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Running head: INTIMATE PARTNER VIOLENCE

Intimate Partner Violence: Educational Workshop Curriculums for Service Providers

By

GraceMarie Schian

A Research Proposal Presented in Partial Fulfillment

Of the Requirements for the Degree

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Intimate Partner Violence: Educational Workshop Curriculum's for Service Providers

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Abstract

Intimate partner violence (IPV) has detrimental effects on a victim that include psychological, verbal and physical abuse. The escalation of violence within a relationship can have devastating effects. In a 2017 report, IPV was reported by close to 30% of women in relationships around the world (Loxton et al.). The impact of IPV has led to many mental health problems, as well as an overall decrease in self-reported health (Loxton et al., 2017). The current research on IPV has been diverse in the countries it has been researched in and continues to expand as more resources through self-reporting and other types of databases are updated with information. Victims often face co-occurring health issues when trying to seek professional help (Mason et al., 2017). Research has shown that there might be a gap in service provided to victims that may impede on the long-term recovery process of the victim (Mason et al., 2017). The creation of a comprehensive educational program that specifically focuses on victims of IPV seems to have a positive correlation with higher levels of satisfaction as it pertains to treatment (Mason et al., 2017; Falb et al., 2014). This study will look at the curriculums of these educational programs and workshops.

Keywords: intimate partner violence, service providers, criminology, victim, health

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Introduction

Victims of intimate partner violence (IPV) often face co-occurring health issues during and after the abuse has stopped. Many times, the victims suffer from psychological, physical and verbal abuse from their partners. Research suggests that IPV affects the health and well-being of people, “in every country, of every age, background, class, religion, and ability” (Mason et al., 2017). Mental health problems, a decrease in self-reported health, and substance abuse have been linked to IPV (Loxton et al., 2017). When victims do reach out for help, victims are referred to service providers to address these issues. These service providers are essential to the road to recovery for the victims. Unfortunately, some research has suggested that there is a lack of cooperation as well as communication between different service providers (Mason et al., 2017). In fact, Mason et al. (2017) state that, “one of the challenges for frontline providers is the lack of effective, evidence-informed inter-professional education or training to help them identify and appropriately respond to co-occurring problems” (p. 1). Therefore, victims have to emphasize a specific health issue over others so that they can receive any treatment at all. However, some studies have shown that through workshops and additional training with service providers, that adequate care can be possible for the victims of IPV (Mason et al., 2017). The research in this study will examine established educational workshops specific to victims of IPV and then suggest additional topics to be included in the curriculums.

Purpose

The purpose of this research is to draw conclusions on educational workshops in relation to service providers and victims of IPV. The research conducted is intended to build upon the positive correlation that Mason et al. (2017) identified in their research project about educational programs for service providers. The research adds an additional viewpoint and synthesis of the

data collected based loosely on these types of elective educational programs for service providers in contact with victims of IPV.

Rationale

This study will contribute to the literature on the topics involved in educational workshops and programs, specific to victims of IPV. There have been limited studies done on the effects of educational programs/workshops on the performance of service providers (Mason et al., 2017; Falb et al., 2014). This study aims to bring attention to the possible influence that educational programs/workshops could have if implemented on a semi-regular basis to service providers.

Research Question

RQ1 What topics should be included in educational workshop curriculums in order to make them effective in providing information for service providers that interact with victims of IPV?

Limitations and Delimitations

A limitation of this study is the lack of original data that will be used. Due to the time frame of this capstone project, and other constraints, data will be pulled from the peer-reviewed article by Mason et al. (2017). This study looks at the role of service providers and how educational programs specifically geared towards helping victims of IPV are proving to be beneficial. A delimitation of the study is that only those studies that specifically mention an educational workshop or program designed for service providers, first responders, medical personnel will be utilized. In this study, the IPV victim's perception of the benefit of additional training for service providers on their recovery process will not be considered.

Definitions

Definitions are necessary to identify early on in this study, to ensure that there is an agreement or at least an understanding of what is being discussed. The terms that will be defined are: intimate partner violence (IPV), service providers, and educational programs.

Intimate Partner Violence (IPV)

The definition of IPV that will be used in this study was written by Mason et al. (2017). IPV, “refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” (Mason et al., 2017, p. 2). While men are also susceptible to IPV, the focus of this study will look at the female experience. Researchers suggest that, “rates of IPV are highest among women, particularly younger women and those in dating relationships” (Mason et al., 2017, p. 2).

