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# Perspectives on Social Work

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# EDITORIAL – Building Scholarship in *Perspectives on Social Work*

Social work is a broad field with social workers across the globe engaging diverse populations in a variety of settings. The scope of *Perspectives on Social Work* (PSW) reflects this spectrum by accepting a variety of submissions covering a myriad of topics in social work. We ask only that submissions encompass social work values and ethical principles. As in the social work profession itself, the values of social work create a common thread for the papers we feature in our journal. We hope to increase the number of submissions we receive as we continue to offer a space for doctoral students to showcase their research.

In 2017, PSW launched several new projects to raise the visibility of our journal while increasing opportunities that support doctoral students and strengthen our peer reviewer network. Our efforts continue as we successfully hosted our second doctoral student networking event during the 2018 CSWE Annual Program Meeting. During SSWR, several PSW board members where in attendance where they had the opportunity to network and invite new doctoral students to become peer reviewers. In February 2019, we hosted a webinar titled, "Hey! You should publish your paper." The doctoral education journey can be a path filled with many unique challenges and struggles. One area that remains critical to the doctoral student's career is the ability to produce scholarly writing. This training taught best practices for turning an assignment paper into a manuscript. It was facilitated by our GCSW faculty member, Dr. Sarah Narendorf and our former PSW editor, Dr. Rebecca Mauldin.

In this issue, you will find three distinct articles that offer scholarship to important areas of social work research and education. Whitney Key (2019), utilized focus groups to learn more about the varying degrees of health literacy of individuals who participate in a cooking class at a social service agency in Chicago; specifically, how individuals understand how behaviors impact their overall health. Her findings highlight the importance of social connections gained in these cooking classes and how they impact the participants' health literacy. Abha Rai's (2019) study explores the extent to which domestic violence content is covered within MSW curriculum in the U.S. and further demonstrated recent increases of domestic violence content in MSW curriculum and in innovative teaching tools. Scott Sainato (2019) builds on his prior research where analyzed Youth to family violence or Non-Intimate – Partner Violence interventions and identified four factors pivotal to the intervention/treatment success. His current study explores these identified factors to conceptually understand why they are effective in addressing violent youth. This article also explores how social work professionals can effectively address violent youth through a practitioner, policymaker, and researcher lens while meeting ethical guidelines of the profession.

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*Editor*

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# Understanding health literacy in the Latino population

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## Abstract

The National Institutes of Health (NIH) defines health literacy as the "degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions." Latinos are disproportionally susceptible to poorer health literacy. Adult Latinos are more likely to suffer from chronic diseases at a higher rate; adult Latinos are 15% more likely to be obese, 45% more likely to have cervical cancer and 65% more likely to have diabetes. Understanding the mechanisms that lead to health literacy within the Latino community could lead to better health outcomes, as well as income, housing, and employment. These include health literacy screening, improving communication with low-literacy patients, costs and outcomes of poor health literacy, and causal pathways of how poor health literacy influences health. This study utilized focus groups to learn more about the varying degrees of health literacy of individuals who participate in a cooking class at a social service agency in Chicago; specifically, how individuals understand how behaviors impact their overall health. The study participants were predominantly Latino Spanish only speakers from low income communities. A total of eight participants who have attended at least four cooking classes in the last six months were included in the focus group discussion. The focus group was conducted in Spanish and observations were recorded by members of the research team. The focus group was open coded for thematic purpose and an interpretive theory was used. Findings highlight the importance of social connections gained in these cooking classes and how they impact the participants' health literacy. By the agency hosting these classes, individuals can create social networks that reinforce healthy habits within the home. It is important for social workers to understand the dynamics that health literacy classes or health literacy education has on their clients' health outcomes.

*Keywords*: health literacy, Latinos, qualitative study

# Introduction

The National Institutes of Health (NIH) defines health literacy as the "degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions." (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011). A statement from the World Health Organization (WHO) Commission on the Social Determinants of Health identified literacy as having a central role in determining inequities in health in both rich and poor countries (WHO, 2007). It is important to understand the role of health literacy in terms of health outcomes, as it effects individuals of every age, race/ethnicity, and education and income level. A study by Paasche-Orlow & Wolfe (2007), identified three causal pathways of health literacy namely; access and utilization of health care, patient and provider relationship and self-care. Self-care is being addressed in this study as it relates health and wellness choices that ultimately improve one's health.

It is known that higher health literacy leads to better health outcomes (Bennet, Chen, Soroui, & White, 2009; Howard, Gazmararian, & Parker, 2005). Although higher health literacy is common among developed countries, it does not always translate to the entire population. Chronic disease rates are disproportionately escalating among lower-income individuals because of the lack of education and resources in the healthcare field (Nutbeam, 2008). In older adults, health literacy is significantly less because of the marginalization of older adults in the healthcare field and the chronic disease rates are higher than the general population (Bennet, Chen, Soroui, & White, 2009). Therefore, there is an imperative need to increase health literacy among a higher need area.

Latinos are disproportionally susceptible to poorer health literacy. 41% of Hispanics (21 million persons) have low health literacy levels (Jacobs, Ownby, Acevedo, & Waldrop-Valverde, 2017). According to Families USA, adult Latinos are more likely to suffer from chronic diseases at a higher rate; adult Latinos are 15% more likely to be obese, 45% more likely to have cervical cancer and 65% more likely to have diabetes (Families USA, 2017). Chronic diseases, such as heart disease, cancer, diabetes and stroke are the leading causes of death for Latinos in America (CDC, 2013). In addition, Latinos aged 18-64 had a larger percentage of individuals who were uninsured in 2010 (2013). These poor health outcomes could be related to gaps in access to care, which is a form of health literacy, but could also be from the lack of self-care and relationships with providers (Paasche-Orlow & Wolfe, 2007). Seeing how the Latino population is rapidly increasing, yet the health of this population is not improving, this is a massive public health issue that needs to be addressed immediately. Increasing the health literacy of the population could help offset these adverse outcomes.

Calvo (2015) found that inadequate health literacy influenced Latino immigrants' quality of care beyond education and income, English proficiency, health insurance coverage, and having a regular place of care. Understanding the mechanisms that lead to health literacy within the Latino community could lead to better health outcomes, as well as income, housing, and employment. These include health literacy screening, improving communication with low-literacy patients, costs and outcomes of poor health literacy, and causal pathways of how poor health literacy influences health outcomes (Paasche-Orlow & Wolf, 2007). The information that this study can provide will influence the increase of health literacy and

how it is implemented into the Latino community. The objective of this study is to understand the mechanisms of health literacy in the Latino population.

**Literature Review**

One predictor to health literacy is understanding the social determinants of health and how literacy mediates or moderates those relationships. Social determinants of health are "the structural determinants and conditions in which people are born, grow, live, work and age" (Marmot et al., 2008, p. 1663). They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care. Racial minorities, low-income and other vulnerable communities experience health disparities more than the general population. Kaiser Family Foundation (2017) defines health disparities as "differences in health outcomes that are closely linked with social, economic, and environmental disadvantage". Researchers have discovered that social factors such as education, race, and socio-economic status, account for over a third of total deaths a year (Hieman & Artiga, 2015). These social factors are important to understand when considering the built environment impacts health, especially mental health care, and how this impacts the treatment of patients.

