DOMESTIC VIOLENCE
EVIDENCE PROJECT

Examining the Work of Domestic Violence Programs Within a "Social and Emotional Well-Being Promotion" Conceptual Framework

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Examining the Work of Domestic Violence Programs within a "Social and Emotional Well-Being Promotion"Conceptual Framework

Overview: This paper examines the work of domestic violence programs within a "social and emotional well-being" framework. It first elucidates how domestic violence negatively impacts survivors' and their children's well-being, and which factors have been shown to restore this well-being over time. It then describes the Theory of Change that is at the foundation of domestic violence programs' work, and details how domestic violence programs creatively engage with survivors and their children to influence the factors known to promote their well-being. It concludes with a review of the empirical evidence examining the extent to which domestic violence programs have been effective in achieving their desired outcomes.

The Problem: Intimate Partner Violence and Its Consequences

Intimate partner violence (IPV) is a serious and pervasive social problem with devastating physical, psychological, and economic consequences for victims. The most recent national survey, commissioned by the U. S. Centers for Disease Control and Prevention, reported that over one-third of women in the United States have been physically assaulted, sexually assaulted, and/or stalked by an intimate partner (Black et al., 2011). One in four men also reported experiencing some form of domestic violence, although stark gender differences were found in the types of abuse experienced as well as the impact of abuse on victims. For example, only 35% of the men reporting domestic violence said that it had negatively impacted their lives, and only 5% said the violence had made them afraid. Women were far more likely than men to have been slammed against something, strangled or suffocated, beaten, or stalked by a current or former partner. Nearly four times more women experienced injury-causing domestic violence, and nearly five times more women needed medical care (Black et al., 2011). Although some couples engage in mutual or low-level violence that does not alter the power dynamics within their relationship, the larger social problem of "battering" includes a pattern of behavior, generally committed by men against women, that perpetrators uses to gain an advantage of power and control over their victims (Bancroft, 2003; Johnson, 1995; Stark, 2007). Such behavior includes physical violence and the threat of continued violence, but also includes psychological torment designed to instill fear or confusion in the victim, and to make her question her abilities. The pattern of abuse also often includes sexual and economic abuse, coerced or forced illegal activity, coerced or forced substance use, social isolation, and threats against loved ones (Adams, Sullivan, Bybee, & Greeson, 2008; Bancroft, 2003; Black et al., 2011; Pence & Paymar, 1993).

Intimate partner violence results in far more than physical injuries, although injuries can be severe or life-threatening (Black et al., 2011), and a third of female murder victims have been killed by intimate partners (Campbell et al., 2007). Other physical health consequences that have been found to relate to IPV include chronic pain, frequent headaches, and difficulty sleeping (Black et al., 2011; Coker et al., 2002; Sutherland, Sullivan, & Bybee, 2001). In addition to physical health consequences, IPV has been found to relate to Post Traumatic Stress Disorder (PTSD), depression, and suicide ideation (Carlson, McNutt, Choi, & Rose, 2002; Coker et al., 2002; Pico-Alfonso et al., 2006; Zlotnick, Johnson, & Kohn, 2006). Further, many women turn to alcohol or other drugs to cope with their victimization (Cunradi, Caetano, & Schafer, 2002; Fowler & Faulkner, 2011; Kilpatrick et al., 1997; Martino, Collins, & Ellickson, 2005).

Battering often includes economic abuse as well, including preventing women[1] from working or going to school, sabotaging their employment or housing, or ruining their credit (A. Adams et al., 2008; Alexander, 2011). These tactics make leaving and staying out of the relationship extremely difficult.

Millions of children witness their mothers being abused each year (Graham-Bermann, Howell, Lilly, & DeVoe, 2011; McDonald et al., 2007), and many of these children are directly abused by the perpetrator as well (Appel & Holden, 1998; Edleson, 1999). A growing body of literature indicates that children who witness abuse against their mothers, even when they themselves are not the targets of violence, are at risk for maladjustment when compared to children who have not been exposed to such violence (see Kitzman, Gaylord, Holt, & Kenny, 2003, for a review). Children's emotional and behavioral reactions to witnessing battering can be severe and pervasive, and include somatic complaints, behavioral problems, withdrawal and depression (Grych et al., 2000; Kitzman et al., 2003). Not all children, of course, respond in the same way to witnessing abuse against their mothers, and some children are more adversely affected than others (Graham-Bermann, Gruber, Girz, & Howell, 2009).

Given that millions of women are victimized by partners and ex-partners each year, and that even more children are exposed by abusers to this violence, communities throughout the United States have created a broad range of supports for these families, including shelter programs, advocacy, transitional housing, support groups, supervised visitation centers, outreach, and counseling services. Domestic violence (DV) programs have never limited themselves to focusing solely on the abuse a woman and her children might have experienced before seeking assistance. They do clearly care about survivors' immediate and long-term safety, but also realize that physical safety is not sufficient to ensuring women's and children's long-term health and well-being. To restore or create that well-being, DV programs are built on a philosophy of "empowerment," or helping adult and child survivors achieve personal, interpersonal, and social power (Sullivan, 2006). This is why services are individually tailored to survivors' needs, and span the range from crisis intervention to intensive advocacy. It is also why a key component of DV work is systems change and social change: people's well-being is directly impacted by the level of supports and opportunities available in their environments.

This paper was prepared for the *Domestic Violence Evidence Project*, an initiative of the National Resource Center on Domestic Violence. The overall goal of the DV Evidence Project is to combine what we know from research, evaluation, practice and theory to inform critical decision-making related to domestic violence intervention and prevention efforts. We encourage you to visit www.dvevidenceproject.org for additional materials, including research summaries, community practice summaries and evaluation tools.

[1] While all those being victimized by a partner deserve effective advocacy, protection, and support, the overwhelming majority of adult domestic violence survivors seen by local programs are women. Intimate partner violence is a gendered social problem, with women being disproportionately targeted and harmed by male partners. For that reason, adult survivors are referred to as "women" and "she/her" throughout this document. This is not meant to minimize the experience of women abused by women, or men or transgendered victims abused by male or female partners. Nor is it meant to ignore the experiences of men or trangendered survivors served by domestic violence programs.

Promoting the Social and Emotional Well-Being of Survivors and Their Children

A ***theory of change*** is an empirically justified articulation of how and why one expects a desired change to occur (Anderson, 2005; Hernandez & Hodges, 2006). It involves identifying the desired long-term objectives (e.g., what are we hoping to accomplish?), and then working backwards to identify how specifically to achieve measurable outcomes tied to the goals (e.g., how do we get there?). It is quite similar to using a logic model to guide one's work, but differs in that it intentionally and explicitly incorporates established theories as well as scientific evidence to create an empirically justified conceptual framework (Hernandez & Hodges, 2001, 2006).

Conceptual frameworks are basically "road maps" designed to connect how we *think about* a problem with how we *address* that problem and what we *hope to accomplish* through our actions. Examining domestic violence work with survivors and their children within a conceptual framework helps programs define and communicate what they do and why they do it. It is also a way to continually examine one's own accountability: How well is a program meeting its goals? Is a program engaging in practices that are likely to lead to their desired goals? Should staff[2] be doing anything differently?

The *Social and Emotional Well-Being Promotion Framework*, hereafter abbreviated as the Well-Being Framework, is an ideal structure to use to describe the goals and practices of domestic violence programs because this framework: (1) accurately represents DV programs' goal of helping survivors and their children thrive; and (2) recognizes the importance of *community, social, and societal context* in influencing individual social and emotional well-being.