Service Providers

For the purposes of this study, the definition of service providers includes any agencies who are recruited or requested for victims of IPV. Examples would be first responders, psychologists, psychiatrists, and any licensed professional who is offering assistance to the victims of IPV. In this case, it will also include health care providers due to the study done by Falb et al. (2014) which included nurses.

Educational Programs and Workshops

In the study conducted by Mason et al. (2017), educational programs and workshops were identified. These programs and workshops were the inspiration for this capstone project and will be discussed further in the results and discussion section. For the purpose of this project, educational programs and workshops are curriculum-based programs offered to service providers. These programs/workshops are based upon helping in the recovery process of victims of IPV and are specific to the role that service providers play in that recovery.

Literature Review

Loxton et al. (2017) tackled the research question of the relationship between IPV and mental/physical health later in life. The authors used subjects from three different birth cohorts in Australia which were the years of 1973-78, 1946-51, and 1921-26 (Loxton et al., 2017). These birth cohorts were used in order to gain a better understanding of IPV on long-term health and wellness. Loxton et al. (2017) had an initial study of 40,395 women, but in their final study they used 16,761 women. The researchers used a chi-square test of association in order to categorize each birth cohort, and then used a software in order to get their statistics for the project (Loxton et al., 2017).

The results of the study conducted by Loxton et al. (2017), showed that there was a correlation between IPV and poor mental/physical health later on in life. Loxton et al. (2017), stated that, “results for physical health are strongly suggestive of a lifetime deficit in physical health that is associated with IPV” (p. 6). The results match up with other research in the field that also indicated that health problems were associated with victims of IPV. Some limitations of this study were that the birth cohorts started as early as the 1920’s. While this research was a longitudinal study, future study should include birth cohorts to account for cultural shifts. To further this research, a suggestion would be to go further into different types of mental and physical health problems such as percentages experiencing post-traumatic stress disorder, anxiety, etc.

Grana, Cuenca, and Redondo (2017) conducted a study that examined the impact of physical and psychological aggression, on reported relationship satisfaction. The authors found that both men and women reported incidences of physical aggression when it comes to dealing with disagreements (Grana et al., 2017). Grana et al. (2017) suggests that more research needs to

be conducted into whether or not IPV stems from situational violence where the aggression comes from disagreements, or if the aggression is coming from the need for control over the partner. Distinguishing the differences between situational violence and need for manipulation is important for future research.

In their study, Grana et al. (2017), utilized 2,988 straight adult couples. The age range of the participants was between 18 and 80. All participants needed to be in a heterosexual relationship and had to have been in a relationship during the study or at least within twelve months of the study. In this study, half of the participants were married (61.7%) and then 29.5% of them were in a relationship but not living together (Grana et al., 2017). Grana et al. (2017) utilized a sociodemographic questionnaire as well as a conflict tactic scale in order to get a better understanding of their subjects and to create variables for their research. This study utilized a conflict tactic scale to generate the self-report questionnaires which were the main source of data. The questionnaire had 39 questions that the subject took as the victim, and 39 questions that the subject took as the perpetrator of aggression. Grana et al. (2017) used a quota sampling method within Madrid in order to get their pool of subjects.

Grana et al. (2017) found that their research matched up with a lot of previous research. There was a 60% reporting of psychological aggression within a committed relationship which was significantly higher than the 15% of reported physical aggression within a relationship. Grana et al. (2017) also found that men were more likely to self-report higher levels of psychological and physical violence. Women were likely to self-report lower levels of psychological and physical aggression. The models that Grana et al. (2017) used showed an interesting finding regarding women's satisfaction with their relationships. It found that women who reported that they were satisfied with their relationships tended to underestimate the

amounts of physical and psychological aggression that they were enduring as well as perpetrating (Grana et al., 2017). A limitation of this study is that the authors only used heterosexual relationships as their subjects. With the growing acceptance of all different types of intimate relationships, it would be important to include other types of relationships within a study about aggression and violence. The sample size could also stand to be increased in order to gain a better perspective of relationships.

Barufaldi et al. (2017) found that the World Health Organization reported that, “35% of all women in the world are the victims of physical and/or sexual violence, mostly by their partners” (p. 2930). Barufaldi et al. (2017) also found that, of women murdered, 38% of them are killed by their partners. In response to these statistics, Barufaldi et al. (2017) focuses on their research by looking into women who are killed and the relationship with reporting violence perpetrated against them in Brazil. The authors used a descriptive study to examine their research, which they pulled from the Mortality Information System as well as the Notifiable Diseases Information System (Barufaldi et al., 2017). The reports in the study that were taken from these databases, were only looked at if they fell between 2011 and 2015.