The Hispanic population in America is increasing at a rapid rate. In Chicago, the same is true; from 1980 to 2010, the Hispanic population doubled, growing from 14.1% to 28.9% of the total population (City of Chicago Department of Public Health, 2017). The Latino population experiences many physical and environmental stressors that make it imperative to have adequate health literacy and access to healthcare. The targeted neighborhoods of the study face high incidences of domestic violence, communicable disease, substance abuse, depression, anxiety disorders, gang violence, and injuries. Rates of mental health-related hospitalizations are significantly higher than the general population (CDPH, 2017). Yet, many remain uninsured or underinsured. An Illinois Health Matters study (2015) reported that 25% (818,488 people) of the adults in Cook County are uninsured and found that Latino adults comprise the largest percentage of uninsured persons at 39% (319,544 people).

A study found English proficiency as the strongest predictor of health literacy while further indicating the importance of primary and secondary language in the assessment of heath literacy level is needed (Jacobson, Hund, & Soto Mas, 2016). Therefore, basic literacy is a factor of health literacy, and with working with a population where English is a second language, this variable needs to be addressed. In DeWalt and colleagues' 2004 systematic review, low or inadequate literacy (compared to adequate literacy) was strongly associated with poorer knowledge or comprehension of health care services and health outcomes. Limited literacy was also associated with higher probability of hospitalization, higher prevalence and severity for some chronic diseases, poorer global measures of health, and lower utilization of screening and preventive services (2004). Knowing that the relationship between literacy and health outcomes is significant, it is necessary to screen for basic literacy levels within the medical system.

A survey by the International Latino Coalition found that Latinos often feel that the health care system in the United States is difficult to navigate, that they feel discarded from the system, and that they feel disconnected from the benefits of coverage and care (2015). This could be a direct result of lack of English literacy. The Centers for Disease Control and Prevention identified roughly 260,000 preventable deaths annually that occurred due to lack of regular doctor visits and lack of health insurance (CDC, 2013). Education of benefits, eligibility, and other resources related to healthcare- all of which contribute to health literacy- are all still significant barriers to minority health and have great consequences to

vulnerable populations without access to these resources. This speaks to the substantial need for health education and increased access to healthcare for vulnerable individuals, which will have significant direct and indirect impact on the health outcomes.

Subsequently, an unhealthy community is a large financial burden to the community at large. Chronic diseases are the largest cause of death in the world, which share key risk factors: tobacco use, unhealthful diets, lack of physical activity, and alcohol use (Yach, Hawkes, Gould, & Hofman, 2004). The World Health Report found that physical inactivity is responsible for 1% of Disability Adjusted Life Years (DALYs) lost globally and for 3% of those lost in established market economies (WHO, 2003). Specifically, most common chronic diseases are costing the economy more than $1 trillion annually—and that figure threatens to reach $6 trillion by the middle of the century (Allender, Foster, Scarborough, & Rayner, 2007; DeVol et al., 2007; Yach, Stuckler, & Brownwell, 2006). Although these statistics relate to the global burden of disease, this is especially costly for the United States as Latinos make up 16.8% (26.8 million) of the workforce and have a direct impact on the economy (Bureau of Labor Statistics, 2019).

There is a need to increase health literacy to better health outcomes among the Latino population in Chicago. Agencies around the area have implemented health and wellness programs to address this need however, few have evaluated whether these programs meet the health needs or address the health needs of their clients. This qualitative study utilizes a focus group methodology to examine how a cooking class in a health and wellness program increases health literacy in Latino community, specifically by understanding how nutritional behavior changes effect perceived physical differences.

## Methods

A focus group is the type of qualitative research methodology used in this study and was chosen because of its usefulness in accessing group norms and meanings (Bloor et al, 2001). Community-based participatory research is one that is bottom-up in terms of redefining health as an empowerment process. A co-constructionist design, whereas each participant has their own unique perception and truth, while interpretive and comparative approaches were used. An interpretive approach is understanding that access to reality (given or socially constructed) is only through social constructions such as language, consciousness, shared meanings, and instruments; and a comparative approach is when one compares one segment of the data with another to determine similarities and differences (Merriam & Tisdel, 2016; Bailey, 2018). These intentional choices of the research team allowed the voices of the participants to better understand the needs of the participants in the health and wellness program. This study was approved by the Loyola University Chicago Institutional Review Board.

*Sample*

Participants enrolled in a health and wellness program at a non-profit agency in Chicago were invited to participate in a focus group about their experiences in the program. Invitations were extended by the health and wellness leader by explaining the study at the beginning of each session. The aims of the health and wellness program were to 1) enroll participants in applicable health insurance programs; 2) teach participants the importance of exercise and dieting and; 3) measure the biometrics of participants.

One of the more popular activities offered is the cooking classes offered at three of the four locations in the city. These cooking classes not only teach the participants healthy cooking strategies on a limited budget, but also ways to integrate their cultural dishes by supplementing healthier ingredients. These cooking classes have been a popular component of the health and wellness program and have a high retention rate among participants (70%). Participants who have attended at least four of the cooking classes were asked to participate in a focus group regarding how health literacy has been addressed in the cooking class. A convenience sampling methodology was utilized and participants self-selected to participating in the focus group. Out of the 17 eligible participants, eight agreed to contribute. Spanish versions of the informed consent were distributed in paper format and were explained to participants; participants signed and kept a copy. This study was conducted under a protocol approved by the Institutional Review Board of Loyola University Chicago.

The demographics of the agency that was utilized for the study are predominantly Latino, Spanish-only speakers, and low-income. In total, eight participants, seven female and one male ranging from ages 19-67, joined the focus group. The overall demographics of the health and wellness program are skewed to having more females than males, therefore disproportionate sample represents the larger sample of the participants in the health and wellness program. Food and refreshments were provided in accordance to the health and wellness goals and no other compensation was given.

*Qualitative Approach*

A thematic analysis approach was used to gain a greater understanding of patients' health literacy and perspectives on self-care specifically related to barriers to nutrition and subsequently any adherence strategies they adopt. Qualitative methodologies are particularly important for the development of conceptual frameworks that focus on the individual, developmental, and sociocultural contexts in which behavior occurs. A better understanding of these can serve as an essential guide to intervention development. This approach also helps us understand some of the cultural issues within a group sharing a similar, potentially life-altering experience.

The focus group was a semi-structured interview that included six open-ended questions around participants' experience in the health and wellness program, their thoughts about their own health, and motivation around health. Constructivist frameworks guided the creation of the semi-structured interview guide (the English version of the questionnaire is below in Figure 1).

Although the instrument was not pretested, the questions did come from observations from the researcher and agency, meaning that the instructor noticed that there were misconceptions about nutrition and health in the community and wanted to know if the health and wellness program helped dispel them and ultimately, improve overall health.

*Figure 1*

| |
|---|
| 1) How is your overall experience in the health and wellness program at AGENCY? |
| 2) How do you feel your health has changed since participating in this program? |
| 3) What made you decide to participate in the health and wellness program? |
| 4) Sometimes what motivates us at a starting point is different than what motivates us to continue with something. What motivated you initially in the program, and what has motivated you to keep going? |
| 5) How do you feel your social networks have changed since you've participated in the health and wellness program? |
| 6)We've talked about goals, motivation, barriers…how do these things come together for you? |

The focus group was conducted in Spanish and was digitally recorded. Three members of the health and wellness team took copious notes, observing physical reactions, and key points. The focus group lasted one hour and after the participants left, the staff and research team de-briefed in English. The transcripts were translated from Spanish to English then back to Spanish for rigor and accuracy. The transcripts were triangulated with the notes taken by the research team and were open coded by hand by four research team members.