The Well-Being Framework

The Well-Being Framework, in general, is a model used to describe factors that are known to contribute to one's quality of life, so that positive factors can be maximized and negative factors can be minimized. Programs designed to promote physical health, for example, might emphasize eating a healthy diet and exercise. Agencies designed to reduce child abuse and neglect might focus on strengthening and supporting teen parents (a high risk group for abusing or neglecting children). The factors targeted for change are generally referred to as being either *risk*, *protective*, or *promotive*, depending on how they impact well-being. A brief description of these concepts is provided next:

Risk factors are conditions or variables located within a person, family, situation or community that contribute to negative outcomes. A boy who watches his father abuse his mother is *at risk* for becoming abusive himself as an adult. This does not mean he will become abusive; it means he is at a higher risk than a boy who does not witness his father being violent.

[2] Throughout this document the word 'staff' refers to both paid employees and volunteers working within domestic violence programs, as most programs rely on at least some trained volunteer labor to achieve their goals.

Protective factors are conditions or variables located within a person, family, situation or community that reduce the likelihood of negative outcomes occurring. Having supportive family and friends *protects* survivors from being trapped with an abuser. It is not a guarantee that such support will protect a survivor, but it is more protective in general than having unsupportive friends and family.

Promotive factors are conditions or variables located within a person, family, situation or community that contribute to positive outcomes. When a mother understands the impact of domestic violence on her relationship with her child, this can *promote* a more positive mother-child bond. When an advocate helps a domestic violence survivor obtain stable housing and a good-paying job, this can *promote* many other positive changes in the survivor's life, including an increase in social support and a greater sense of overall well-being.

Domestic violence programs do reduce risk factors and enhance protective factors that have been linked to re-victimization and impaired well-being. However, they are interested in more than preventing a negative event (e.g., abuse, PTSD) from occurring. The primary focus of domestic violence programs is to *enhance promotive factors* that contribute to survivors' and their children's well-being.

Predictors of and Pathways to Well-Being

Subjective well-being has been defined as the overall evaluation of one's quality of life (Deiner, 2009). It has been conceptualized as including three components: (1) a cognitive appraisal that life is good [life satisfaction]; (2) experiencing positive levels of pleasant emotions; and (3) experiencing relatively low levels of negative moods. Social well-being has to do with the extent to which one has the material and interpersonal resources needed to be healthy, safe, and happy.

If, then, subjective well-being is the state of being healthy, happy and prosperous (Merriam-Webster online dictionary definition), what factors have been found to predict well-being? Research has clearly demonstrated that *intrapersonal*, *interpersonal*, and *social factors* influence one's social and emotional well-being -- how one feels internally (e.g., hopefulness about the future, self-efficacy) is directly related to one's overall well-being and quality of life, but interpersonal and social factors are equally important determinants of well-being (e.g., Bonanno, Brewin, Kaniasty, & La Greca, 2010; Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Galea et al., 2002; Hobfoll, 2001; Norris et al., 2002). Financial and housing stability, safety, community supports, and access to healthcare are examples of social factors that consistently have been found to relate to adults' and children's health and well-being (Braveman & Gruskin, 2003; Ferguson, 2006; Raphael, 2006). Intrapersonal, interpersonal and social factors are also interdependent; as we achieve success in meeting our goals we feel more efficacious and hopeful, and this self-efficacy then leads to greater success. *Conservation of Resources (COR) Theory* (Hobfoll, 1989, 1998) provides a theoretical framework that describes this process well.

Conservation of Resources (COR) theory theory posits that psychological distress following traumatic or highly stressful life events is strongly influenced by "resource loss," in that trauma often results in individuals losing economic, social, and interpersonal resources central to their well-being (Hobfoll, 1989, 1998, 2001). For women with abusive partners, this could include consequences such as having to relocate and leave family and friends, in

addition to experiencing physical injuries, depression, and/or a reduced sense of self. The theory postulates that if this trauma-induced 'resource loss' is followed by resource gain, psychological distress will be reduced and well-being will be increased. For example, if safety is re-established, justice is achieved, and skills are enhanced, these resource gains would counteract the resource losses and reduce the negative impact of the trauma. There has been considerable empirical support for this theory across numerous populations (e.g., Hobfoll, Johnson, Ennis, & Jackson, 2003; Hobfoll & Lilly, 1993; Hobfoll, Mancini et al., 2011; Hobfoll, Tracy, & Galea, 2006; Wells, Hobfoll, & Lavin, 1999).

Hobfoll (2001) also refers to resource loss and gain "spirals," explaining that resource loss often results in further resource loss, while gain often initiates further gain. This theory was supported for IPV survivors by the work of Sullivan and colleagues (Anderson et al., 2003; Bybee & Sullivan, 2002; Sullivan, 2006; Sullivan & Bybee, 1999), who followed women with abusive partners for two years after they had exited a domestic violence shelter. Half of the sample had been randomly assigned to receive intensive advocacy services designed to increase their access to community resources and social support post-shelter. Consistent with COR theory, women who had worked with advocates for 10 weeks continued to show improvement even two years later compared to women in the control condition. They reported more social support, greater effectiveness accessing resources, higher quality of life, and less reabuse. Further, regardless of experimental condition, women who experienced the greatest amount of violence and secondary stressors after shelter exit (i.e., more 'resource loss') reported higher depression that either persisted or worsened over time (Anderson et al., 2003). Conservation of Resources theory was further supported through the longitudinal study conducted by DePrince and colleagues (2012), which found that IPV survivors who did *not* receive proactive advocacy experienced increased distress over time (resource loss spiral). These findings support the expectations of domestic violence programs, that improving intrapersonal, interpersonal, and social factors will lead to higher quality of life (i.e., well-being) for survivors and their children.

The following sections briefly review seven predictors of well-being that are typically targeted by domestic violence programs. At the intrapersonal level, these are (1) self-efficacy and (2) hope. Predictive factors at the interpersonal and social levels include (3) social connectedness and positive relationships with others, (4) being safe, (5) good physical, emotional and spiritual health, (6) possessing adequate resources, and (7) social, political and economic equity.

Intrapersonal predictors of well-being. Intrapersonal factors are those located within an individual (e.g., how one thinks and feels, one's personality traits). Social and emotional well-being is strongly influenced by the following two intrapersonal factors that have also been found to be damaged as a result of intimate partner violence victimization: self-efficacy and hopefulness.

> ***Self-efficacy.*** Self-efficacy is the belief that one is competent and able to perform the actions needed to achieve a goal (Bandura, 1977). Across many studies and numerous populations, self-efficacy has been found to influence one's social, physical and emotional well-being (Boehmer, Luszczynska, & Schwarzer, 2007; Hack & Degner, 2004; Hampton, 2004; Hochhausen et al., 2007). A domestic violence survivor's self-efficacy is often diminished not only by the abuser's pattern of ridicule, control and domination, but also by prior community

responses that have not only failed to help her but that may have re-victimized her or made the situation worse (R. Campbell, 2006, 2008; Rivera, Sullivan, & Zeoli, 2012).

Domestic violence programs also recognize that self-determination and agency are socially situated. Both are influenced strongly by a person's history, current and past interpersonal relationships, social location, and community and cultural context. Self-determination does not necessarily mean independence or individual autonomy, and these constructs are intentionally rejected within some cultures that highly value interdependence and communalism. Helping a survivor gain or maintain control over her decisions and actions can and does occur within multiple contextual frameworks, and in consideration of a survivor's family, community, and cultural needs.