The results of the study conducted by Barufaldi et al. (2017) showed that between 2011 and 2015, self-report of victimization increased by two. It was also found that, “in 2015, women were the victim in 67.1% of the cases of reported violence” (Barufaldi et al., 2017, p. 2931). Of all the data gathered for this study, it was found that around 15% of women who had been killed had a significant history of being a victim of violence (Barufaldi et al., 2017). These statistics demonstrate that women who have been victims of violence before are at a higher risk to become victims again. It also showed that they were at an increased risk of being killed through that violent encounter than the general population. Limitations of this study were that it was only

done through databases. While the databases are helpful with large amounts of information, many of them do not have descriptive information pertaining to the particular crime, meaning that, while the statistics may be correct, the entire story is not being disclosed which could overreport or underreport data. Further research could be conducted using a different study design, which could provide additional research to help answer the question about violence and likelihood of repeated victimization and death.

Another study that will be examined looks at ways to provide workers the best resources and training to help with the recovery and healing of victims of IPV. Mason et al. (2017) explains that IPV does not discriminate when it comes to their victims. In fact, Mason et al. (2017) states that, “women in every country, of every age, background, class, religion, and ability are victimized and their health and well-being affected” (p. 2). Prior research has shown that victims of IPV typically have co-occurring issues that follow such as mental health problems, physical problems, and substance abuse (Mason et al., 2017). Even with this information, policies that are in place to help these victims do not provide adequate treatment. In fact, many victims are forced to put an emphasis on one issue so that they can receive some type of assistance.

The study conducted by Mason et al. (2017) gave out surveys to these workers that are usually the first point of contact for services to these victims. Mason et al. (2017) utilized a few different methods in their research. They used online pre- post-test surveys, as well as in-person evaluations (Mason et al., 2017). These interviews and surveys were recorded from June 2012 to June 2015 and a total of 1,111 participants were used in the study (Mason et al., 2017). The subjects of the study underwent workshops in Canada (Ontario) which provided an outline on providing the best care to victims of IPV. The results of the study showed that many of the

workers had been unknowingly and knowingly engaging in attitudes that were not helpful to the victims such as victim blaming (Mason et al., 2017). It also showed that the victims were being shuffled from one service to another which ended up not helping them at all. The workshops showed to have decreased the stigmatization that these workers had against victims of IPV and showed that they picked up valuable information on proper responses (Mason et al., 2017). The study showed that through this type of curriculum, stigmatization could be decreased, and inter-agency cooperation could increase. Mason et al. (2017) also found that, “unlike previous studies, we have also demonstrated that a significant component of the curriculum can be delivered through an accessible online curriculum, potentially reaching more providers” (p. 6). The results of the study stand to benefit not only the victims of IPV but also the service providers.

The study conducted by Mason et al. (2017) did have limitations. While they had control over the pre-test submissions, the post-test responses were significantly lower, coming in at 55% (Mason et al., 2017). This lower percentage could have messed up the results of the study because not everyone responded. Another limitation of the study was that many of the participants had an interest in learning about victims of IPV and how they could help them. Therefore, the subjects were being chosen out of convenience.

IPV has been a prevalent issue in Mexico City, and nurses at various clinics tend to be the first line of contact with victims (Falb et al., 2014). In this study, the nurses were given a one-day training that focused on treating victims of IPV, and how to interact with them. The results of the study showed that victims felt like they received better care and treatment from the nurses who had received the brief training (Falb et al., 2014). The results of this study align with the results from incorporating a comprehensive curriculum for service providers developed by Mason et al.

(2017). Better training of service providers and first responders can be linked to long-term health of victims of IPV (Mason et al., 2017; Falb et al., 2014).

Theoretical Framework

Many researchers have found that IPV has a lot to do with power and control (Giordano et al., 2016; Leisring & Grigorian, 2016). Two criminological theories help to explain IPV which are social learning theory and feminist theory. Social learning theory looks at risk factors and how previous exposure to violence can have an impact on an individual later. Children who grow up in an environment where there is violence or aggression may internalize it (Giordano et al., 2016). Social learning theory suggests that individuals learn from what they see and experience (Giordano et al., 2016). In the case of IPV, aggression and violent behavior become a norm and then reactions to those events may be dulled due to the exposure (Giordano et al., 2016).

