont.

- ***"Some people deserve to be abused."***

  No one deserves to be abused. The only person responsible for the abuse is the abuser. Violence is wrong and it is against the law.

- ***"Domestic violence/IPV doesn't happen to men."***

  While the majority of domestic violence/IPV victims are women, men equally experience abuse. Approximately, 10% of men in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner and reported at least one measured impact related to these or other forms of violence in a relationship (Black et al., 2011).

  It can sometimes be even more difficult for male victims to come forward. It is important to know that there are domestic violence/IPV programs that provide services to all victims of abuse regardless of gender.

Source: (Mendel .S., & Debnar. S., 2013)

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Examples of Abusive Behaviors

Abusers will attempt to control their partners in a variety of ways. The following are examples of abusive behaviors to look out for when counseling IPV clients:

- **Use of isolation:** The abuser may try to cut off his/her partner from family and friends, limit outside involvement in events or activities, behave jealously and be suspicious of the individual.
- **Intimidation:** The abuser may use threatening behavior or verbal aggression, may abuse pets or other animals, strike or throw objects at their partner, or destroy property.
- **Coercion:** The abuser may threaten to find someone else if their partner does not comply with their demands, involve the children, threaten to harm his/her self or commit suicide if their partner break off the relationship.
- **Deny or Blame:** The abuser may blame their partner, blame everyone else for their problems or deny any wrong doing. Abusers may say "you make me angry" or "you are hurting me".

Source: (Mendel .S., & Debnar. S., 2013)

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Examples of Abusive Behaviors Cont.

- **Economic:** The abuser may control all aspects of the finances and deny their partner access to bank accounts, cash and credit cards, prevent their partner from getting or keeping a job, keep their partner from going to school and limit their partner's health prescriptions and dental insurance.
- **Emotional**: The abuser may try to manipulate their partner's emotions, be hypersensitive, easily overreact, try to humiliate or ridicule their partner in public, may play "mind games" to make their partner feel bad or guilty, threaten to expose their partner's weaknesses or spread rumors about them.
- **Dual personality:** The abuser may have sudden mood changes and appear to be two different people, they may act differently in public than when alone with their partner.
- **Physical:** The abuser may use physically assault such as hitting, shoving, grabbing, slapping, strangling, burning, biting, kicking, or may use force such as holding partner down or restraining them during an argument.

Source: (Mendel .S., & Debnar. S., 2013)

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The Cycle theory of violence

- The cycle theory of violence, which is mostly known as the "cycle of abuse" was theorized by Walker (1979), to explain the pattern of an abusive relationship. The cycle consist of **three distinct phase** and each phase vary in both time and intensity for different couples.
- **I.** the tension building phase which consist of increasing conflict and tension. The victim in this phase is exposed to verbal, emotional and minor incidents of physical violence. The victim tends to minimize these incidents, place blame on themselves or external situations for the abusive behavior.
- **II.** the acute battering incident phase is characterized by uncontrollable violence. This phase constitute the shortest part of the cycle but has the highest risk for physical or sexual damage. Victims isolate themselves after violent incidents in this phase and may wait several days to seek medical attention as well as minimize their injuries by refusing to acknowledge to themselves or others regarding the severity of the abuse.

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The Cycle theory of violence cont.

III. The third and final phase is called the loving-contrition or popularly known as the honeymoon stage where the batterer exhibits conciliatory behaviors and may attempt to convince the victim of their intent to change (Walker, 1979). At this phase, the batterer apologize and engage in loving behavior in some relationship, or a decrease and temporary cessation in the violence in other relationships.

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Reflective exercises

Take a moment to reflect on any experienced, witnessed, or any IPV situation you have heard about.

- What are/were your thoughts regarding such situation(s)?
- What are/were your feelings regarding such situation (s) ?
- What are/were your reactions towards those situations?

Thank you for completing this session

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Introduction

- Many clients (especially, over half of women) seen in a range of mental health settings are either being abused or have been abused by an intimate partner.