- ***Hope***. Hope is the belief in a positive tomorrow (Hinds, 1984; Snyder et al., 1997; Stoddard, McMorris, & Sieving, 2011). The extent to which one feels hopeful, however, is intricately related to one's sense that they can *create* that 'positive tomorrow.' As Snyder and colleagues (1991) noted, "hope is influenced by the perceived availability of successful pathways related to goals. The pathways component refers to a sense of being able to generate successful plans to meet goals" (pp. 570–571). Hope, then, is distinct from but interrelated with one's sense of self-efficacy. Hope is viewed as a critical factor relating to overall well-being because it fuels one's willingness to do what is necessary to maintain or regain health and well-being (Snyder, 2002). There is ample empirical support for this assumption. Adolescents with elevated levels of hopelessness are at risk for delinquency, violence and engaging in risky behavior (Bolland, 2003; Stoddard, Henly, Sieving, & Bolland, 2011; Valle et al., 2004), all of which negatively impact social and emotional well-being. Conversely, the extent to which adolescents feel hopeful is influenced by their sense of social connectedness, especially with family and school (Resnick, Ireland, & Borowsky, 2004; Stoddard et al., 2011), and a good deal of research has shown that hope moderates the relationship between stressful life events and adolescent well-being (Stoddard et al., 2011; Valle, Huebner, & Suldo, 2005).

  Hope is an important factor in the lives of adults as well. Elevated hope has been found to relate to reductions in PTSD, anxiety, and depression (Gilman, Schumm, & Chard, 2012; Larson et al., 2007; Wu, 2011). Schrank and colleagues (2012) conducted a meta-review of studies examining the relationship between hope and well-being, and concluded that programs intending to increase hope should include components that involve both (1) staff collaborating with clients to meet client goals; and (2) an emphasis on efficacy, spirituality and well-being. Not coincidentally, these components are central to the work of domestic violence programs.

Interpersonal and social predictors of well-being. It is essential to remember that one's ability to be "well" is socially situated. It is often not enough to simply change the way an individual thinks and feels -- factors at interpersonal, community and societal levels need to be addressed as well. This section reviews the evidence behind the following predictive factors of well-being that are typically targeted by domestic violence programs: (1) social connectedness and positive relationships with others; (2) being safe; (3) having good physical, emotional and spiritual health; (4) possessing adequate resources; and (5) social, political and economic equity.

- ***Social connectedness and positive relationships with others.*** support has been found to reduce one's risk of psychological distress after trauma, not just because of the comfort received from others but through

instrumental help and practical assistance that accompanies emotional support (Brewin et al., 2000; Norris, Baker, Murphy, & Kaniasty, 2005). In the context of intimate partner violence, social support has been well-documented as positively impacting survivors' well-being (e.g., Beeble, Bybee, Sullivan, & Adams, 2009; Goodman, Dutton, Vankos, & Weinfurt, 2005; Coker et al., 2002; Tan, Basta, Sullivan, & Davidson, 1995; Thompson, Kaslow, Short, & Wyckoff, 2002; Suvak, Taft, Goodman, & Dutton, 2013). Social support is an especially important resource to increase for survivors, as abusers often rely on isolating their victims from supportive family and friends in order to escape detection and to limit women's options for help (Stark, 2007). As women's social support increases, then, so do their options, not only for escape once violence has occurred, but for proactive assistance if violence is threatened or implied. Social support serves in a more general sense to increase people's access to community resources and opportunities (Hobfoll, 2001; Hobfoll & Lilly, 1993), some of which serve to protect women from future assault. Finally, social support has been found to predict lower PTSD severity for women who have experienced multiple forms of violence (Schumm, Briggs-Phillips, & Hobfoll, 2006).

- ***Safety.*** Safety involves not just physical, but emotional and economic safety as well. People who are experiencing violence or the chronic threat of violence report lower quality of life compared to those not under such siege (Evans-Campbell et al., 2006; Ramos & Carlson, 2004; Sagi-Schwartz, 2008; Williams et al., 1997). Survivors and their children deserve to be free of physical and sexual abuse, but also of threats, intimidation, stalking, economic abuse, coercion, and isolation. Advocates work extensively and creatively to assist survivors in maximizing their and their children's safety, while recognizing that the abuser is ultimately responsible for whether they are battered again (Davies & Lyon, 2014).

  Staff work diligently and creatively with survivors and their children to maximize their emotional, physical and spiritual health. To address physical health concerns, an increasing number of domestic violence programs have on-site health clinics or strong partnerships with local health clinics. Spiritual well-being is attended to as well. Staff provide various means through which families can practice their faith or spirituality, either on-site or through community engagement and partnerships. Emotional well-being is attended to both informally and formally. Informally, all organizational activities are designed to maximize emotional well-being (e.g., through empathic listening, being respectful, and being caring and encouraging). Formally, many programs have counselors on staff and also assess for mental health needs that may require additional supports (e.g., psychiatric intervention). Counseling is provided for both adults and children to address the common mental health sequelae of abuse (e.g., depression, PTSD, anxiety).

- ***Possessing adequate resources.*** As with social support, access to community resources has commonly been associated with higher quality of life, especially when the community resources are relevant to an individual's personal goals and strivings (Diener & Fujita, 1995; Diener et al.,1999). Access to community resources can specifically serve to protect women from abusive partners (Bybee & Sullivan, 2002; Sullivan & Bybee, 1999). Whether those resources include police protection, restraining orders, safe housing, employment, transportation, child care, or something else, adequate access to community commodities and opportunities have been shown to shield women from violence by intimate partners and ex-partners.

- ***Social, political and economic equity.*** There is clear evidence that social inequities lead to poorer health and well-being outcomes for children and adults (Braveman & Gruskin, 2003; Ferguson, 2006; Flores, 2010; Galea et al., 2002; Hobfoll, 2001, 2003; Norris et al., 2002; Raphael, 2006; US Department of Health and Human Services, 2000). In addition to inequities that impact people related to their "gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation" (US Department of Health and Human Services, 2000, p. 14), survivors of intimate partner violence and their children experience system injustices specifically related to their victimization. Often referred to as "secondary victimization" by the system, survivors are often blamed for the abuse they have experienced or denied the help needed to protect themselves and their children (R. Campbell, 2006, 2008; Rivera, Sullivan, & Zeoli, 2012). Further, some survivors are discriminated against by landlords, or in the workplace, either because of the abuse they have experienced or because of their marginalized status in society. Domestic violence advocates work creatively, at the individual as well as systems levels, to maximize survivors' access to the supports they need and to reduce the social, political and economic inequities that they face.

- ***Health***. Promoting emotional, physical and spiritual health is another goal of DV programs. Victimization is considered to be a form of trauma, which is defined as a serious, overwhelming event that is perceived as a threat to one's life or physical integrity. Traumas can impact people's emotional, physical and spiritual health in a variety of ways, with more severe traumas being linked to more severe negative outcomes (e.g., PTSD, depression, anxiety, suicide ideation; Bennice, Resick, Mechanic, & Astin, 2003; Golding, 1999; Kaslow et al., 2010). Cumulative trauma, which is the experience of multiple traumatic events over the course of one's life, has been linked to even more serious mental health outcomes (Banyard, Williams & Siegel, 2001; Kubiak, 2005; Pimlott-Kubiak & Cortina, 2003).