To ensure internal validity, the codes were discussed among the research team and themes were determined by the group. An inductive analysis was used because it allows for the patterns, themes, and categories of analysis to emerge. The descriptive analysis described the respondents' life situations and characteristics while the thematic analysis elaborated the structures of the basic constructs and new constructs that arose in the early analysis. Two readers reviewed transcripts to identify all relevant ideas. Their notations were compared and discussed. The process was repeated until there was agreement on the ideas and concepts. Some of the concepts were broken down into various subcomponents of the theme.

## Results

A thematic analysis was used in interpreting the results from the focus group. From the hour-long focus group, five themes emerged from the cooking classes: learning to cook better, social support, feeling of acceptance, and mental and physical health outcomes.

*Learning to Cook Better.* The purpose of the healthy cooking classes was for participants to learn how to cook better, therefore it is no surprise that this was a key outcome of this study. Participants overall said that they practice the lessons learned in the cooking classes at home and have subsequently changed their eating habits because of this.

*...know certain vegetables, but I would not take others because I did not know how to use them*" *[Latina woman, recent immigrant to the United States, age 62].*

Another participant said in reference to how the cooking classes have taught her how to make better choices when grocery shopping.

*I followed because I learned many recipes and I like how Andrea [cooking class instructor] teaches them. Well now I'm more excited because I know what it is and I like to go [Latina woman, mother of two children, age 19].*

Most participants spoke about how attending the healthy cooking classes have helped them make better choices for them and their family members when grocery shopping.

Since many participants were low-income, and therefore receiving Supplemental Nutrition Assistance Program (SNAP) benefits, food ingredients included items that were affordable and could be procured through a food pantry. An example of this was using a recipe that included both fresh and canned vegetables. One woman who recently migrated to the United States from Chile mentioned that she did not know what canned vegetables were and could not afford to make healthy meals for her and her daughter

on her SNAP budget alone, but because of the cooking class, she was able to integrate canned vegetables from the food pantry into her diet and therefore was able to re-budget her food. These cooking lessons allowed her to incorporate affordable, healthy items into her meal plans by teaching her ways to supplement different types of food.

*Social Support.* Social support was also a main finding of the study. The social support gained from the cooking classes not only reinforced bonds among the participants, but it also gave the participants motivation to teach their friends and family the lessons gained at home. One participant said that she was sending the recipes to her family members back home in Mexico.
*the recipes to encourage them [to eat healthier] [Latina woman, first generation, age 53].*

Another mentioned that family discussions revolve around food and therefore, have strengthened family bonds.

*After 4 weeks, a lot of the conversations in my home have changed. With my daughter-in-law, it used to be just hi and bye. When I showed my family the video of us cooking, they were asking me where I was at. I talked to them about it. …Therefore, the conversations have changed in my group. Now we talk more about food. We have bible classes and we talk about the importance of a diet" [Latino male, first generation, age 60].*

The cohesive nature of the class has also made the learning environment supportive for the participants and has held them accountable for making healthier choices in the home. One participant mentioned that she was intimidated at first about coming to the classes but because of the supportive nature of the class, but other members have encouraged her to come and participate. She now has attended over four classes and has incorporated these recipes at home.

*As I said, to continue learning and the reason I have continued is because I like how Andrea gives her classes. I believe that not only does the body have to change (food) but also involve meditation, exercise, etc. We all have many needs - not just looking after food. Everything she has said I have already heard it but it is important that more be heard. You have to be well in many areas. I followed because I learned many recipes and I like how Andrea teaches them. Well now I'm more excited because I know what it is and I like to go [Latina woman, age 40].*

This nature of social support within the classroom has led to the next theme of feeling accepted within the classroom and the community at large.

*Mental Health Outcomes*. Through the supportive and educational nature of the classroom, participants mentioned the transformation they encountered throughout the course. Many mentioned the motivation to change eating and lifestyle habits. One individual mentioned her desire to increase her well-being.

*I always want to be involved, especially in well-being. Where I work, I also did something similar - to learn healthy eating. If I come it's because I want to continue learning and I like all this natural and I have always liked it [Latina female, age 19].*
Another spoke about the motivation she had throughout the process.

*Sometimes the things that motivate us in the beginning are different from what motivates us to continue doing something. That motivated them in the beginning and because they have continued with that motivation to continue going to the classes [Latina female, age 53].*

Many of the participants noted the feeling of acceptance within the classroom, which speaks to the previous finding of social support. One individual said:

*I am very happy and thanked them for accepting me for a program that was not for me. I've already been accepted [Latina woman, age 40].*

Another said that her daughter was no longer involved at the agency; however, she was still able to attend the classes and she was incredibly grateful for that.

*Also, thank you very much to everyone. My daughter is no longer part of [agency] for two months but I could still come here [Latina woman, age 67].*

The one male in the group mentioned his apprehension of attending the class because of his gender. He said that he not only learned from the class, but he felt accepted in attending and continued to learn from the class.

*The only thing is that they are just women. I do not know if they feel uncomfortable with me there. But it has always caught my attention to learn. This is the response from the man who meant that he didn't know how he'd be received in an all-female group, but now feels accepted" [Latino male, age 60].*

*Physical Health Outcomes*. The cooking classes helped participants modify their eating habits and make healthier choices. Some of these modifications led to outcomes regarding participants' physical outcomes such as weight loss, more energy, and better digestion.

*I've already lost 21 pounds by leaving out oils and flours" [Latina female, age 67].*

*Since I started to take care of more and eat more natural I have felt more energetic, my skin feels different" [Latina female, age 19].*

*And my health, now that I feel I have lost weight. I feel lighter. You feel yourself in your body when you change clothes or something like that or by tying your shoes" [Latina female, 53].*

Besides the weight loss and the increased energy, most of the participants noticed the connection of food and fluids and the digestive process. Some of the parents in the room complained how they or their children were having difficulty going to the bathroom. These cooking classes took a holistic approach to teaching individuals about food and therefore, addressed all aspects of the digestive process. After participating in the classes for a while, one said,

*I give her [daughter] granola and I give her different things and she goes to the bathroom more often [Latina female, age 19].*

*I drink a lot of fluids, but I take it alone and it has helped me a lot with digestion [Latina female, age 67].*

This outcome is important because the participants who were having difficulty with the digestive process mentioned that they were taking laxatives and other medication to help with this issue and since attending the classes, they have ceased the use of them.

## Discussion

The cooking classes that took place increased the participants' health literacy by engaging them in the food preparation and cooking process by explaining the health benefits of certain foods. These classes not only engaged the participants in the learning process, but also empowered them to take the lessons learned back to their families and friends. The holistic nature of the classes not only taught the participants how to cook, but the benefits of healthy cooking and the impact of healthy cooking can have on them physically and mentally. This process addresses the self-care causal pathway in the Paasche-Orlow & Wolf (2007) model of health literacy. In addition, these classes spoke to the definition of health literacy in which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011).

One theme that stood out was social support. There has been strong evidence linking social support to positive health outcomes. Evidence supports that the more social support one has, the better health that individual has (Rikard, Thompson, McKinney, & Beauchamp, 2016; Gottlieb, 1985; Sarason, Levine, Basham, & Sarason, 1983). Many of these studies explore the correlation between the two. Some have focused on the process that social support has on general well-being and life satisfaction (Adam, King, & King, 1996; Cohen & Wills, 1985). Studies have focused on both the positive and negative effects of personal relationships on one's health through a stress model. Cohen and Wills hypothesized that one way is a direct model where the support relieves stress from the individual (1985). The other is a buffering effect, meaning when someone is under stress; the social support comes through and potentially protects the person. Similarly, another study found that personal relationships have a profound impact on work and life satisfaction and that the nature of the relationships- i.e., conflict vs support- have a greater impact on work performance (Adam, King, & King, 1996). In another study investigating older adults' involvement in social activities and health behaviors, the primary outcome was that there was a strong association with positive health behaviors and social support (Sarason, Sarason, Shearin, & Pierce, 1987). The ultimate result from these studies is that social support has a large effect on one's health.