The feminist theory looks at gender inequality and societal influence on patriarchal attitudes (Giordano et al., 2016). Giordano et al. (2016) explains that, “a central theme is that violence against women can best be understood as a means of maintaining control over female partners” (p. 2). According to feminist theory, gender socialization has led men to believe that they are supposed to hold the control as well as dominance over their partners (Giordano, et al., 2016).

Both of these theories were used to explain IPV. Frustration-aggression hypothesis was considered, but ultimately decided against. Frustration-aggression hypothesis is where, “a feeling of frustration (thus a sense of tension, which occurs when our efforts to reach a desired goal are thwarted) evokes negative affect and anger, and therefore can lead to aggression” (“Anger under control”, 2013, para. 1). This theory was considered but not used in the theoretical framework because it was more focused on a reaction rather than social norms and interactions.

Qualitative vs. Quantitative Research

Quantitative and qualitative data bring different advantages to research. Quantitative data uses numbers and statistics while qualitative data uses nonnumerical data such as descriptions and words (Babbie, 2013). Quantification of data can be extremely helpful in terms of ease of comparison and summarization (Babbie, 2013). Quantitative data allows for statistics to be used, however sometimes the meaning of the data can be lost in the process. Qualitative data has the advantage of richer meanings of the data, but can also have the downfall of being limited by verbal descriptions (Babbie, 2013). Therefore, it is important to examine research that has a qualitative approach as well as research that has a quantitative approach. This is important for the depth of research and to gain a full understanding of the data relating to IPV.

Barufaldi et al. (2017) conducted a descriptive study of death linked to aggression against women in Brazil. For this particular research project, a qualitative design was taken due to the sensitive nature of the topic. The data for the research was pulled from the SIM (Mortality Information System) and the SINAN (Notifiable Diseases Information System) (Barufaldi et al., 2017). From these databases, Barufaldi et al. (2017) were able to pull information to answer their hypothesis about whether or not women who reported aggression experienced a higher rate of death over those who never reported aggression. Since the researchers in this case were using a descriptive design, they were able to pull participants from the databases from the years between 2011 and 2015 (Barufaldi et al., 2017). A large sample of females was able to be evaluated, due to the design of the study.

Another example of a qualitative design was conducted by Grana et al. (2017). Their article involved collecting data from individuals who were either cohabitating or married (Grana et al., 2017). Participants were given a sociodemographic questionnaire, the CTS-2 (Revised

Conflict Tactics Scale), and for the married couples the QMI (Quality Marriage Index) (Grana et al., 2017). The participants for the study were selected through a quota sampling method in Madrid (Grana et al., 2017). Many different aspects of intimate partner interaction were measured through the surveys. Grana et al. (2017) were looking for data on: partner agreement, multilevel modeling of agreement, relationship satisfaction and physical aggression, and finally relationship satisfaction and psychological aggression. While this study did involve some statistical numbers, the qualitative design was more looking for responses of the partners in the relationships.

Mason et al. (2017) took a quantitative approach to their research. In order to address the gap between service providers and victims of IPV, Mason et al. (2017) developed an in person and online curriculum for service providers. Pre-tests and post-tests were administered during the experiment to determine the impact of the, “evidence-informed, competency-based curriculum” (Mason et al., 2017, p. 1). Mason et al. (2017) used a number of methods in order to conduct their research. In addition to the pre-tests and the post-tests, participants also had to complete an in-person evaluation that included closed as well as open-ended questions. This evaluation was used in order to gauge the participants’ beliefs on the subject, knowledge and skill (Mason et al., 2017). Mason et al. (2017) ended up holding 52 workshops across Ontario, Canada between June 2012 and June 2015. The method of selection for participation in this study was open-ended. News of the workshops was shared with service providers in the Ontario, Canada province and was open to anyone who showed interest. In order to conduct the statistical analysis, Mason et al. (2017) used coding for the open-ended questions of the evaluation. The codes were organized into three different categories: “bridging silos, attitude change and self-care” (p. 3).

The last article that will be mentioned is by Loxton et al. (2017) and they utilized a quantitative approach. Loxton et al. (2017) did their study on the impact of IPV on victim's health over a long period of time. They utilized a longitudinal cohort study and utilized three cohort groups of women in Australia (Loxton et al., 2017). In order to gather the participants for their study, Loxton et al. (2017) randomly pulled from the Australian Medicare database. After the participants were selected and surveyed, a chi-square test of association was utilized to convert the information into statistics (Loxton et al., 2017).