  Being victimized over a lengthy period of time or in particularly severe ways can lead to feelings and behaviors that make daily functioning more difficult (Warshaw, Brashler, & Gill, 2009). While not all adult or child survivors of domestic violence experience these psychological aftereffects, many do – especially if they have experienced additional traumas such as child abuse, sexual abuse, or community violence. Survivors who are having trouble concentrating, who are in a state of constant high anxiety, or who are not sleeping (just to name a few examples) may find it difficult to make decisions or feel emotionally in control of their lives. Unless these underlying traumas are explained to survivors and dealt with, they may not be able to achieve the ultimate goals of health and well-being.

Additional predictors of children's well-being. DV programs recognize that children exposed to abuse against their mothers are at increased risk for physical, emotional, behavioral, social and cognitive problems (for recent reviews of the impacts of children's IPV exposure, see Gewirtz & Edleson, 2007; Kitzmann et al., 2003). While children are a heterogeneous group with distinct and varied experiences and needs, DV programs focus on ameliorating negative effects of exposure and building children's strengths and capacities. The seven predictors of well-being just reviewed are relevant for children as well as adults, and are the focus of change for both adult and children's programs. However, in addition to these well-being predictors, programs for children also work to improve those factors that have been shown to enhance children's ***resiliency.***

The most consistent factor cited as promoting children's resiliency post-trauma is a secure attachment to the non-abusive parent or other significant adult caregiver (Graham-Bermann et al., 2006; Kliewer et al., 2004; Mullender et al., 2002; Osofsky, 1999; Pedro-Carroll, 2001). Enhancing children's self concept (Daniel & Wassell, 2002), social/relational competencies, and support networks (Pedro-Carroll, 2001) have also been identified as important to enhancing their social and emotional well-being, and all are directly targeted by domestic violence programs. Children's programs include developmentally-appropriate educational and support components designed to help them understand the trauma they have experienced and provide them with coping and problem-solving skills. Programs also engage in age-appropriate safety planning with children and help them deal appropriately with their anger, fears and confusion. Finally, many programs engage in activities designed to strengthen the mother-child bond, such as family safety planning, family support groups, and joint recreational activities.

Theory of Change: How Domestic Violence Programs Impact the Intrapersonal, Interpersonal, and Social Predictors of Well-Being

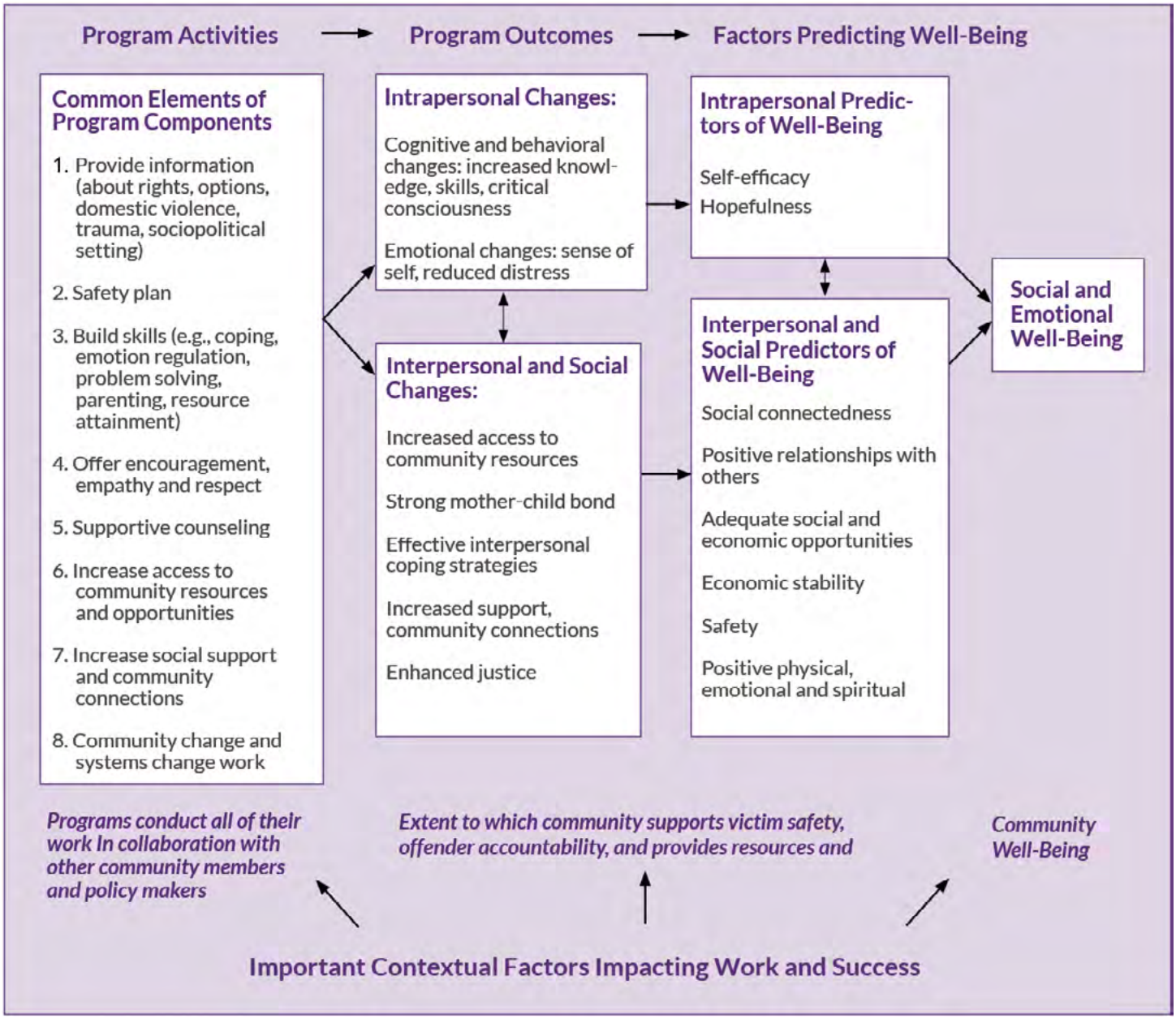
Domestic violence programs engage in a wide range of activities designed to positively impact the intrapersonal, interpersonal and social predictors of well-being for both survivors and their children. Specifically, they work to (1) increase women's and children's sense of self-efficacy as well as their hope for the future, and (2) directly increase their access to community resources, opportunities, and supports (including social support). Consistent with Conservation of Resources theory, these improvements create a positive spiral in survivors' lives, resulting in more positive social and emotional well-being over time.

While the actual programs may differ across agencies (e.g., shelter, counseling, advocacy, transitional housing, supervised visitation, children's programs, support groups), services for both survivors and their children tend to share eight key features. In partnership with the women and children, DV program staff engage in the following activities:

1. providing information about adult and child survivors' rights, options and experiences
2. safety planning
3. building skills
4. offering encouragement, empathy, and respect
5. supportive counseling
6. increasing access to community resources and opportunities
7. increasing social support and community connections, and
8. community change and systems change work.