Social support can increase health literacy by making individuals accountable for their actions and empowering them to make healthy decisions in the home. This was evident in the cooking classes by the participants creating an environment of acceptance and supporting one another to make healthy decisions in the home. This supportive environment empowered individuals to teach their family members what they learned in the classroom, which strengthened the familial and social bonds. This passage of healthy

information from the classroom to the home has increased the health literacy of the family because of the practice of new healthy choices their family members are using and the health outcomes they are reporting, such as weight loss and digestive improvements. As Jacobs et al (2017) discovered in their study investigating health literacy among Latinos with chronic disease, certain psychological and sociocultural variables might influence managing chronic illness including medication adherence, but the details provided by participant narratives provided a deeper, richer understanding of the underpinnings and possible interrelatedness of these factors.

This qualitative study is not without limitations. The participants who chose to participate were self-selecting, meaning that they chose to partake in the study, and therefore, it is not a true representation of the feelings of everyone participating in the health and wellness program and is prone to bias. In addition, the demographics were skewed in that there were seven females to one male, opening the group up to gender bias. The instrument was not pretested and therefore, could possibly not truly reflect the sentiments of the group.

## Conclusion

Health literacy and social support are linked to positive health outcomes. This is very important for populations that face a host of chronic health outcomes. Social workers need to understand the connection of culture and ways of learning when it comes to health literacy. For the Latino population in particular, social learning is important for increased health outcomes. By incorporating a cohesive social environment, one could increase health literacy among a population.

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# State of Domestic Violence Content in MSW Curriculum in the U.S.

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## Abstract

Domestic violence remains a serious concern in the U.S. and stopping family violence is one of the 12 grand challenges for social work. Further, the core values of our profession are deeply rooted in social justice, dignity and worth of the person and importance of human relationships. This makes the preparedness of social work students to address domestic violence crucial. Social work students need to be provided with support to work with survivors, perpetrators and their families, while engaging in prevention of domestic violence. The present study explores the extent to which domestic violence content is covered within MSW curriculum in the U.S. Out of the 266 MSW schools accredited by the CSWE; we received 64 responses with a 19.5% response rate. About 70.4% of the programs surveyed offered at least one dedicated course on domestic violence. While there still remains a great need to expand the domestic violence curriculum in MSW programs, this study demonstrated recent increases of domestic violence content in MSW curriculum and in innovative teaching tools.

*Keywords:* domestic violence, social work curriculum, teaching tools, competency

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## Introduction

Domestic violence is a serious concern in the U.S. The National Coalition Against Domestic Violence (2015) defines domestic violence (DV) as willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. The estimates by the Centers for Disease Control and Prevention (CDC)'s National Intimate Partner and Sexual Violence Survey show that between 9.7 - 32.4% of women and 2.3 - 28.3% of men in the U.S. have experienced stalking, sexual and physical violence by an intimate partner in their lifetime (Smith et al. 2017). There are several social, economic, behavioral, mental and physical health concerns that are associated with experiencing DV (Callahen, Tolman & Saunders, 2003; Miller-Perrin, Perrin & Renzetti, 2017). These concerns may impact the quality of life experienced by

survivors. Individuals who have experienced DV are more susceptible to re-experiencing violence at a later point in their lives (Hendy et al., 2003; Miller-Perrin et al., 2017).

According to the national survey conducted by the National Center for Injury Prevention and Control, the most common groups to whom abuse is disclosed includes friends, family members, counselors, the police, health care professionals, and crisis hotlines (Breiding, Chen & Black, 2014). This means that social work professionals such as case managers, therapists and counselors, are very likely to make contact with survivors of DV. Social work professionals could also be actively engaged in working with the families of survivors through bystander interventions or with perpetrators through accountability programs. Of note, stopping family violence is one of the 12 grand challenges for social work (Edleson, Lindhorst, & Kanuha, 2015). The 12 grand challenges are a call to action for social work to tackle serious, interrelated, and large-scale challenges, to promote individual and family well-being and a just society. Further, the core values of the social work profession as highlighted by the NASW Code of Ethics elucidate the importance of social justice, dignity and worth of the person and of human relationships (NASW, 2017). This makes it critical for social work students to learn evidence-based DV interventions and be skilled in collaborating with health care and criminal justice professionals to provide services to survivors, their families, as well as perpetrators, while engaging in DV prevention.

**Existing knowledge about Domestic Violence Curriculum**

In a 2003 investigation, the National Institute of Medicine found very little systematic educational content on family violence in schools of social work in the U.S. There were only three out of 258 BSW and five out of 74 MSW programs that offered DV courses (Cohn, Salmon & Stobo, 2002). Danis and Lockhart (2003) observed no social work professional standards or competencies for addressing DV. They identified only two articles on DV published in the *Journal of Social Work Education* in the 20 years between 1983 and 2003. Until 2002, publications around inclusion of content on DV in social work curriculum were extremely rare (Cohn et. al., 2002; Danis & Lockhart, 2003; Warrener, Postmus, & McMahon, 2013). Social work students often faced difficulty in integrating the vast body of research and literature while trying to understand how to work with survivors of violence (Begun, 2014).

In a study conducted by Tower (2003) with medical social work students (n=188), it was found that 36% of students had no exposure to DV during their MSW education, while 64% received some information during coursework. Furthermore, only a small percentage (25%) of the sample indicated having a standalone course on DV. In a survey by Black, Weisz, and Bennett (2010) conducted with social work MSW students (n=124) to assess their ideas about DV, the authors found that the students lacked knowledge and expertise about intervening tactics that could be helpful for DV survivors.

Studies have shown that DV courses and training are a crucial component in MSW programs. This training has a positive correlation with improved attitudes, clearer beliefs, and effective professional efficacy to work with DV survivors (McMahon, Postmus, Warrener, Plummer, & Schwartz, 2013; Postmus & Merritt, 2010; Postmus, McMahon, Warrener, & Macri, 2011; Wilkin & Hillock, 2014). However, social workers did not feel that they were prepared during their MSW education to address DV (Danis, 2003). Stover and Lent (2018) proposed 180 hours of training with guidelines on DV intervention as a national standard for providers as they found the lack of such training among social workers could be detrimental to the lives of survivors.

Since the study by Danis and Lockhart (2003), there has not been a study that examined DV content in social work curriculum. The extent to which DV courses are being taught in social work programs and the manner in which social work competencies are incorporated within DV courses are not fully known. In addition, it is not enough for social work students to just be able to read about DV through research studies to be able to effectively work with DV survivors/ perpetrators and their families. Without actually receiving education and training on DV (i.e., definition, types, and cycles of DV, impact of DV on children, legal options for DV survivors and their families, screening of DV, safety planning, crisis intervention, etc.), many students will be unequipped to effectively assist DV survivors/perpetrators and their children.

The purpose of this study are to examine: 1) the perceptions and availability of DV courses in MSW programs and, 2) the academic content on DV, teaching methods, and the extent of its congruence with the Council on Social Work Education-Educational Policy and Accreditation Standards (CSWE-EPAS) competencies. Our study will be instrumental in filling gaps about the limited knowledge pertaining to the extent to which MSW programs incorporate a DV curriculum and; in understanding the manner in which CSWE-EPAS competencies are incorporated into the content being offered by MSW programs. Our study will be the second national study after Danis & Lockhart's study (2003) to explore social work curriculum on DV across accredited MSW programs in the U.S.