The presentation of domestic violence/IPV vary widely and inquiring only when abuse is suspected will miss significant number of clients who are at risk. In mental health settings, **all clients should be asked about current and past abuse.**

- Routine inquiry is essential to avoid misdiagnosis and misinterpretation of symptoms and facilitate appropriate Intervention. Clients should also be asked about perpetration and be referred to appropriate batterer intervention programs if they acknowledge abusive behavior toward a partner.

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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IPV Education/Training: session 2

Screening for Domestic violence/IPV

Questions to add to telephone intake protocol

- **A. Obtain Safe Contact Information:**
  - Safe address
  - Safe phone number
  - Safe contact person

- **B. Safety Risk Assessment**

Danger to Self and Others and Danger from Others:

Are you safe? Are you currently in danger from someone you know or care about?

Has any one you know hurt or threatened to hurt you or someone you care about?

Are you in danger right now?

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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Screening for Domestic violence/IPV cont.

Intake questions for initial danger/safety screen

- Suggested statement for domestic violence/IPV screening

questions: I don't know if this has happened to you, but because so many people experience abuse and violence in their lives, it's something we always ask about. Could you tell me if there is anyone in your life right now that/who……

- makes you afraid?
- hurts or threatens to hurt you?
- tries to control or isolate you?
- Hits you, call you names or sexually abuse you?
- Stalks you?

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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Screening for Domestic violence/IPV cont.

- Based on initial domestic violence/IPV and mental health screening, determine level of danger and prioritize interventions:

A. Assess for immediate DV/IPV risk and immediate safety needs

Example of questions to assess Risk

- Is your partner in the house/apartment with you? Is he/she likely to return? When?
- Is it safe for you to talk right now? If not, is there somewhere you can go to make a call?
- Do you feel you are in immediate danger? Or, Do you think he/she is dangerous?

Example of questions to assess client's safety

- What do you feel would be the safest thing to do right now? What would you like to do?
- Do you have an order of protection? Do you have someplace safe you can go?
- Do you have a way to get there? Do you need help finding a place?

Do you have the National Domestic Violence Hotline: 1-800-799-SAFE (7233) ?
TTY: 1-800-787-3224

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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Screening for Domestic violence/IPV cont

B. Assess for immediate mental health risk ,crisis and Safety Needs

Example of questions to assess Risk

- Do you feel you are you in danger of hurting yourself or someone else?
- Has something happened that has made you to feel this way?
- Is there someone there with you? Can they help you stay safe or will they make things worse?

Safety

- Conduct usual mental health crisis assessment and intervention

C. Assess for indicators of high DV/IPV risk and urgent safety needs

Example of questions to assess Risk

- Do you feel you are in danger from your partner?
- Does your partner have a weapon or have access to weapons?
- Is the abuse is escalating/becoming more frequent, severe or frightening?
- Has your partner forced you into having sex when you didn't want to? How recently?
- Has he/she recently tried grabbing you by the neck or tried to choke or strangle you?
- Has your partner been violent outside the home? Has this happened recently?

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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Screening for Domestic violence/IPV cont

Example of questions to assess Safety Needs

- Are you able to leave safely? With your children?
- Do you have a protective order?
- Do you need emergency shelter? Is there another place where you can go?
- Can you take important documents with you?
- Do you have the National Domestic Violence Hotline: 1-800-799-SAFE (7233) ? TTY: 1-800-787-3224
- Phone number you would prefer I call to leave messages?

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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DV/IPV screening tools/assessments

Example of DV/IPV screening tools or assessment available to mental health providers include but not limited to:

- conflict tactics scale (CTS), created by Murray A. Straus in 1979
- CTS2 (an expanded and modified version of the original CTS) and the CTSPC (CTS Parent-Child)
- Initial DV Screening and Assessment Form
- Domestic Violence Danger Assessment Form
- Comprehensive DV Assessment form
- Comprehensive Mental Health Assessment: Client Safety Plan
- Domestic Violence Danger Assessment Form
- Record of Domestic Violence & Trauma Assessment and Intervention Form

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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How to record DV/IPV in client's chart

Example of suggestions for documentation of DV/IPV in mental health records:

- **1**. Document Abuse: Record your observations and what the client tells you: Record client's statements about specific acts of abuse detailing as many facts as possible. Quote the client directly. if possible, describe: physical acts, time of day and where it happened. Record client's demeanor: upset, crying, trembling, numb, etc.
- **2.** Establish a history of abuse, especially if client has obtained services from you or your agency in the past and the past abuse was documented
- **3.** Establish a causal relationship between domestic violence and mental health issues or diagnosis, e.g. Depression, PTSD, Anxiety

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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How to record DV/IPV in client's chart cont.