Domestic violence advocates often refer to the constellation of these eight components as engaging in "empowering practice." Empowering practice involves interacting with survivors in ways that increase their power in personal, interpersonal and political arenas (R. Adams, 2008; Gutiérrez & Lewis, 1999; Sullivan, 2006). It is

a helping relationship through which the staff member shares power with the survivor, and is a facilitator, not a director, of services. The advocate works with the survivor to facilitate access to knowledge, skills, supports and resources. Direct outcomes of these program activities can be documented at intrapersonal, interpersonal and social levels. Intrapersonal changes include both cognitive (e.g., increased knowledge and skills) and emotional (e.g., feeling more hopeful) improvement. Interpersonal changes would include such things as increased safety and social support, while social-level changes might include increased access to community resources. Figure 1 on illustrates the Theory of Change underlying how program service components are expected to impact the factors that influence well-being.



The eight key components of domestic violence services, illustrated in the left column of Figure 1, are described in more detail next.

Eight Common Features of Domestic Violence Services

1. ***Provide Information.*** Knowledge is power. Therefore, a key objective of DV programs is to increase adult and child survivors' knowledge about a variety of topics important to their long-term well-being. Across all programs and different types of contact, staff inform survivors about their rights, options, and the community resources they have available to them. They also raise survivors' consciousness about the dynamics of domestic violence and other forms of violence they may have experienced (e.g., child abuse, sexual assault, community violence). They offer information about how the children might be responding to the violence, and help survivors think through their next steps. In short, they provide any and all information survivors might need to understand their experiences within the larger sociopolitical context, to make the best decisions for themselves, and to heal emotionally from the abuse.

2. ***Safety Plan.*** A basic tenet of every domestic violence victim service program is to engage in safety planning with survivors and their children (Davies, Lyon, & Monti-Catania, 1998). Advocates recognize that "safety plan" is a verb rather than a noun, and that strategies must be flexible and individualized to each survivor's experience and context. While it is understood that these efforts may or may not be successful, given the individual circumstances surrounding each incident of abuse and that the perpetrator is ultimately responsible for his decision to be violent or not, a variety of strategies are discussed to help survivors decide for themselves what might reduce future risk of abuse. These strategies generally center on having plans for immediate escape should violence occur (e.g., having a predetermined location to flee to, having clothing and important documents assembled and hidden), but conversations also include risk reduction strategies (e.g., obtaining a restraining order, changing locks, changing phone numbers). Staff help survivors think through both batterer-generated risks (e.g., the abuser's prior behaviors, threats, access to her and the children) as well as life-generated safety risks (e.g., neighborhood safety, access to help from various systems, level of supportive networks) and, together, staff and survivors generate plans for addressing each. Staff also engage in age-appropriate safety planning with the children, to help reduce their risk of future harm and to help them determine appropriate exit strategies if needed.

3. ***Build Skills.*** Knowledge is critically important, but having the skills to put knowledge into practice is crucial to enhancing self-efficacy. DV program staff use a variety of strategies, including instruction, modeling, and role playing, to help survivors and their children enhance the skills they self-identify as needing. These skills will differ across individuals but for adults might include resume writing, how to prepare for and conduct themselves in court, parenting skills, repairing the mother-child bond that may have been intentionally weakened by the abuser, and developing more positive coping skills (e.g., handling flashbacks). Staff also work with children on a number of skills that have been shown to relate to youth well-being, including problem solving, coping, and social and emotional regulation (Graham-Bermann et al., 2007; Johnson et al.,

2002; Lieberman et al., 2006). For example, they may help children develop self-soothing skills for when they waken from nightmares, and/or help them better regulate their emotions and social skills with others.

4. ***Offer Encouragement, Empathy and Respect.*** Across all services, domestic violence staff are expected to treat survivors with empathy, support and respect. Staff are trained to be nonjudgmental, respectful of differences, and to be culturally competent. Cultural competence involves employing specific knowledge, behaviors and policies to effectively work in cross-cultural situations. These philosophical underpinnings guiding the work are key, not just because they represent a courteous way to treat other human beings, but because these attributes have been found to increase people's sense of self and self-efficacy (Maton et al., 2004; Saleebey, 2006). Self-efficacy is influenced not just by prior experiences of success, but by encouragement from others (Bandura, 1977; Bandura & Cervone, 1983; Hyde, Hankins, Deale, & Marteau, 2008). Staff members' encouragement, empathy and respect encourage survivors to recognize their skills and strengths. Staff also address the physiological factors that can impact one's ability to engage in new behaviors (Hyde et al., 2008). For example, staff may be called on to help adult and child survivors recognize signs of anxiety (e.g., "butterflies in the stomach," fear, trembling), to normalize this, and to offer strategies for self-regulation.

5. ***Supportive Counseling.*** DV programs have created a number of venues through which they can help adult and child survivors understand and heal from the trauma they have experienced. Whether through individual counseling, support groups, crisis intervention or casual conversations, staff help survivors and their children understand that they are not alone in their experience and are not responsible for their victimization. They also help them understand common responses to trauma (e.g., trouble concentrating, sleep problems, being easily startled) and provide them with the knowledge, skills and time they need to heal. Every person responds to trauma differently, so staff help each survivor identify the impact that the abuse has had on them, and how to identify and cope with events that may 'trigger' the same physiological or emotional reactions they experienced when being abused. Processing the abuse also involves helping women and their children recognize that they are not alone nor responsible for their victimization.

6. ***Increase Access to Community Resources and Opportunities.*** While knowledge about community resources and how to obtain them is extremely important, survivors' actual ability to access new resources and opportunities is highly dependent on what is available in the community. Empowerment-based advocacy involves working actively with survivors to help them gain access to these limited or difficult-to-access resources and opportunities. Advocacy ranges from ensuring that a survivor's rights are upheld through the court process, to helping her obtain housing or employment. The role of the advocate is to engage in dialogue and critical analysis with the survivor, reviewing all sides of the issue and determining costs and benefits of different courses of action. The advocate must have the skills to actively listen and ask pertinent questions, help brainstorm potential options and strategies, and strategize how best to meet the survivor's needs. To be effective, advocates also need to be aware of and well-connected to the local community. They need to know relevant state and local laws and policies, and they should know individual people in frequently used agencies who are in control of needed resources. This means that a great deal of advocates' work is conducted in the community — effective advocacy does not happen from behind a desk.

7. ***Increase Social Support and Community Connections.*** As noted earlier, social support is critical to the well-being of all adults and children, and is especially important for women with abusive partners or ex-partners. DV program staff work to increase women's and children's social support and community connections in four general ways. First, some services are intentionally offered in group settings (e.g., support groups, shelters), through which women and their children can talk with other survivors and form new supportive relationships. Second, staff discuss the importance of social support and community ties with survivors and talk about current support networks as well as possibilities for expanding support. Many survivors want to maintain strong ties in their communities or need to build new community networks, and program staff can be extremely helpful in honoring and supporting this need. Third, in some programs staff intentionally educate and support the family and friends of survivors so that they are better able to assist the survivor in both emotional and tangible ways. And fourth, most DV programs engage in community education work as a means of educating those people who are in a position to support survivors and hold offenders accountable.

8. ***Community Engagement and Social Change Work.*** Recognizing that well-being is not independent from community-level factors, staff do not focus solely on working with individual survivors. They also engage in a variety of efforts to create communities that hold offenders accountable, promote justice, and that provide adequate resources and opportunities for all community members. This is accomplished through systems-level advocacy efforts (generally targeted at the criminal justice, health care, welfare, child protective service, and other systems), prevention activities, community education activities, and collaborative community actions.