## Method

### Research Design and Data Collection

This study employed a cross-sectional design (Engel & Schutt, 2013) to explore the current state of DV content in social work curriculum in the U.S. An approval to conduct research from the Institutional Review Boards (IRBs) at the authors' Universities was obtained prior to conducting the study. Data was collected online via Qualtrics from January to February in 2017.

The names and contact information of MSW program directors/chairs from 266 CSWE accredited MSW programs in the U.S. were obtained from the CSWE website. The reason for focusing on MSW programs was because MSW is considered a terminal degree for the profession (Anastas & Kuerbis, 2009). This makes it essential for social workers with a MSW to be prepared to address DV before they begin engaging in micro and macro DV practices and intervention delivery.

An email with an online survey link was sent to 266 MSW program directors/chairs in the U.S. Additionally, personalized email requests to complete the survey were sent to some MSW program directors and faculty of schools of social work that were known to the authors. A DV listserv was also used to send the survey to DV researchers who may be knowledgeable about DV courses offered by their social work programs. They were asked to either complete the survey themselves or forward it to the MSW director/chair of their social work programs. The body of the email explained the purpose of the study to the participants and provided them with a link to the survey. The email consisted of the contact information of the primary investigator (PI) and the IRB, in case the participants had any questions or concerns regarding the study. Survey methodologists such as Dillman, Smyth and Christian (2014) recommend two to three reminders to surveys in order to increase the response rate. Therefore, two

reminder emails were sent to the participants between January- February 2017.

The first page of the survey consisted of a consent form for the participants, which included the purpose of the study and emphasized upon the voluntary nature of participation. It was made clear through this consent form that the participants had the option of leaving the survey at any point. To protect confidentiality, no identifying information was collected, and the participants were not asked to sign the consent form.

**Survey Questions and Data Analysis**

It took approximately 10-12 minutes to complete the survey with average-to-good internet speed. Because DV and intimate partner violence (IPV) are used interchangeably, we included both terms in the survey. The questions included in the survey were: Type of college (public, private or religiously affiliated), size of the program, opinions on the need for DV/IPV courses in MSW program curriculums, the number and type of DV/IPV courses offered, duration for which the courses had been offered, the number of students who enrolled in the courses, and the number of faculty members who were considered as DV/IPV experts.

To understand the academic content on DV/IPV being incorporated in classrooms and the extent of its congruence with the CSWE-EPAS competencies, we provided the participants with an option to email syllabi of the DV/IPV courses offered at their programs. The online Qualtrics file was imported to Statistical Package for the Social Sciences (SPSS) 24 to analyze the data (Berkman & Reise, 2012). A thematic analysis was used to analyze the DV/IPV course syllabi. Research notes were maintained by the researchers throughout the process of data collection and analysis.

## Results

The section below describes the findings of the present study. The findings have been divided into subsections discussing program characteristics, participant perspectives on DV/IPV courses, types, titles and levels of MSW courses offered, syllabi analysis and other findings.

**Program Characteristics**

Out of the 266 schools, we received 64 responses with a 19.5% response rate. Table 1 lists the program characteristics of the study respondents. The respondents representing public, private, religiously affiliated universities were 66% (*n*=37), 21% (*n*=12), and 13% (*n*=7), respectively. Most of the MSW programs had 0-100 students (25.9%) or 101-200 students (27.8%), and 11.7% of the programs had larger than 1,000 students (see Table 1).

**DV Course Offerings and Participant Perspectives on DV Courses**

*MSW students and their learning of DV/IPV.* When asked about the level of agreement with the following statement, "MSW students should learn about domestic violence or intimate partner violence," the overwhelming majority of the respondents agreed (18%, *n*=12) or strongly agreed (64%, *n*=41). Interestingly, there were differences in responses depending on the type of university. Among the respondents from public universities, 80.6% (*n*=30) agreed/strongly agreed that MSW students should learn DV/IPV content, while 75% (*n*=9) of the respondents from private universities affirmed agreement (strongly agreed or agreed). It is noteworthy that 100% (*n*=7) of the private religiously affiliated universities strongly agreed that MSW students should learn about DV in their classroom.

*MSW programs and dedicated DV/IPV courses.* When asked if the MSW programs should offer dedicated courses on DV, a significant number of participants agreed or strongly agreed (67%, *n*=43) on the need for having a dedicated course on DV/IPV. The need for having a dedicated DV course also differed by university type. 63.9% (*n*=25) of public universities, 66.7% (*n*=8) of private universities, and 85.7% (*n*=6) of religiously affiliated universities agreed or strongly agreed on the need of having a dedicated course on DV/IPV.

It was reported that 27.8% (*n*=15) of the MSW programs did not have any dedicated courses on DV/IPV. Furthermore, 59.3% (*n*=32) of the programs had one dedicated course on DV/IPV, 7.4% (*n*=4) had two courses, and 5.5% (*n*=3) had more than two courses (see Table 2).

Of the MSW programs that had dedicated DV courses, 70.3% (*n*=26) said that the course was offered every year as an "elective", while only one school "required" a DV/IPV course (see Table 2).

*Students enrolled in DV courses.* When asked about how many students take courses on DV/IPV every year, 39% (*n*=25) reported 1-20 students, 50% (*n*=32) reported 21-50 students, 11% *(n*=7) reported 51-200 students. Additionally, 78% of the programs reported the presence of a "DV/IPV expert" among their faculty.

**Types, Titles and Levels of MSW Courses Offered**

When asked about the type of DV/IPV course offered, 47% (*n*=20) reported that they had an overview course (which broadly provided an overview of DV), 42.9% (*n*=18) programs had a micro level course (which provided an explanation of DV at an individual level and had a clinical focus), and 9.5% (*n*=4) had a macro level course (which explained DV as a larger problem both of the individual and the society and focused on the discussion of systemic-level gaps) (see Figure 1).

Furthermore, respondents were asked about the title of the courses they offered; 40% (n=12) of the course titles had the term "IPV," 23% (n=7) of the course titles had the term "family violence," 17% (n=5) of the course titles had the term "domestic violence," and 10% (n=3) of the course titles had the term "community" in addition to IPV/DV/family violence, and 10% (n=3) had other terms, such as "women's studies", "abusive family systems", and "marriage and family systems" in addition to "IPV/DV/family violence" (see Figure 2).

**Thematic Analysis of DV Course Syllabi**

This section presents an overview of eight MSW level syllabi provided by the respondents. The courses ranged from seminar courses, clinical practice courses, or macro practice courses. Only one of the reviewed courses was offered online. All the courses were offered in the second year of the MSW program. Some syllabi specifically mentioned prerequisite course requirements, such as having taken direct practice classes before opting for a course on DV/IPV.

*Course Objectives.* The general objectives of the courses were tied to CSWE-EPAS competencies, course contents, assignments, and other evaluations. Some of the course objectives were: (a) understanding the prevalence, types, impact, dynamics, and complex nature of IPV/DV, (b) learning

the impact of diversity and oppression, (c) awareness of ethical responsibilities, dilemmas, and culturally responsive interventions, (d) capacity to conduct safe and effective risk assessments and safety planning, (e) demonstrating knowledge of culturally sensitive interventions and best-practices, and (f) demonstrating knowledge of an array of systems and services. To a large extent, the objectives were similar across courses with slight modifications based on the emphasis of the course. One exception to these objectives was a clinical practice course describing the broader objective of the course as enhancing student's skills in identifying, assessing and/or intervening either along or on behalf of family members in cases where DV exists.