- **4. Describe how addressing DV can/will help alleviate mental health issues**

Example statement:

"It appears that a significant component of Mrs. Lee's depression is related to feeling trapped in an abusive relationship with her husband and feeling that she does not have the resources necessary to leave. It is likely that treatment for the depression along with access to community domestic violence resources will improve both the depression and increase Mrs. Lee's range of options."

- **5.Describe client's strengths**

Examples: Resources and support network, relationships with and concern for her children, continued ability to care for children ,openness to seeking help, etc.

- **6.Describe treatment/follow-up plan**

Examples

Make sure suggested services are actually available, explain rationale for plan, explain any reasons why client would not use suggested services, Link provision of services to alleviation of mental health issues, describe benefit of services to client's parenting capabilities.

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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How to record DV/IPV in client's chart cont.

7. Example of what to avoid when documenting DV/IPV record

- a. Do not use language that raises doubt, particularly "alleges", "claims", or "denies".
- b. Do not use neutral language, particularly phrases such as "domestic dispute" or "relationship problem".
- c. Do not use legal terms like "assault" or "battery".
- d. Do not describe the domestic violence incident or injury without the abuser: "Client was hit in the head" vs. "Ms. Stone's partner (name) hit her on the head with a baseball bat."

8. Additional helpful information

- a. Referral source for client
- b. Use non-blaming terms: "Client stated" or "Client reported"
- c. Establish the source of information: client told you, you observed it, other family member told you.
- d. If physical signs of abuse are still evident, take a photograph.
- Ask permission, date and sign the photograph

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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Interventions for IPV clients

INTRODUCTION

- Services to IPV victims were part of a broader social system in the 1900's until 1967 when the first agencies began to provide shelters to victims of IPV emerged (Lemon, 2009). The initial perspective of IPV intervention programs took a victim-centered approach, but, there has been a shift since the 1980s towards more perpetrator-centered interventions with a criminal justice perspective dominating the intervention response to IPV (Goodman & Epstein, 2005).
- "Male batterer programs in the US have become the primary means of intervention of domestic violence cases brought to the criminal courts" (Gondolf, 2011). Interventions approach used in batter treatment programs include psychodynamic approach with a gender-based, cognitive-behavioral approach, couples counseling, and culturally-oriented proposed approaches for batter intervention (Gondolf, 2011).

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Interventions for IPV clients cont.

The most dominate interventions mentioned in literature for IPV perpetrator programs are the Duluth model and the Cognitive Behavioral Therapy (CBT) base interventions.

- The Duluth "power and control model": this mode of intervention suggests that relationship violence is rooted in "patriarchal societal learning rather than a constellation of cognitive or emotional triggers" (Pence & Paymar, 1993, pg.7). This intervention approach is educational where group facilitators uses consciousness-raising to challenge perpetrators beliefs about power, control, and dominance over their spouse (Barner & Carney, 2011).
- CBT: Developed primarily by psychologists and it tends to make violence the primary focus of treatment. The pros and cons of violence is pointed out along with providing skills training; anger management, conflict resolution skills, assertiveness, and relaxation techniques to promote alternatives to the use of violent behaviors (Stover et al., 2009).

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Interventions for IPV clients cont.

Other intervention approaches for both victims and perpetrators include:

- Motivational Interviewing: evidence based approach to overcoming the ambivalence that keeps victims/perpetrators from making desired changes in their lives (Miller & Rollnick, 2002).
- Circles Of Peace by Mills, (2009b) : involves conferences between victims, offenders and sometimes includes supportive family members and friends. CP uses an intake assessment that includes a safety screening to ensure the safety of victims if they choose to participate.
- Other interventions for IPV victims includes but not limited to; providing shelters, medical services, e.g. prenatal clinics, community involvement and service , police social service outreach and advocacy (Stover et al., 2009).