Most of the studies reviewed utilized databases or questionnaires to collect data. In these cases, the operational definitions of the variables did have an impact on the type of research design that they conducted in their study. Loxton et al. (2017) utilized the Medical Outcome Study Short-Form (SF-36) in order to measure health and quality of life. Loxton et al. (2017) did this in the form of a 36 question self-reported survey and the participants could rank anywhere from 0 to 100 (Loxton et al., 2017). Loxton et al. (2017) utilized this method to create a uniform rating for overall health and wellness in their longitudinal study. Loxton et al. (2017) also operationalized the definition of IPV by asking their participants: "Have you ever been in a violent relationship with a partner/spouse?" (p.3). Mason et al. (2017) utilized coding in order to operationalize their definitions for attitude change and self-care. Barufaldi et al. (2017) operationalized their definition of mortality rates as it referred to IPV through their calculation involving the division of mortality rates among victims of violence and mortality rates among the general population. The operational definitions were further defined as the SIM and the SINAN defined what constituted as reported aggression to children, adolescents, adults and elderly women (Barufaldi et al., 2017). Finally, Grana et al. (2017) operationalized their variables

through the use of the CTS-2 and a sociodemographic questionnaire. Through the results of the surveys and questionnaires, the prevalence of aggressive behavior was uniformly recorded.

All four of the studies that are being examined utilized some type of questionnaire or survey in their procedural requirements. Of the studies that pertained to interviewing subjects, it was a theme that the researchers instituted a pre-test and a post-test. These tests were utilized in order to measure the difference in the time that had elapsed and to measure if there was an effect on the individual. The study conducted by Barufaldi et al. (2017) did not utilize this technique because they were pulling from the databases specific to Brazil. In the study conducted by Loxton et al. (2017) the initial participants were drawn from the Australian Medicare database, but then each birth cohort was asked the same questions in the survey.

With the topic of discussion being on IPV, many of the researchers utilized components from both qualitative and quantitative research designs. Grana et al. (2017) utilized a qualitative design but also pulled from quantitative data in order to put some numbers behind the research. Mason et al. (2017) utilized a quantitative approach, but then provided descriptions and specific quotes from the open-ended evaluative survey. IPV can be examined through many different research designs, which helps with creating multi-dimensional results on the impacts and treatment of IPV. Combining qualitative and quantitative research projects pertaining to IPV helps with understanding the statistics behind the impact of it, as well as understanding the experiences of the victims.

IPV is incredibly far reaching and has detrimental effects on the victims long after the abuser is removed from the situation. Examining the qualitative and quantitative research designs, procedural requirements, and operational definitions of variables will help in strengthening the future research studies surrounding IPV.

Methodology

Using the peer-reviewed article by Mason et al. (2017), a qualitative analysis was utilized for this study. This article was mentioned in the literature review section and was obtained through the Academic One File Regis University online database. In this case, original data was unavailable, which influenced the methodology for this capstone project. Mason et al. (2017) were chosen because of the existing research and discussion on the topic of educational workshops and service providers. The article written by Mason et al. (2017) provides data on self-rated competency scores by service providers who went through an educational workshop. The data that was gathered from the article by Mason et al. (2017) will be re-examined in order to answer the proposed research question of the study. The data found in this article will help supplement the lack of literature on the topic of curriculums of educational workshops.

Sample

For the purposes of this capstone project, the data will be drawn from the research conducted by Mason et al. (2017). Table 2 will be used which is located in the article written by Mason et al. (2017) and is titled, "Learners' self-rated competency scores from pre-test and post-test" (p. 5). For the original study, there were 1111 participants. For the data set located in Table 2, only 56% of the participants responded for both the pre- and post-tests. The second table that will be used in this study is Table 3 which is titled, "Correct responses between pre and post-test (knowledge and belief-based questions)" (Mason et al., 2017, p. 5). This data set utilized 624 matched pre-test and post-test answers. Both of these tables were extracted from the research done by Mason et al. (2017) and this article was accessed through the online Regis library. These tables can be found in the Appendix section.