   The goal of most, if not all, domestic violence programs is to help create communities that value all of their members and that promote individual and community well-being. This work involves a great deal of time and energy on the part of DV staff, who often engage in their communities at multiple levels. They likely participate in Coordinated Community Response (CCR) Councils, meet regularly with key community members to improve protocols, policies, and practices, work on related social issues (such as poverty, discrimination, housing, employment, child welfare), and engage in cross-trainings with other professions. These complex, time-consuming, and generally underfunded efforts are key to DV programs' social change work.

Addressing Survivors' Needs as Mothers

The majority of survivors seeking services from domestic violence programs are mothers of minor-aged children (Lyon, Lane, & Menard, 2008; NNEDV, 2011; Tutty, 2006). In response to this, domestic violence agencies provide services and advocacy that focus on meeting the children's needs, their mothers' needs as parents, and the families' needs. Programs recognize that mothers' social and emotional well-being is fundamentally intertwined with their children's well-being, and that mothers and children have separate as well as interrelated needs. Therefore, they offer an array of services and supports to meet survivors' diverse needs as parents. These needs may be of an interpersonal nature (e.g., women wanting to improve their parenting and/or to understand the emotional impact of the abuse on their children), or may be more socially situated (e.g., mothers needing help with Family Court, Child Protective Services, protecting their child at school).

Mothers continue to be concerned about their children's ongoing safety and well-being, especially if the abuser is the children's father and has continued contact with them. Abusers may not only pose a physical or emotional

threat to the children directly, but many intentionally use the children to continue harassing, intimidating, and monitoring the mothers (Beeble, Bybee, & Sullivan, 2007; Walker, Logan, Jordan, & Campbell, 2004). In short, survivors' concerns for their children tend to heavily influence the decisions they make about staying in or leaving the relationship (Kurz, 1996; McCaw et al., 2002; Tutty, 2006) as well as all other decisions (e.g., employment, re-locating, seeking counseling). Domestic violence programs recognize that, unless the children's and family's needs are considered as a whole (with family often including extended family and fictive kin), mothers' social and emotional well-being will not be achieved.

DV program staff also work creatively to repair the mother-child bond that is so often intentionally damaged by the abuser (Bancroft, 2003; Beeble et al., 2007; Peled, Davidson-Arad, & Perel, 2012). It is common for batterers to undermine survivors' parenting and to attempt to turn the children away from their mothers as part of the abuse, and it is critical for the well-being of both mothers and children to have this bond healed.

Evidence Linking DV Program Activities to Desired Outcomes

What empirical evidence exists that DV programs are impacting the well-being of IPV survivors and their children? Unfortunately, few studies have examined the long-term impact of domestic violence services on survivors over time. However, the studies that have been conducted have consistently found such services to be helpful. ***Shelter*** programs, for example, have been found to be one of the most supportive, effective resources for women with abusive partners, according to the residents themselves (Chanmugam, 2011; Few, 2005; Goodkind et al. 2004; Itzhaky & Ben Porat, 2005; Lyon, Lane, & Menard, 2008; Tutty, 2006; Tutty, Weaver, & Rothery 1999; Wettersten et al., 2004). While many of the studies examining shelter impact to date have been relatively small and/or qualitative, two large-scale studies have been conducted that comprehensively examined women's needs at shelter entry as well as the services they received and the outcomes of those services. One study included 368 women from ten shelters across Canada (Tutty, 2006) and the other involved 3,410 women from 215 shelters across eight states in the United States (Lyon, Lane, & Menard, 2008). Both surveyed survivors at shelter entry and exit, allowing for the first examinations of change over time within shelter. In the Canadian sample, 207 women completed both pre and post surveys; in the US sample, 565 women completed both. Findings across both studies were quite similar, with the vast majority of survivors reporting that they felt safer, more hopeful, and possessing more safety strategies post-shelter.

Tutty (2006) also examined changes in trauma-related symptoms, using the *Impact of Event Scale – Revised* (Creamer, Bell, & Failla, 2003). Women were asked how much they continued to be bothered by symptoms indicative of post-traumatic stress (e.g., I had trouble concentrating; I was jumpy and easily startled). One hundred eighty women completed this scale at both shelter entry and exit. The majority of items were endorsed at the "moderately bothersome" level by women at shelter entry, with almost all decreasing to "bothering a little bit" by shelter exit ($p < .0001$).

Finally, it is noteworthy that a number of studies have asked women what they would have done if shelter had not been available to them, and the responses have been sobering. Women's responses included that they would have been homeless, would have continued to be beaten, or that they would have prostituted to support

themselves and their children. Some women noted that they would have been murdered, or would have either killed themselves or their abusers (Lyon et al., 2008; Sullivan et al., 2008; Tutty, Weaver, & Rothery, 1999). Clearly, shelters provide not only immediate and long-term support for abused women and their children but are in some cases life-saving as well.

Advocacy services are a core component of most domestic violence programs. Advocacy efforts are generally classified as either individual-based -- working with or on behalf of individuals to ensure access to resources and opportunities -- or systems-based, which involves improving institutional responses (Peled & Edleson, 1994; Sullivan, 2006). In reality, though, many advocacy efforts involve both working to change systems *and* assisting individuals simultaneously. The impact of broad-based advocacy has been evaluated by two longitudinal studies incorporating experimental designs. In the first, survivors were randomly assigned to receive 10 weeks of post-shelter advocacy services or services-as-usual, and then interviewed every six months over two years (Allen, Bybee, & Sullivan, 2004; Sullivan, 2006; Sullivan & Bybee, 1999). Women who worked with advocates experienced less violence over time, reported higher quality of life and social support, and had less difficulty obtaining community resources over time. This low-cost, short-term intervention using unpaid advocates was effective not only in reducing women's risk of re-abuse, but in improving their overall social and emotional well-being.

A second study randomly assigned women with DV-related police reports to one of two conditions: in the referral condition, women were contacted by court advocates and given the phone number of the local domestic violence program (DePrince et al., 2012). In the outreach condition, the local domestic violence program proactively contacted survivors and offered advocacy services to them. Participants were interviewed three times over one year. At one-year follow-up, women in the proactive advocacy condition reported less depression, fear, and PTSD symptoms compared to the women in the referral group. Further, those in the referral condition reported *increased* distress symptoms between T2 and T3. Both of these studies have results consistent with Conservation of Resources theory (Hobfoll, 2001). In the first, survivors who had more social support and who reported fewer difficulties obtaining community resources reported higher quality of life and less abuse over time (Bybee & Sullivan, 2002). In the second, findings suggest that resource loss led to further resource loss for survivors in the referral condition, whose distress increased, rather than decreased, over time.

The only evaluation of a ***legal advocacy*** program as of this writing is Bell and Goodman's (2001) quasi-experimental study conducted in Washington, DC. Their research found that survivors who had worked with advocates reported less abuse six weeks later, as well as marginally higher emotional well-being compared to survivors who did not work with advocates. Their qualitative findings also supported the use of paraprofessional legal advocates. All of the survivors who had worked with advocates talked about them as being supportive and knowledgeable, while the women who did not work with advocates mentioned wishing they had had that kind of support while they were going through this difficult process.

Evaluations of ***support groups*** have shown positive findings as well. The 10–12 week, closed support group is a common type of group offered to survivors, and typically focuses on safety planning, promoting mutual support,

and discussing dynamics of abuse. Tutty, Bidgood, and Rothery's (1993) quasi-experimental evaluation of such support groups revealed significant improvements in women's self esteem, sense of belonging, locus of control, and overall stress over time. These findings were corroborated by a randomized control trial of an 8-week group led by a trained nurse that focused on helping survivors increase their social support networks and access to community resources (Constantino, Kim, & Crane 2005). At the end of the eight weeks the survivors who had participated in the group showed greater improvement in psychological distress symptoms and reported higher feelings of social support.