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Summary and Questions

- How do you screen for signs of IPV among clients?
- What are the therapeutic interventions for working with IPV victims/survivors?
- How do you document IPV incidents in a victim's/survivor's chart?
- What is the counselors' role in assisting IPV victims/survivors?

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Thank you for completing this session

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Assessing IPV victim's readiness for change

INTRODUCTION

The decision to leave an abusive relationship or not is very complex and a personal choice. IPV victims would have to consider many things (including the availability of resources and support in the community) in order to make a decision. It is important for mental health providers to be informed about the stages of change to help IPV victims when they are ready.

The Transtheoretical Model (TTM), commonly known as the "stages of change" assesses an individual's readiness to act on a new healthier behavior, and provide strategies to guide the individual through the processes of change. TTM was proposed by Prochaska, Norcross, and DiClemente, (1992). The stages of change involves: precontemplation, contemplation, preparation, action, and maintenances.

- **Precontemplation (not ready):** At this stage the individual has no intention to change behavior in the foreseeable future. Individuals in this stage may be uninformed, under informed or deny the problem.

Prochaska, Norcross, & DiClemente, (1992)

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Stages of change cont.

- **Contemplation (getting ready):** At this stage, an individual is aware of the problem and interested in learning about the problem. However, Individuals contemplating change are often ambivalent. Contemplation is not a commitment or a decision to change .
- **Preparation (ready):** Individuals in this stage appear to be ready and committed to make a change. Individual may read or learn more about what they need to do to change their behavior with regards to the presenting problem. They may also consider pros and cons of change .
- **Actions:** Individuals in this stage actively take steps to change by putting their plan into action. Individuals tend to be open to receiving help and likely to seek support from others.
- **Maintenance:** This stage involves being able to successfully avoid any temptation of relapsing or returning to old abusive situations. The individual in this stage is committed to maintaining the change and may remind themselves of the progress they have made.

Prochaska, Norcross, & DiClemente, (1992)

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Creating a safety plan for IPV victims/survivors

INTRODUCTION

- Careful planning is necessary to increase an IPV victim's safety if he/she is considering leaving an abusive relationship. It is important for mental health professionals to be informed regarding safety planning for IPV victims/survivors to increase their safety.
- Put the client in touch with the National Domestic Violence Help Line (1-800-799-SAFE (7233)) to help make an immediate and concrete safety when domestic violence/IPV has been identified during a telephone intake. Such a plan can help a client to keep his/her children and herself/himself safe until more detailed services can be put into place.
- Always remind the client to call 911 when he/she is in an immediate danger because the violence may get worse when she/he show signs of independence or try to leave.
- Help clients to create an initial safety plan especially when they are unable or unwilling to contact any DV/IPV help line. The following points are ways a mental health provider can help a client to increase his/her safety:

(Mendel .S., & Debnar. S., 2013)

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Creating a safety plan for IPV victims/survivors cont.

1. **Ask the client what he/she has done so far to protect herself/himself and her/his children.** Examples may include:

- Putting guns and knives out of sight
- Sending the children to someone else's home when there is increased danger
- Have a bag packed, keep it hidden, but accessible, in case the client need it quickly.
- Encourage client to identify safer rooms in his/her home where there are less potential weapons and to practice how to get out of his/her home quickly and safely.
- Identify a trusted neighbor you can tell about the abuse. Ask that they call the police if they hear you being assaulted.
- Encourage client to think of several places he/she could go if he/she had to leave home and make plans for any pets you have.
- Discuss with client the possibility to open a savings account in his/her name only in order to have a secure place to save money for herself/himself.

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015, and
(Mendel .S., & Debnar. S., 2013)

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Creating a safety plan for IPV victims/survivors cont.

- Encourage client to memorize the phone numbers of local domestic violence /IPV programs.

2. Encourage the client to take basic steps to increase her/his safety and her children's safety:

- Determining if abuse can be anticipated and leaving before it occurs
- Gathering the most important papers, benefits cards, medicines, emergency funds and keys and putting them where they can be quickly found if she/he needs to leave
- Staying out of kitchens and bathrooms (which are often the most dangerous rooms in
- the house), rooms where abuse is more likely to occur or rooms from which it is difficult to get help or escape
- Teaching children to escape, get help, or call 911
- Obtaining an Order of Protection and keeping it with her/him at all times

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015 , and (Mendel .S., & Debnar. S., 2013).