Measurement

For this study, the independent variables are the educational workshops and programs as well as the additional topics. The dependent variables are the effectiveness of the added curriculum topics for the educational workshops and programs. This capstone project offers additional topics to existing educational workshops and programs. Since original data was unavailable, additional topics to educational workshops and programs as well as the effectiveness of them being implemented in the future will serve as measurement tools.

Procedure

The data sets from Table 2 and Table 3 were re-examined. This was done to get control for what worked in this particular educational workshop curriculum. From there, the proposed research question about what should be included in future educational workshops was discussed.

Results

The data in Table 2 showed that self-rated competency scores increased in every category that was tested (Mason et al., 2017). The elements that were included were: “co-occurring conditions, initiating conversation, responding to crisis, helping during distress, building organizational partnerships, and self-care” (Mason et al., 2017, p. 5). Table 3 showed that the number of correct answers regarding knowledge and belief questions in the pre-test and post-test increased from 9.7 to 11.2 (Mason et al., 2017).

There is a lack of literature on the topic of educational workshops specific to service providers dealing with victims of IPV. Therefore, the data tables from Mason et al. (2017) were used to provide a controlled workshop for what topics showed statistical significance between pre-test and post-test questions. Since statistical significance was found in the existing topics in the study conducted by Mason et al. (2017), additional topics will be addressed in the next

section regarding the research question. In the next section, the research question will be discussed.

Research Question

Research Question 1: What topics should be included in educational workshop curriculums in order to make them effective in providing information for service providers that interact with victims of IPV?

After reviewing the data provided by Mason et al. (2017), it is clear that more research needs to be done regarding the curriculum of educational programs and workshops. The research question developed for this capstone project, seeks to provide original analysis of the existing data.

The curriculum provided by Mason et al. (2017) did not address any topics that directly involved work with law enforcement. By the time that many victims of IPV come into contact with service providers, they have already been through the system or had contact with a police agency. The first topic suggestion for the curriculum would be on police interaction and involvement. In order to achieve this, key law enforcement personnel that deal with calls of service pertaining to victims of IPV would need to be brought in to speak. If service providers are informed on the workings of law enforcement, they would be able to refer their clients on a case by case basis depending on the severity. In these instances, an order of protection or restraining order may be the next step once information has been disclosed to the service provider. This type of interaction could also benefit the topic already mentioned in Table 2 about building organizational partnerships (Mason et al., 2017). Service providers would have the chance to talk with law enforcement officers after the conclusion of the presentation. The hope

would be that information would be exchanged and future questions pertaining to victims of IPV could be discussed if a case came up.

Another topic that was not covered in the data set provided by Mason et al. (2017) that might be beneficial to improving the curriculums of educational programs, would be case management and prioritization. Many of these service providers are given many cases at once. If time is not managed well, clients will suffer because the quality of care decreases. The topic of case management could include: coping methods when stress arises, time management and a uniform system of case prioritization. Coping methods would benefit service providers because it can be a stressful job. Finding methods to decompress, and then refocusing efforts towards providing the best care possible is essential to the role of service providers. Case prioritization might include a ranking system that considers threat level. This ranking system would be a part of effective case management and time management.

The educational program created by Mason et al. (2017) was developed as one-day learning experiences. In just one day, the responses of competency by the service providers on various topics dramatically increased. With this information, the suggested change to the educational programs and workshops moving forward would be to increase the number of days. With so many topics being covered in one day, a lot of information can get lost. If the educational workshops and programs were to be spread out over different days throughout the year, the hope would be that the competency responses would increase closer to the 5.0 max on the Likert scale. The intended outcome would be a 5.0 competency response on the Likert scale to every single topic covered in the educational workshop or program. In order to make this a more realistic goal, the days of the program could be a part of a series where certain topics are reviewed on specific days throughout the year. Completion of the series could be recognized as a

certification course specific to victims of IPV. Offices could provide incentives in order to have their employees certified in these programs and workshops.

Discussion

Educational programs and workshops specific to victims of IPV have not been a common practice to engage in for service providers, which is apparent through the lack of literature on the topic. Some studies (Mason et al., 2017; Falb et al., 2014) have designed and tested curriculums for service providers and then received feedback using pre-tests and post-tests. Since these programs and curriculums are still being developed, this capstone project tried to provide suggestions based on existing data.

The analysis of Table 2 and Table 3 within the study, revealed that there were statistics that showed that self-rated competency rates increased over five topics. The five topics were: co-occurring conditions, initiating conversation, responding to crisis, helping during distress, building organizational partnerships, and self-care (Mason et al., 2017). These topics were considered, and then new topics were suggested in the results section. These included: a topic on law enforcement, case management and prioritization, an increase in program length, and a potential certification program.