*Teaching tools.* In addition to in-class teaching-learning, online activities such as forum discussions, reading reviews and out of class activities such as mock intervention case studies with clients, were incorporated to enhance comprehensive learning goals. In seminar and clinical courses, one of the major components in instruction was special guest lectures from researchers and practitioners in the areas of DV/IPV and other forms of violence. The assignments and teaching contents were systematically in-line with EPAS competencies (CSWE, 2015), which will be discussed in a later section.

*DV topics.* The general topics largely covered by most courses were the historical and cultural dimensions of gender oppression and its linkages with DV (such as the impact of DV on children, law, policy, practice and ethics). The syllabi we collected broadly focused on the U.S., although there were some that focused on DV internationally, giving special attention to The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the role of international organizations in the context of DV. One syllabus was systematically designed with a life-span approach to DV beginning from early childhood until old age. Topics such as cyber stalking, teen dating violence, DV issues of military personnel, the economic dimension of DV, and DV against LGBT, (dis)abled, older adults and other vulnerable populations were integrated into half of the syllabi. There was just one syllabus that discussed DV in relation to immigrant and refugee women and their unique needs while experiencing DV.

**Assignments, evaluations & CSWE competencies.** Evaluation of students is an important component in achieving course objectives and fulfilling the EPAS competencies (CSWE, 2015). Across the macro, clinical, and seminar courses, there were safety planning assignments and mock simulations (*competency 1*- demonstrating ethical and professional behavior; *competency 2*- engaging diversity and difference in practice). In a seminar-based course, the student's evaluation included assignments on topics around practice-based learning and IPV interventions, integration of theories, practical solutions along with assignments on safety and IPV advocacy (*competency 4*-engaging in practice-informed research and research-informed practice; *competency 9*- evaluate practice with individuals, families, groups, organizations and communities).

Clinical courses incorporated reflective assignments to understand students' knowledge about DV from the perspective of family members and social workers (*competency 3*-advancing human rights and social, economic and environmental justice; *competency 6*- engaging with individuals, families, groups, organizations and communities; *competency 7*-assessing individuals, families, groups and organizations and communities; *competency 8*-intervening with individuals, families, groups, organizations and communities). Some courses placed more emphasis on the engagement of students with reflective papers and others on the theory and history of oppression and feminism (*competencies 3 & 4*.) These assessments were expected to assess the students' ability to synthesize course learnings and the extent of

their reflexivity. One course emphasized macro policy-based learning by observing court proceedings on DV. The students were then expected to record their observations on paper (*competency 5*-engage in policy practice).

It is important to note that some of the courses had a major emphasis on values and ethics while reflecting on DV. Some syllabi listed details of practice behaviors under each of the learning competencies. The use of competency-based evaluation assignment strategies included in the syllabi allowed students to demonstrate knowledge, skills, values, cognitive, and affective processes.

## Discussion

Integrating DV in social work curriculum was one of the key recommendations in a summit on violence against women organized by Office on Women's Health (OWH) of the U.S. Department of Health and Human Services (NASW, 2002). In addition, the emphasis on strengthening the curriculum on DV has been expressed in various forums and through initiatives by national social work organizations like CSWE, National Association of Social Workers (NASW), and Society for Social Work and Research (SSWR). Despite such a strong push toward integrating DV courses within the social work curriculum there have been gaps; which our study endeavored to fill. The purpose of our study was to explore gaps in research pertaining to the extent to which a cohesive DV curriculum has been employed in MSW programs in the U.S. We were also interested in exploring the utility of the CSWE-EPAS competencies across the syllabi employed by schools teaching a DV course.

In recent times, the American Academy of Social Work & Social Welfare has classified, Stopping Family Violence as one of the 12 Grand Challenges of social work. They promote violence-free relationships, communities, and encourage a safer space for children (Edleson et. al.,2015). Social workers are bound to promote social justice, dignity and worth of the person and safeguard human relationships (NASW, 2017) making it vital for them to be adequately trained and skilled in working with DV survivors and their families. It is imperative that social work students are trained in addressing DV situations, providing the necessary support to families and contributing toward ending family violence. More so, it is essential that schools of social work integrate these core values of the social work profession into the syllabi used to train students in working with DV survivors and their families.

The present study shows that in the past 15 years since Cohn et al.'s (2002) and Danis and Lockhart's (2003) study, social work education has made some progress in educating social work students on DV by offering more dedicated DV courses to MSW students. We saw that out of our respondents, at least 32 schools had one dedicated DV program. Among our sample, 15 programs added dedicated courses on DV in the past five years. Moreover, a large proportion of the participants in our study agreed with the need to enhance MSW course content with DV specific courses. Even the social work programs that did not offer DV courses, expressed the need to introduce DV courses in their curriculum.

In this vein, it is essential for social work program administrators to constructively support these curriculum modifications. Creative learning strategies used in classrooms not only involved basic knowledge-level learning, but also yielded the attainment of higher-order thinking through learning by doing (Danis, 2016; Vermunt, 1996). Such creative methods of content delivery help in the teaching of a sensitive and complex topic such as DV/IPV. Additionally, field placement and practicum courses across

MSW programs can be helpful in providing hands- on learning experiences to students in working with individuals experiencing DV. MSW programs are encouraged to focus on placing their students in DV agencies to offer students an opportunity to directly interact with families facing DV. In-class discussion about the experience of these students would also be beneficial to others who are not in a similar placement.

There has also been increased infrastructural progress on constructing specialized DV courses, although there is more thrust on such DV-focused courses at public and private universities in comparison to private religiously affiliated universities as noted in our study. Religion is often a reason DV survivors stay in abusive relationships, and sometimes abusers use scripture to reinforce their power and to control survivors. Spiritual abuse is a commonly occurring power and control tactic among immigrant families (Bent-Goodley, St. Vil, & Hubbert, 2012; Choi & Cramer, 2016). MSW students at religiously affiliated social work programs may have more opportunities to interact with religious survivors of abuse through placements. Therefore, it is even more important for them to learn about DV and be aware of how religion can be a roadblock, as well as a resource, for survivors and their families.

*Recommendations for Social Work Education*

It is evident that there has been progress in the field of social work education when it comes to training students on issues around DV. However, there are a few areas for improvement on DV courses. First, the course content should incorporate discussion on the issues of culture, diversity, oppression, and social justice vis-à-vis DV, so that social work students can develop a working knowledge and sensitivity to issues specific to DV and diversity (culture, race, ethnicity, gender, economic level, developmental state, disability, immigration status, and sexual orientation). While we do not know the extent to which discussion of culture and diversity are included in all the DV courses offered in the sample, there were only a few syllabi that we reviewed that depicted the emphasis on the intersections of class, race and gender while addressing DV.

Crenshaw (1991), in her research on battered women, stated that the victims of DV in Los Angeles were mostly poor women and women of color, and disproportionately likely to be unemployed. She observes that the race, gender, and class convergences, and generic interventions will have limited scope in these cases. Similarly, women from immigrant communities face unique and additional challenges in accessing legal and social services (Cramer, Choi & Ross, 2017; Danis & Lockhart, 2003) as they have unique needs (Rai & Choi, 2018). However, only one syllabus we reviewed included content on immigrant survivors of DV. The focus on diversity is integral within a social work DV curriculum, as incorporating diversity and difference in practice is one of the competencies of the CSWE-EPAS (2015).