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Creating a safety plan for IPV victims/survivors cont.

Discuss the following if a client plans to return home

- Review previous episodes for information that identify predictable patterns and locations that may be dangerous
- Discuss whether the client can anticipate an escalation of violence.
- Discuss what situations or conflicts tend to lead to abuse. When and where do most abusive incidents occur? What expressions, comments, or gestures come before abusive incidents?
- Discuss the possibility of leaving the house once she /he knows the violence is inevitable.
- Discuss what has worked to keep her safe or minimize injury in the past and whether she thinks such strategies could work again.
- Ask whether there are weapons in the home. Can she/he have them removed or can she/he remove them.
- Develop and rehearse an escape plan.

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015

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Confidentiality and IPV

INTRODUCTION

The disclosure of abuse may carry the risk of retaliatory violence. In light of this, asking about domestic violence /IPV requires that every measure be taken to maintain privacy and confidentiality. Do not ask about abuse in the presence of a possible perpetrator, or in the presence of another person whom a client has not privately identified as someone she or he can trust with that information. Such questions should not be asked during a couple's therapy session, or through an untrained translator.

- **1.** Clients should be informed that the information they provide is confidential (within the confines of the law) and will not be revealed to their partner or anyone else without their permission. Discuss situations that would necessitate breaching confidentiality (e.g., child abuse, harm to self or other, and elder abuse).
- **2.** It is important to note that, under **Michigan Mandatory Reporting statute (MCL 400.11),** mental health providers are mandated to report suspected child abuse or neglect. Mental health providers are also required to report elder abuse or neglect.

Source: NCDVTM (2004)
http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Responding-to-DV-Tools-for-MH-Providers.pdf, retrieved on 2/8/2015.

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Confidentiality and IPV

- **3.** Though the consequences of IPV is well documented in literature, it does not necessary require mandatory reporting. However, mental health providers can assist IPV victims/survivors to independently make an informed choice to whether report the abuse to law enforcement officers or not.

What to Expect if Intimate Partner Violence Occurs and is Reported to the Police :

1. If reported, the police must investigate
2. The police must arrest the suspect if they find reasonable cause that a crime was committed
3. The police must complete a report (regardless of arrest or not) and forward it to the prosecutor.
4. The prosecutor determines whether or not to proceed with the case, as well as the crime(s) with which to charge the suspect.

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What to Expect if Intimate Partner Violence Occurs and is Reported to the Police cont.

5. The suspect (defendant) is charged with a crime; the defendant is arraigned and bond set in district court

6a. If the defendant is charged with a misdemeanor, a pretrial hearing is held in district court. A trial date may be set, or the defendant may plead guilty or no contest.

6b. If the defendant is charged with a felony, the district court may hold a preliminary examination to see if the case should be tried in circuit court. The defendant may also agree to trial in circuit court without a preliminary examination, or plead guilty or no contest

7. If the defendant has not pled guilty or no contest, a trial is held in district or circuit court.

8. If the defendant pleads guilty or no contest, or is found guilty ("convicted") the court sentences the defendant

9. If the defendant is found not guilty ("acquitted") the court no longer has any authority over the defendant

Source: (Mendel .S., & Debnar. S., 2013).

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Laws to protect DV/IPV victims

- **Simple And Aggravated Domestic Violence MCL 750.81 – 750.81a :** Defined as an assault without a weapon which inflicts serious or aggravated injury. Increased penalties are provided for aggravated domestic assault.
- **Arrest Without A Warrant; Assault And Battery or Infliction of Serious Injury within Household MCL 764.15a :** This law is commonly known as the domestic violence warrantless arrest statute. It allows the peace officer to make an arrest if the officer has "reasonable cause" to believe that an assault has taken place, or is taking place, and the person who committed the violation and the victim has had a child in common, resides or has resided in the same household as the victim, has or has had a dating relationship, or is a spouse or former spouse of the victim.
- **Assault And Battery; "Dating Relationship" Defined MCL 750.81(2), (3), (4), (6) :**According to this law, "dating relationship" means frequent, intimate associations primarily characterized by the expectation of affectional involvement .
- (Mendel .S., & Debnar. S., 2013).