These programs are going to cost money, time, and resources. However, if these programs continue to be evaluated, added to, made more concise; then they could be implemented all over the country and world. Mason et al. (2017) discuss the possibility of making the educational programs and workshops available online. With higher education already making the transition into online education, allowing service providers access to the curriculums online may cut down on the costs as well as problems relating to access.

Additional Limitations

Any time that data is being borrowed from another study, it is important to point out the limitations of the study. This helps to ensure that the data is not being hand-picked to answer the researcher's questions, especially since original data was not conducted. In the case of Mason et al. (2017) the pre- and post-tests were vital to the study. While over 1,100 service providers participated in these workshops, Mason et al. (2017) only had a 55% response rate. This meant that only 55% of the service providers gave Mason et al. (2017) both a pre- and post-test response. The 55% response rate could have impacted the competency scores.

A limitation of the original analysis was that the analysis was not quantitatively tested. The original analysis provided suggestions on additional topics for the educational workshops and programs. It is unknown if these topics would impact the care given to victims of IPV if they were implemented in these educational workshops and programs for service providers. There is room for future research on the topic, which will be detailed in the next section.

Future Research

Due to the time constraints and topic of this capstone project, there is a lot of room for future research on this topic. If time, money, and resources had not been an obstacle for this capstone, the alternative approach to the study would have been to collect original data. This would have been possible through designing an educational workshop for service providers in the area of Denver, CO. A similar approach to the study conducted by Mason et al. (2017) could have been a basis for adding on additional topics to the course. From there, surveys would have been a helpful methodological approach to collecting data. This type of methodology would be effective because it could gather information quickly, have a large sample size, and would be easy to quantify the data if a quantitative research design would be introduced later. While there are many advantages to this kind of qualitative

methodology, the disadvantages that come with it will have to be discussed and managed. The questions that will be written and chosen for the final survey will have to be thoroughly thought out. One of the disadvantages of surveys is if the questions are weak or biased (Babbie, 2013). This could cause an issue with the results and success of the study. Therefore, to address this disadvantage, multiple steps would have to be taken in order to ensure that the questions are appropriate and relevant to the study. The other disadvantage that would have to be managed and planned for would be the response rate to the survey (Babbie, 2013). Babbie (2013) discusses the concern for nonresponse bias which manifests itself when all participants do not complete the survey. This would be managed through the reporting of the actual response rates, cooperation rates, refusal rates, and contact rates (Babbie, 2013).

A narrative analysis might be an alternative to explore in the future research on IPV and service providers. With this type of analysis, response coding could be used like in the article written by Bosacki et al. (2006) on bullying. Narrative analysis allows for each service provider to share their experiences. This allows for more explanation on certain events and does not narrow down an individual's experience to variables and categories. When dealing with service provider's experiences, it would be important to know what incidences had the most impact on them. This could help in identifying mock situations for training purposes, in order to make curriculum's better equipped.

Ethics

Any time that human subjects are used in a study, it is important to understand and identify the ethical implications that could arise. Regarding service providers that interact with victims of IPV, voluntary participation and no harm to the participants is essential when looking

at possible ethical challenges. The individuals who decide to participate in the study will need to make it explicitly clear that they volunteered without any outside pressures. Subjects must also show that they understand the concept of informed consent, meaning, “that subjects must base their voluntary participation in research projects on a full understanding of the possible risks involved” (Babbie, 2013, p. 64).

Ensuring anonymity and confidentiality will be vital to tackling ethical challenges in the study due to the job security of service providers. As for analysis and reporting, it is important to disclose all findings of the study regardless of the outcome. Limitations as well as failures of the study are disclosed in the findings so that other researchers can understand the results (Babbie, 2013).

Consideration must also be made towards the implications of the study findings. Again, due to the sensitive nature of victims of IPV and service providers, the way the results are presented and interpreted will need to be monitored closely. Depending on the results of the study, there may be unknown implications on the jobs of service providers as well as the well-being of victims of IPV. Most of the researchers who conducted similar studies on victims of IPV tended to group victims based on birth cohorts (Loxton et al., 2017) as well as health problems (Mason et al., 2017). Specifics about the victims were avoided which is how many of the studies addressed ethical challenges regarding their study.