Second, the findings point toward the need to employ innovative ways to offer DV content to more MSW students (i.e., online or hybrid courses). While we do not know the portion of DV courses being offered online among our sample, only one syllabus we reviewed indicated that it was offered online. Offering DV courses online will certainly increase the accessibility of courses for MSW students; however, it is important to consider the utility of teaching asynchronous online courses on DV. Danis (2016) recommends that while teaching an online DV course, there should be an opportunity for students to pursue their assignments with clients, more opportunities for group activities, periodic review/feedback of content delivery, and sharing of innovative resources across social work programs so as to enable a

more holistic learning. Innovative classroom and virtual environments, incorporating aspects such as technological tools, flipped classroom learning, digital classroom learning, are more effective in content delivery (Danis, 2016; McKeachie, & Svinicki 2010). We believe that further introduction of innovative teaching strategies, including hybrid courses, more engaging online content, flipped classroom learning and guest lectures by experts can help close this gap in online teaching of DV. Field placement liaisons and coordinators are encouraged to work with DV agencies so that students have an opportunity to directly learn by interacting with families facing violence.

Finally, in addition to educating and training MSW students on clinical interventions with DV survivors, DV courses should also encourage students to engage in DV policy practice. The Violence Against Women Act (VAWA) and Trafficking Victims Prevention Act (TVPA) provide important protections for survivors, including immigrant survivors of DV, sexual assault, and human trafficking. Therefore, it is essential for social work students to be educated on policies like VAWA and TVPA that protect survivors of DV. Furthermore, DV courses should provide an opportunity for social work students to engage in policy practice, analyzing policies' impact on survivors of DV, and calling on elected officials and law enforcement officials to help create an environment that does not leave certain survivors of DV in danger (i.e., immigrant survivors).

*Limitations*

This study provides an important contribution toward building literature around the current state of DV content in MSW curriculum. In addition, the recommendations on understanding the need to create such content and the areas in which the content needs to focus on, are noteworthy. Despite this, there are a few limitations to the study. The first is the 19.5% response rate, which may impact the generalizability of the results. With the response rate of 19.5%, this study has a higher response rate than a similar study conducted in 2003. However, it still does not capture 80% of CSWE accredited MSW programs in the U. S., which may or may not offer dedicated DV courses. Lastly, while the attempt of the research study was to posit a comprehensive state of DV content in social work curriculum, the researchers were only able to access eight full length syllabi, which limits the in-depth understanding of DV courses offered to MSW students. Therefore, a more comprehensive study that also examines the websites of MSW programs and obtains and reviews syllabi of DV courses would be necessary to obtain a full picture of the status of DV content in social work education.

## Conclusion

We believe that our study has been helpful in filling the gap in research of social work education by examining the extent to which DV curriculum is being integrated in MSW programs. Our study is the most up to date after the study conducted by Danis & Lockhart (2003). Despite the seemingly small ($n$=32) number of MSW programs with at least one DV course, we have seen an overall consensus about the importance of a DV course across MSW programs that were surveyed. The syllabi that we received were aligned to the CSWE-EPAS competencies making it clear that schools are focused on integrating core competencies among future social work personnel working in the area of family violence. These competencies are closely aligned to the core values of the social work profession as enlisted in the NASW Code of Ethics (NASW, 2017).

With significant progress made on educating social work students on DV, surveying MSW students and social work practitioners regarding their knowledge and competencies to address DV would help evaluate the true impact of increased content on DV in the social work curriculum. It is imperative that the next generation of social workers are well equipped to provide DV intervention and prevention services, which will ultimately contribute to the grand challenge of stopping family violence and staying authentic to the core mission of the profession. The role of social workers is crucial in addressing family violence and ensuring the safety of children. We urge national level organizations such as CSWE, SSWR, and the NASW to develop social work professional standards or social work competencies for addressing DV. Finally, social work educators, researchers, students are all urged to collaborate on developing expertise on best practice models suitable for preventing and addressing DV.

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# Determining the effectiveness of interventions for NIP-YFV

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## Abstract

Youth to family violence or Non-Intimate – Partner Violence (NIP-YFV) is a serious issue affecting youth, families, and communities (Sainato, 2018). NIP-YFV is any physical or psychological harm committed by the youth against a family member. This article is a follow-up to Sainato's (2018) study which was one of the first to analyze NIP-YFV interventions for effectiveness with violent youth. Four factors were identified as pivotal to the intervention/treatment success. This article further explores these identified factors to conceptually understand why they are effective in addressing violent youth. This article also explores how social work professionals can effectively address violent youth through a practitioner, policymaker, and researcher lens while meeting ethical guidelines of the profession. Implications and recommendations are further discussed to build on this study to take a step towards reducing and eliminating NIP-YFV.

*Keywords*: non-intimate partner violence; family violence; youth violence; youth to parent violence; youth violence interventions

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## Introduction

Youth to family violence or Non-Intimate – Partner Violence (NIP-YFV) is a serious issue affecting youth, families, and communities (Sainato, 2018). Non-Intimate Partner – Youth Family Violence (NIP-YFV) is "any act by a child that intimidates the parent to gain power and control and is aimed at causing them physical, psychological, or financial harm" (Cottrell, 2001, p.107). NIP-YFV is a serious issue as evidenced by the report from The National Center of Juvenile Justice reporting over "100,000 violent acts committed by youth against a family member in 2013 alone with most of these acts consisting of physical assault (80.7%) and intimidation (11.1%)" (Puzzanchera, Smith, & Kang, 2015, para 2). Understanding why interventions are effective for youth to parent violence is critical for social workers because they have an ethical obligation to "monitor and evaluate policies, the implementation of programs, and practice interventions" (National Association of Social Workers, 2017, 5.02A). social

workers work with youth and families in a variety of settings including child protective services, foster care and mental health agencies. This article aims to aid social workers to meet their ethical guidelines by implementing effective evidence-based interventions with violent youth. In order to implement "best practices", this study identifies and explains why certain factors are important for treatment success and the strong and weak methods studies implement to address these factors. Last, the implications for social work practitioners, policymakers, and researchers are discussed.

## Identified Factors of Treatment Success for NIP-YFV

Identifying the reason a treatment is or is not successful is important for social work practitioners as they work with their clients. Sainato (2018) identified four factors related to treatment success with NIP-YFV including intervention/treatment, participants, research methodology, and measurement. The following sections define and provide examples of each factor, explain and provide strong and weak methods to address the factors.

### Intervention/Treatment Factor

The intervention/treatment factor consists of any family, individual or combination utilized in NIP-YFV interventions. Also, any training for the therapists as required as part of the therapeutic intervention. For example, therapists being trained in Solution Focused Brief Therapy (SFBT) as the therapeutic modality chosen to address violent youth.

Beyond defining the intervention/treatment factor, this section describes strong and weak methods studies use to address this factor. Studies that utilize a combination of both individual and family therapy is a stronger method to address the intervention/treatment factor than studies that utilized one or neither therapy (Borduin et al., 1995; Chamberlain & Reid, 1998; Sexton & Turner, 2011). A search of the literature found several studies (Scherer et al., 1994; Eddy et al., 2004; Jordan et al., 2013) that utilize strong methods (both individual and family therapy) as well as several studies that did not (Caspi et al., 2008; Patterson, 2002; Portwood et al. 2011). Within the intervention/treatment component, training is a critical component. Training of the therapists adds strength to the study and because "the perceived and declarative knowledge increases and holds true across treatment modalities and therapists" (Beidas & Kendall, 2010, p.20). Based on this evidence, several studies (Henggeler et al., 1992; Leve & Chamberlain, 2005; Caldwell & Van Rybroek, 2001) used this strong method whereas other studies (Rybski, 1998; Hogue et al., 2002; Caspi et al., 2008) did not. Utilizing both types of therapies (family, individual) as well as training for the therapists provides a strong method studies can use to address the intervention/treatment component. The next section discusses the participant factor.