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Laws to protect DV/IPV victims cont.

- **Spousal Rape Law MCL 750.520**
  Public Act 138 of 1988 amended Michigan's criminal code to provide that a person be charged with and convicted of criminal sexual conduct "even though the victim is his or her legal spouse."
- **Personal Protection Orders MCL 552.14; 600.2950; 600.2950a**
  A victim of assault or stalking may obtain a personal protection order to restrain the person who committee the offense from doing one or more of the following:

1) entering onto premises;
2) assaulting, beating, molesting, or wounding the victim;
3) threatening to kill or physically injure the victim;
4) removing minor children from the person having legal custody in violation of a custody or parenting time order issued by the court;
5) engaging in stalking behavior;

(Mendel .S., & Debnar. S., 2013).

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Laws to protect DV/IPV victims cont.

6) purchasing or possessing a firearm;
7) interfering with the victim's efforts to remove the victim's children or personal property from premises solely owned or leased by the person to be restrained;
8) any other specific act or conduct that interferes with personal liberty or that causes a reasonable

- **Criminal Sexual Conduct Statute MCL 750.520b - e**
  There are four degrees of criminal sexual conduct.
- First and third degrees involve forced or coerced sexual penetration usually known as rape.
- Second and fourth degrees involve forced or coerced sexual contact.
- **Stalking MCL 750.411h :**Stalking is defined as a willful course of conduct involving repeated or continuing harassment of another individual that would cause a reasonable person to feel terrorized, frightened, intimidated, threatened, harassed, or molested, and that actually causes the victim to feel terrorized, frightened, intimidated, threatened, harassed, or molested.
- (Mendel .S., & Debnar. S., 2013).

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IPV resources

Local: Wayne County

- **YWCA/Interim House Metro Detroit** ; Address: P.O. Box 21904 Detroit, MI 48221. Phone:(313) 862-3580 Fax:(313) 862-4190 Crisis:(313) 862-5300.
- **Wayne County SAFE Program;** Address: Detroit, MI 48234 Phone:(313) 964-9701 Fax:(313) 369-5501 Crisis:(313) 430-8000 .
- **First Step;** Address: Plymouth, MI 48170-3840 Phone:(734) 416-1111 Fax: (734) 416-5555 Crisis:(734) 459-5900 or 1-888-453-5900

STATE

- **Michigan Coalition to End Domestic & Sexual Violence;** 3893 Okemos Road, Suite B2, Okemos, MI 48864 . Phone: (517) 347-7000 TTY: (517) 381-8470 web: www.mcedsv.org
- **Michigan Department of Human Services Cash, Food, Medical, or Home Assistance –** Toll-Free: 1-855-275-6424 Report Abuse/ Neglect – Toll-Free: 1-855-444-3911 web: www.michigan.gov/dhs

(Mendel .S., & Debnar. S., 2013).

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IPV Education/Training: session 3

IPV resources cont.

- **Michigan Crime Victim Notification Network (MCVNN)** Free and confidential service for victims to access information and receive notifications regarding their offender's custody status and court events.
  Toll-Free: 1-800-770-7657 TTY: 1-866-847-1298 ;
  www.michigan.gov/mdch
- **National Domestic Violence Hotline – 24/7**
  Translators for more than 170 languages are available. Call can be routed to a domestic violence service provider in the victim/survivors' area. Hotline: 1-800-799-SAFE (7233) TTY: 1-800-787-3224 ;
  www.thehotline.org
- **RAINN (Rape, Abuse & Incest National Network) National Sexual Assault Hotline – 24/7**
  Call can be routed to a sexual assault program nearest to the victim/ survivor. Hotline: 1-800-656-HOPE (4673) ; www.rainn.org

(Mendel .S., & Debnar. S., 2013).

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Questions

- How would you assess for a victim's/survivor's readiness to change?
- How would you assess for a victim's/survivor's safety, and how would you help the client to create a safety plan?
- what happens when IPV/DV is reported by the client?
- What are some of the IPV /DV laws in Michigan State?