The collection of secondary data is present in this study. Whenever other data is being used, there is always potential for abuse to occur. However, secondary data can be incredibly important when used without crossing any ethical lines. Prasad (2013) suggests that harm can be avoided with the secondary use of data by only using information that is nonidentifying of the

subjects and readily available to the public. With these considerations in mind, the ethical issues revolving around the criminological research being conducted can be kept to a minimum.

Conclusion

IPV affects many people all over the world, every single year. This capstone project aims to suggest improvements to the curriculums of educational programs specific to victims of IPV. The literature on IPV shows that there are psychological and physical health risks that are associated with IPV as well as continue long after the abuse has stopped (Barufaldi et al., 2017; Falb et al., 2014; Grana et al., 2017; Loxton et al., 2017; & Mason et al., 2017). Many victims of IPV have co-occurring health issues that need to be addressed when they are seeking professional help. Service providers are typically the first line of defense when it comes to combatting these co-occurring health issues that arise from IPV (Mason et al., 2017). Research has suggested that educational programs for service providers and nurses might help in the recovery and healing process of victims of IPV (Falb et al., 2014; Mason et al., 2017). Continuing the research on health issues of victims of IPV and the association of education of service providers, will help to provide better care and treatment for these victims. Increasing quality of care for victims of IPV will help in their road to recovery from a psychologically and physically damaging experience. Expanding the educational workshop curriculums will allow for growth within the roles of service providers.

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Appendix

Retrieved from Mason et al. (2017) Table 2 (p. 5)

Table 2 Learners' self-rated competency scores from pre-test and post-test^a

Competency Domain	n	Pre-Test		n	Post-test	
		Median (IQR)	Mean (SD)		Median (IQR)	Mean (SD)
Co-occurring Conditions ^b	617	3.00 (2.00–4.00)	3.0 (1.0)	620	4.00 (4.00–5.00)	4.2 (0.7)
Initiating Conversation ^c	618	3.00 (3.00–4.00)	3.3 (1.1)	620	4.00 (4.00–5.00)	4.3 (0.7)
Responding to Crisis ^d	616	3.00 (3.00–4.00)	3.2 (1.0)	619	4.00 (4.00–5.00)	4.1 (0.8)
Helping During Distress ^e	614	3.00 (2.00–3.00)	2.7 (1.1)	619	4.00 (3.00–4.00)	3.8 (0.9)
Building Organizational Partnerships ^f	615	3.00 (2.00–3.00)	2.5 (1.2)	619	4.00 (3.00–4.00)	3.8 (1.0)
Self-care ^g	618	4.00 (3.00–4.00)	3.5 (1.0)	620	4.00 (4.00–5.00)	4.3 (0.7)

^aSign test was used to compare the difference between the pre and post-test responses

^b "I understand the ways in which domestic violence, mental health, and substance use problems are interconnected." ^c "I can initiate conversation, ask questions about, and appropriately refer a woman who has experienced domestic violence and has mental health and/or substance use problems." ^d "I can respond to crises related to DV, mental health and/or substance use." ^e "I can help a woman manage her distress even if she begins to dissociate while talking to me." ^f "I can outline the steps to building useful organizational partnerships." ^g "I can recognize the signs of burnout or compassion fatigue and have strategies for self-care"

Retrieved from Mason et al. (2017) Table 3 (p.5)

Table 3 Correct responses between pre and post-test (knowledge and belief based questions)^a

Question No.	Pre-test (n = 624)	Post-test (n = 624)	P-value ^b
1	363 (58%)	500 (80%)	<0.0001
2	513 (82%)	567 (91%)	<0.0001
3	314(50%)	439 (70%)	<0.0001
4	228 (37%)	419 (67%)	<0.0001
5	540 (87%)	573 (92%)	0.0007
6	572 (92%)	558 (89%)	0.09
7	599 (96%)	602 (96%)	0.61
8	512 (82%)	551 (88%)	0.0004
9	367 (59%)	464 (74%)	<0.0001
10	537 (86%)	570 (91%)	0.0005
11	234 (38%)	255 (41%)	0.18
12	513 (82%)	573 (92%)	<0.0001
13	243 (39%)	315 (50%)	<0.0001
14	548 (88%)	595 (95%)	<0.0001
Total Correct Answers ^c	9.7	11.2	<0.0001

^aUnanswered questions were considered incorrect

^bMcNemar's Test was used to compare the difference between pre and post-test responses

^cFor average correct answers, a paired t test was used