### *Participants*

The individuals who take part in NIP-YFV interventions play a vital role in the success the intervention has on violent youth. Participants include any individuals (youth, parent, siblings) who take part in the treatment. Participation consists of being part of the therapy or other methods including parent interview or observation reports of the violent youth. Involvement of both the youth and parent are key because "parents have a significant impact on the lives of their children and this if the parents are actively working in treatment, it is more likely that they will be making changes that will result in an environment more conducive to positive youth outcomes" (Karver et al., 2006, p.59). Another review of the literature shows several studies (Borduin et al., 1995; Ogden & Halliday-Boykins, 2004; Dekovic et al., 2012)

included both youth and families in the treatment process whereas other studies (Caldwell et al., 2006; Nowakowski & Mattern, 2014; Santisteban et al., 2003) did not. Involving both the youth and parents in the treatment brings strength to the study and increases the likelihood of treatment success. The next section discusses the factor of research methodology is important to treatment success for NIP-YFV.

**Table 1.1 Hierarchy of Evidence (Higgins & Green, 2011)**

| Level | Description |
|---|---|
| 1 | Experimental studies (e.g., RCT with concealed allocation) |
| 2 | Quasi-experimental studies (e.g., studies without randomization) |
| 3 | Controlled observational studies |
| 3 A | Cohort studies |
| 3 B | Case-control studies |
| 4 | Observational studies without control groups |
| 5 | Expert opinion based on theory, laboratory research or consensus |

*Level 3 is separated into A and B to distinguish with cohort studies being a higher level of evidence than case-control studies

Based on the table, Level 1 (RCTs) is the highest level of evidence and Level 5 (Expert opinion) is the lower level of evidence. There is another evidentiary support that shows the strength of RCTs "is the best evidence" (Petrisor & Bhandari, 2007, p.12) when analyzing interventions. According to this evidence, several strong and several weak studies were identified through a review of the literature. Studies that used a strong research methodology (RCTs) include Wagner et al., (2014); Ogden & Hagen, (2006); Caldwell (2011) and weaker research methodologies (Case-control) were used in Jordan et al., (2013); White et al., (2013); and Butler et al., (2011). The research methodology factor is another way to help determine the effectiveness of the interventions as they address NIP-YFV. The following section defines and describes measurement as the last factor for treatment success.

*Measurement*

The factor of measurement consists of any instruments or methods the intervention used to measure characteristics related to youth violence. For example, a study may use an anger scale to measure the anger or aggression in the youth. In the study conducted by Jordan et., (2013), the measurement, Navaco Anger Scale and Provocation Inventory (NASPI) was utilized. NASPI measures arousal, cognition, provocation, anger regulation, and behavior. Other measurement methods may include interviews of the youth or parent and observation reports completed by the parent to measure any violent acts by the youth. These are just a few of the ways interventions can measure violence in youth. According to Rubin and Babbie (2005), a strong measurement must include high reliability/validity, use triangulation, and address both the interpersonal and personal factors related to NIP-YFV. Reliability is important because it demonstrates the consistency in findings and the ability to replicate the study. Validity is also important because it determines the overall accuracy to show if the measure is actually measuring the factors it is targeting. Triangulation helps increase the reliability and validity of the findings because it uses multiple methods to measure a certain factor. For example, if the study wanted to measure recidivism in the youth, they can use a measure such as arrest reports, interview the youth, and obtain observations reports by the parent. Each of these helps determine if violence as reduced and does not rely on one single measure to determine effectiveness. Once again, a review of the literature was completed to identify studies that used strong and weak methods of measurement in addressing NIP-YFV.

Results found multiple studies used strong methods including Ogden & Halliday-Boykins, 2004; Henggeler et al., 1997; Scherer et al., 1994 and other studies (Caldwell & Van Rybroek, 2001; Sexton & Turner, 2011; Portwood et al., 2011) used weaker methods.

## Discussion

This paper described the serious issue of NIP-YFV along with four identified factors (intervention/treatment, participants, research methodology, measurement) for treatment success. Each factor was described, the importance it has for treatment success, and studies that used strong and weak methods to address each factor. It is important to note that studies that use a strong method to address one factor (e.g. participants) do not guarantee effectiveness. This study demonstrated the need to address all four factors. Studies that implement strong methods in all four factors have a higher likelihood of success than studies that do not. The next section discusses the implications of this study has on social work practitioners, policymakers, and researchers.

*Study Implications*

This study's aim was to demonstrate effective methods in addressing NIP-YFV, and provide evidentiary support for social work practitioners, policymakers, and researchers working with violent youth.

*Practice Implications*

There are several practice implications social work practitioners should consider. First, based on the evidentiary support of utilizing both family and individual therapy as the strongest method in working with youth (Borduin et al., 1995; Chamberlain & Reid, 1998; Sexton & Turner, 2011). Social work practitioners should strive to provide or ensure violent youth are using both therapies. Second, based on the findings that youth and parents participating in treatment produce better results (Karver et al., 2006) than only youth or parents in the intervention. social workers should involve the parents in some direct or indirect method such as therapy, interview, or observation. Third, social workers who work with violent youth should be encouraged to use multiple methods to measure violence. This will help ensure the accuracy and an overall reduction in violence.

*Policy Implications*

Along with the practice implications, there are several implications for social work policymakers. First, based on the evidence presented of the strong methods to address these factors, social workers should be advocates for their clients. As policymakers, social workers can create or support policies that mandate any intervention with violent youth include strong methods for addressing the factors. For example, social work policymakers should encourage the inclusion of both youth and family therapy as part of the treatment protocol based on evidentiary support. Second, social workers can again create or support a policy that uses strong research methodologies such as RCTs as it has shown to be the best evidence" (Petrisor & Bhandari, 2007, p.12). Third, juvenile courts can examine what punishment they give NIP_YFV youth. For example, instead of jail time, court can mandate therapy for the client and family. Last, another policy could reflect on how police officers address this situation when they arrive. By educating police officers, they can provide support and resources to the family instead of arresting and

removing the youth from the home. Policymakers can be advocates and help create changes interventions can utilize to effectively address NIP-YFV

*Research Implications*

The previous sections discussed the practice and policy implications social workers should consider. Along with these implications, this section discusses several implications social work researchers can implement. First, this study is among the first to analyze the effectiveness for interventions for NIP-YFV. Due to this fact, more research is needed to identify and analyze other studies' interventions for effectiveness. Second, Sainato (2018) was the first to analyze the NIP-YFV interventions using a systematic review and narrative synthesis. Future research can implement new methods such as a meta-analysis to evaluate the interventions. Last, this study discussed the four factors related to treatment success with NIP-YFV. Future research can evaluate if other factors should be included and help determine if the four factors (intervention/treatment, participants, research methodology, measurement) should be given different weight in determining effectiveness.

## Conclusion

Determining the effectiveness and evaluating interventions is an important part of social work as they work with clients to provide "best practices" and meet their ethical obligations. This study provides an evidence base social workers can use in any NIP-YFV area (practice, policy, research). In addition to this evidence base, this study provides some recommendations for social work practitioners, policymakers, and research can implement as they work with violent youth. This was a first step in addressing NIP-YFV, but more is needed to help reduce and eliminate youth to parent violence.

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