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The End

Thank you for completing this Training

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ABSTRACT

INTIMATE PARTNER VIOLENCE (IPV) COUNSELOR EDUCATION: EXPLORING OPINIONS, KNOWLEDGE AND PERCEIVED PREPAREDNESS TO COUNSEL IPV CLIENTS

by

ALVIS AYABA-APAWU

May 2016

Advisor: Dr. John Pietrofesa

Major: Counseling

Degree: Doctor of Philosophy

Intimate partner violence has both physical and psychological effects and its monetary cost on the economy is enormous. IPV affects large number of people regardless of their religious affiliations, gender, sexual preference, or nationality. Because counselors are most likely to counsel IPV clients due to the high prevalence of partner violence, in depth knowledge of IPV is required to effectively handle IPV cases. Existing literature shows that novice counselors feel inadequate and experience difficulties in counseling IPV clients. To understand the challenges associated with counseling IPV clients, the current research study explores the opinions, knowledge, and perceived preparedness of counseling students to counsel IPV clients

In the study, thirty (30) master's students in a counseling program were recruited. Fifteen participants were randomly assigned to the experimental group and another fifteen to the control group. There were three main hypotheses for this study. Hypothesis 1: There is no significant difference in the mean scores of perceived preparedness between the experimental group and the control group after IPV education.

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Hypothesis 2: There is no significant difference in the mean scores of students' IPV Knowledge between the experimental group and the control group after IPV education.

Hypothesis 3: There is no significant difference in the mean scores of students' opinions between the experimental group and the control group after IPV education.

The first and third hypotheses were tested with repeated measures ANOVA, and the second hypothesis was tested with the kruskal-Wallis and the Mann-Whitey nonparametric tests. The results showed that the opinions, knowledge, and the perceived preparedness of students in the experimental group improved significantly in contrast to students in the control group. In addition, the opinion of students, their IPV knowledge and perceived preparedness were highly correlated. The results of this study demonstrate the need to adequately prepare counseling students to counsel IPV clients, rather than the reliance on the general academic curriculum.

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AUTOBIOGRAPHICAL STATEMENT

Education

Wayne State University (Detroit, Michigan) 2011 – 2016
Doctor of Philosophy (Ph.D.) Counselor Education and Supervision
Dissertation: IPV Counselor Education: exploring opinions, knowledge, and perceived preparedness to counsel IPV clients.

East Tennessee State University (Johnson City, Tennessee) 2008 – 2010
Master of Arts (M.A) Marriage and Family Counseling

University of Cape Coast (Cape Coast, Ghana) 2003 – 2007
Bachelor of Arts (BA). Social Science
Thesis: Poverty and HIV/AIDS.

Professional Experiences

Clinical Supervisor (Supervised master's counseling students at WSU) 08/2011 – 12/2014
Counselor-intern, Stone Crest Center (Psychiatric Hospital, Detroit, Michigan) 04/2013 – 08/2013
Counselor-intern, Frontier Health (Johnson City, Tennessee) 07/2009 – 12/2009
Counselor-intern, Watauga Counseling Center (non-profit) (Elizabethton, Tennessee) 01/2009 – 05/2009

Professional Experiences (Volunteering)

- Volunteered at DMC Children's Hospital - 2011: Engaged in Play therapy with children on admission to facilitate recovery.
- Volunteered at Macomb juvenile court as a drug addiction group counselor - 2012 (Choices, decision making and consequences were examined using motivational therapy Adolescents' strengths and resources were also examined in relation to their goals)

Awards/Scholarships

- Graduate Professional Scholarship: Awarded by the School of Graduate Studies, Wayne State University 2015/2016
- Dr. Karen Annual Scholarship: Awarded by College of Education, Wayne State University 2015/2016
- Linda Leet Endowed Scholarship: Awarded by College of Education, Wayne State University 2014/2015
- International Peace Scholarship: Awarded by Philanthropic Educational Organization (P.E.O) 2013/2014
- Watson Endowed Scholarship Fund: Awarded by College of Education Wayne State University 2013/2014
- International Peace Scholarship: Awarded by Philanthropic Educational Organization (P.E.O) 2012/2013

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