Peled and colleagues (2010) designed and examined the efficacy of a support group intervention specifically focused on survivors' *mothering*. Using an empowerment approach that recognizes the specific challenges faced by abused mothers (e.g., having the perpetrator intentionally undermine her parenting; protecting the children) this 16 week group includes four main topics: (1) "being a mother," (2) "my parents and parenting," (3) parenting skills, and (4) dealing with abuse while mothering. Mothers were surveyed before and after the intervention as well as three months later, and compared to women who either opted out of the group or who were partners of men who had participated in a group on fathering. Consistent with prior studies that have found abused women to be no better or worse parents than non-abused women (Holden & Ritchie, 1991; Sullivan et al., 2000), both groups reported moderate parental self-efficacy and low mothering-related stress pre-intervention. However, post-intervention, the women who had received the group intervention reported higher parental self-efficacy and optimism, as well as lower mothering-related stress, while the women in the comparison group actually showed a decline in these areas. Improvement in mothering-related stress was maintained across the three month followup.

The vast majority of domestic violence victim service programs offer *counseling* as one of their core services. Typically, professionally trained counselors offer "empowerment counseling," a process through which one person helps another gain or regain their sense of personal power (Gutiérrez & Lewis, 1999). Empowerment counseling within domestic violence programs involves helping survivors recover their personal sense of power and control. It can also be useful to survivors to learn about the typical dynamics endemic to domestic abuse, which can help women feel less isolated or 'crazy.'

In addition to being empowerment based, many counseling services incorporate a variety of therapeutic approaches (e.g., cognitive-behavioral, solution-focused, art therapy) tailored to the individual needs and desires of survivors. Some programs offer individual counseling, while others offer group counseling, and still others offer both (Howard, Riger, Campbell, & Wasco, 2003). The general intent behind counseling interventions is to alleviate the distress that often accompanies victimization (e.g., depression, anxiety, posttraumatic stress symptoms, guilt, shame) and to increase survivors' sense of self and well-being.

To date, there are few evaluations of domestic violence counseling services and most of those that exist tend to involve examining client change over time without benefit of comparison or control groups. However, a small number of clinical trials suggest that brief counseling designed specifically for IPV survivors can reduce depression and increase well-being. For example, Johnson and colleagues designed a program for women living in domestic violence shelters, which they named *HOPE: Helping to Overcome PTSD through Empowerment*. HOPE

involves 9-12, twice-a-week, 60-90 minute individual sessions (over a maximum of eight weeks) that address issues especially salient to abused women. Based heavily on Herman's (1992) multi-stage model of recovery, it involves three stages: (a) re-establishing safety and a sense of self-care, (b) remembering and mourning, and (c) reconnection (Herman, 1992). The treatment prioritizes women's safety needs, does not include exposure therapy, and focuses heavily on women's empowerment. Specifically, therapists focus on women's individual needs and choices, and help them develop any skills needed to reach their personal goals. Later sessions focus on building cognitive and behavioral skills to manage PTSD symptoms and triggers, while optional modules are available that address common co-occurring issues such as substance abuse and managing grief.

A number of positive findings were reported from this study. Compared to women in the control condition, those in the HOPE condition were less likely to experience abuse six months after leaving shelter. Further, women receiving services as usual were 12 times more likely to experience reabuse than were women who received at least 5 sessions of HOPE. With regard to PTSD symptoms, there were no significant condition differences over time except for emotional numbing (in the desired direction). Those randomized to receive HOPE also showed significant improvement over time on depression severity, empowerment, and social support compared to women in the "services as usual" group. A similar intervention conducted in Spain reported similar decreases in depression and PTSD (Crespo & Arinero, 2010).

Mancoske and colleagues (1994) compared grief resolution counseling to feminist-oriented counseling and found both to increase self-efficacy and self-esteem. However, their study did not include a no-treatment control group, so it is unclear to what extent change was due to the passage of time or other services being received. Similarly, McWhirter (2011) compared emotion-focused therapy with goal-oriented therapy for IPV survivors. She collaborated with homeless shelter service providers and residents themselves who had experienced IPV and who were mothers in designing the study. Inclusion criteria were that the women were residing in a homeless shelter, had experienced IPV within the prior year, and reported at least one child present during at least one of the assaults. The goal-orientated treatment used motivational interviewing and CBT principles to enhance women's and children's understanding of their goals and how to attain them. The emotion focused group focused heavily on understanding and expressing feelings, and exploring personal belief systems. Women and children were interviewed one week prior to the treatment, and at the end of the 5 week intervention.

Children in both groups reported decreased family and peer conflict, and increased emotional well-being and self-esteem. Women reported decreased depression, and increased family bonding and self-efficacy across both conditions. Those in the goal-oriented group reported greater decreases in family conflict, while women in the emotion-focused counseling noted greater increases in social support. However, again there was no "no treatment" control condition, so it is unclear how much of these changes were due to the passage of time or other services being received by the families.

Howard and colleagues (2003) compared community-based counseling outcomes for abused women, by whether they had been sexually assaulted by their assailants as well. This study compared 357 battered women with 143 battered and raped women who participated in counseling at one of 54 domestic violence programs in Illinois. Women completed self-administered measures pre and post counseling. Almost two thirds of the sample was non-Hispanic white (64%); 27% were Black, and the other 9% were Latina, Asian American or Native American.

The vast majority of the women had participated in individual counseling (92%), 4% received group counseling, and 40% had been members of both individual and group counseling.

After controlling for prior abuse (which was higher for raped women), both groups improved in well-being and coping after counseling. However, women who had been both physically and sexually assaulted had lower scores than the other women both before and after counseling. The investigators concluded that women who are sexually as well as physically abused in their relationships may enter therapy in more distress and experiencing more self-blame, and may therefore need either more counseling sessions or counseling that included a greater focus on sexual assault.

There has been a burgeoning of trauma treatments in the U.S. that focus on the mind-body connection, and such interventions are far more prevalent internationally. Empirical support for such interventions with IPV survivors, however, is extremely limited. Two treatments, however, have been experimentally evaluated and show promise. The first involved examining the impact of music therapy and progressive muscle relaxation on anxiety and sleep patterns (Hernández-Ruiz, 2005). Twenty eight shelter residents, after being matched by current sleep difficulty, were randomly assigned to five, 20-minute sessions of either music therapy and muscle relaxation (intervention) or silently lying on a couch (control). The intervention reduced women's anxiety and increased their sleep quality.

The other intervention involved having women "give testimony" about the abuse they had experienced and/or use yogic breathing techniques to alleviate depression (Franzblau et al., 2008). A community sample of 40 women (half Black, half white) who self-identified as having experienced IPV within the prior two years were randomly assigned (within race) to one of four conditions: giving testimony, yogic breathing, giving testimony and yogic breathing, and control. Each intervention condition lasted 45 minutes over four consecutive days (90 minutes for the combined intervention), and no participants dropped out of treatment. Women in the combined testimony/breathing program as well as those in the breathing condition reduced their depression more significantly than did women in the control group (whose depression levels did not change). These interventions are promising; however, given how small each study was and that there was no follow-up after either intervention ended, findings should be interpreted cautiously.

Transitional housing programs for survivors of domestic violence are a vital resource for many low-income women striving to become free from abuse (Davis & Srinivasan, 1995; Melbin, Sullivan, & Cain, 2003). While still few in number, today there are transitional housing programs for domestic violence survivors in every state in the nation. All offer survivors housing in which they can live for a set period of time (usually one to two years), or until they can obtain permanent housing. Survivors often pay a small percentage of their income for rent, and most transitional housing programs also include support services such as counseling, housing assistance, and employment assistance. Melbin and colleagues (2003) interviewed women who had participated in one of six different transitional housing programs in a Midwestern state. Many survivors noted that, had the transitional housing program not been available, they would have either returned to their assailants, been homeless, resorted to prostitution, or would be incarcerated. Given the scarcity of low-income housing across the nation, and the continued danger many women face from their assailants even after they end the relationship, transitional housing programs hold great promise for enhancing economic stability for women with abusive ex-partners.

The lack of longitudinal studies examining the impact of such services on women's lives, however, limits our understanding of the extent to which transitional housing impacts women's economic stability, psychological well-being, or safety over time.

Unfortunately, there continues to be a dearth of studies examining the ***impact of domestic violence services on children's well-being***. However, the few studies that have examined the efficacy of either support and education groups or play therapy with children exposed to abuse against their mothers have been quite promising.

Kot and colleagues (1998) created a play therapy intervention specifically for young children (aged 4-10) residing with their mothers in domestic violence shelters. Play therapy has been found to be efficacious for young, traumatized children in general (Ray, Bratton, Rhine, & Jones, 2001), but Kot modified the treatment to consider issues specific to witnessing family violence (e.g., self-blame, safety) and condensed a 10 week protocol into 45 minute sessions over 12 consecutive days to account for the brief time families are often in shelter. Using a wait-list control comparison, the study noted that children who received play therapy showed significant improvement in self-concept and overall behavior.

Based on the success of this initial intervention, Tyndall-Lind and colleagues (2001) compared Kot's individual play therapy with similar therapy offered in a group setting for siblings. The two intervention groups were equally effective; the children receiving either intervention improved on self-concept and overall behavior relative to the control group. Smith and Landreth (2003) then compared Kot's individual play therapy and Tyndall-Lind's sibling group play therapy to a group play therapy using mothers, rather than therapists, as facilitators. They provided mothers with specific training, and found similar results to the prior studies – children who received any of the three play therapy groups improved on self-concept and overall behavior compared to children in the control group. It is noteworthy that children's mothers were found to be as effective as trained therapists in reducing their children's behavioral problems. While these three studies were each relatively small, and with significant attrition (as some families left shelter before the study ended), they nonetheless offer some evidence for the effectiveness of play therapy with young children exposed to abuse against their mothers.

Support and education groups for children exposed to intimate partner violence have also demonstrated promising results. One study compared a 10 week group for children (aged 6-12) to an intervention where mothers received a 10 week parenting support group while their children received the support and education group (Graham-Bermann et al., 2007). Families were recruited into the study through newspaper ads, social service organizations, and domestic violence shelters. Both intervention groups were compared to a wait list control, across eight months followup, and both reduced children's internalizing behaviors over time. The intervention targeting both mothers and children's showed the greatest improvements on children's behavioral and internalizing problems, and attitudes toward violence.

Sullivan and colleagues designed a 16-week post-shelter intervention that provided advocacy services to mothers while offering a 10-week support and education group to their children (aged 7-11) that was similar to that offered by Graham-Bermann (Sullivan, Bybee, & Allen, 2002). Compared to a control group of families receiving services as usual, both mothers and children noted significant improvements post-intervention and through eight months followup. Mothers reported decreased depression as well as increased self-esteem and

quality of life, while children had higher self-confidence and higher self-worth. Taken together, all of these studies suggest that the typical types of interventions provided by domestic violence programs to children (support and education groups for older children, play therapy for younger children) may be effective in reducing their behavioral problems and increasing their sense of self.

This brief evidence review was presented to illustrate that there is increasing support for the long-term effectiveness of typical domestic violence services in enhancing the social and emotional well-being of survivors and their children over time (Jonker, 2015; Macy et al., 2009; Rizo et al., 2011; Sullivan, 2010). However, a great deal more research is needed. In 1998, the National Research Council identified evaluation of domestic violence interventions as "one of the most critical needs of this field" (p. 59), and this still holds true today. A great deal of the research and evaluation in the field to date has suffered from a variety of methodological problems, including, but not limited to, small sample sizes and samples with limited generalizability (e.g., predominantly white samples), nonexperimental designs, cross-sectional designs which preclude identifying causal relationships, high attrition, and measures lacking established validity and reliability. Since original passage of the Family Violence Prevention and Services Act in 1984, followed by the the Violence Against Women Act in 1994, a considerable influx of dollars has entered communities. It is essential that programs and policies be guided by sound empirical evidence in order for those funds to be best utilized. While the most rigorous studies include both randomization and longitudinal designs, these require large grants that span multiple years. Only by funding additional large-scale, rigorous evaluations will our knowledge base considerably increase about what works, and for whom.

It is also important to focus research and evaluation in communities of color, conducted by knowledgeable researchers from those communities. Many of the published studies to date lack adequate representation of people of color, which is sometimes but not always reflective of the services currently being provided. A great deal more work must occur to ensure that culturally competent and culturally relevant research guides programmatic efforts. Similarly, more work is needed to understand the effectiveness of interventions for adolescents, lesbians and gay men, immigrants and refugees, those with disabilities or multiple needs, and for other traditionally marginalized groups.

Conclusions

Domestic violence programs work not only to protect survivors of IPV and their children from further harm, but to promote their long-term social and emotional well-being. The *Social & Emotional Well-being Promotion Framework*, therefore, reflects the mission of domestic violence programs, and provides a useful model for organizing and articulating how the work of these programs promotes the well-being of survivors and their children over time.

Consistent with Conservation of Resources theory, DV programs try to repair the 'resource loss' that generally follows traumatic events and to engage with survivors and their children to instigate more 'resource gains.' They do this by enhancing women's and children's knowledge, skills, self concepts, sense of hope, social connections, safety, health, stability, and access to community resources. The expectation is that this these improvements create a positive spiral in survivors' and their children's lives, resulting in more positive social and emotional well-

being over time.

Although few in number, the studies that have evaluated domestic violence services suggest that these programs do indeed positively impact numerous factors predictive of well-being. Women who have used shelters report feeling safer, more hopeful, and possessing more safety strategies as a result of their shelter stay. Advocacy services have been shown to lead to women experiencing less violence over time, less difficulty accessing community resources, increased social support, and higher quality of life. Support groups have led to survivors feeling a greater sense of belonging and higher self esteem, while experiencing less distress. A group focused on survivors' mothering increased women's parental self-efficacy and optimism about the future while decreasing their mothering-related stress. Counseling has led to decreases in depression, anxiety and PTSD symptoms, while helping women feel better about their lives. Therapeutic interventions for children have been shown to improve their self concepts and reduce their behavioral problems.

Recognizing that well-being is impacted by social and community level factors, DV programs also engage in a variety of efforts to create communities that hold offenders accountable, promote justice, and that provide adequate resources and opportunities for all community members. In short, programs work to make significant changes across intrapersonal, interpersonal, and social levels to promote the well-being of survivors and their children. While there are still more questions than answers in this field, the empirically supported framework described in this document suggests that domestic violence programs are engaging in effectual practices that are likely to achieve their goal of enhancing the well-being of survivors and their children.

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