Domestic Violence Victim Services

It is somewhat difficult to believe today that services for victims of intimate partner violence were virtually non-existent just thirty years ago. The serious problem of domestic violence was first recognized and named in the United States in large part due to the Women’s Liberation Movement, but in conjunction with the Civil Rights Movement and the Anti-Poverty Movement. Feminists, other community activists, and survivors of domestic violence were instrumental in opening the first emergency shelters created specifically for battered women (Schechter, 1982). These first shelters were often no more sophisticated than women opening their homes to other women, but as public awareness of this problem increased, shelters proliferated throughout the country so that today there are thousands of domestic violence programs across the United States.

The first domestic violence-focused interventions were, by necessity, targeted toward ensuring victims’ immediate safety from abuse. Women who were abused often had nowhere to turn, and there were few laws or policies in place to protect them. Lack of public awareness in general regarding the causes and consequences of this problem led to inadequate or even harmful responses to women’s formal and informal help seeking (Gondolf, 1988; Sullivan, 1991). It was never assumed, however, that emergency shelter would be enough to end this widespread social problem. Interventions continued to be created, not only to address victims’ immediate safety needs, but to address their emotional, economic, health-related, educational, spiritual and longer-term safety needs as well. There was also an understanding that domestic violence would continue until batterers were held accountable for their actions and prevented from recidivating (National Research Council, 1996). And, finally, many efforts were focused on educating the
general public about this issue and creating systems change, with the recognition that society as a whole must oppose intimate partner violence in order for it to be ultimately prevented.

As our understanding about the dynamics of intimate partner violence has increased, so too have the types of community-based programs for survivors. Empirical studies that have involved listening to survivors themselves have reported that, whether seeking help to end the violence while maintaining the relationship, or seeking help to end the relationship as well as the violence, women turn to a variety of community systems to protect themselves and their children. Women turn to informal help sources such as family and friends, but also to formal sources such as the police, health care professionals, religious leaders, and the social service system (Abu-Ras, 2007; Allen, Bybee, & Sullivan, 2004; Bui, 2003; Gordon, 1996; Morrison, Luchok, Richter, & Parra-Medina, 2006). Unfortunately, women have often been unsuccessful in obtaining the help need from the very agencies and institutions designed to provide it (Baker, Cook, & Norris, 2003; Donnelly et al., 2005; Gordon, 1996; Zweig, Schlichter, & Burt, 2002).

No single book chapter can adequately describe the spectrum of services currently being offered to assist victims of intimate partner violence. This chapter, then, focuses only on providing an overview of the most commonly offered victim services found throughout the U.S. Where there have been systematic evaluations of such services, empirical results are presented. The next section includes the two most common crisis-oriented services for domestic violence survivors: shelter and first response teams. Following that are more long-term services, including transitional housing, counseling, support groups, advocacy, services for children, and visitation centers. The chapter concludes with a discussion of gaps in our existing knowledge and suggestions for next steps.
What do we know?

Crisis-Oriented Services: Shelters and First Response Teams

Domestic violence shelter programs. Although the earliest shelter programs offered little more than beds and short-term support, today community-based shelter programs are likely to provide emergency shelter, 24-hour crisis lines, support groups, counseling services, advocacy, and programs for children. Unfortunately, the number of programs available is still much lower than the need. Because of how expensive shelter programs are to operate and maintain, they are primarily located in more populated urban areas rather than in rural, frontier, or Native American reservation communities. However, even in urban cities the few shelters that exist continue to operate at or above capacity, and all have procedures in place to accommodate women when they are full (which generally involves hotel vouchers or referrals to other emergency shelters).

Shelter programs have been found to be one of the most supportive, effective resources for women with abusive partners, according to the residents themselves (Bennett et al., 2004; Sullivan, O’Halloran, & Lyon, 2008; Tutty, Weaver, & Rothery, 1999). While no woman wants to uproot her children or leave her home for a communal living setting unless she has no other options, shelters remain an important resource for a significant number of women and their children. In addition to immediate safety, women report receiving helpful information, support, advocacy, and safety planning during their stay in shelter. Positive outcomes from staying in a domestic violence shelter include knowing more about one’s rights and options, knowing more about community resources, having more safety strategies to call upon, and feeling more hopeful about the future (Sullivan et al., 2008).

Another intervention that involves providing immediate safety and support at the time of the violence occurring is the first response team, which generally consists of trained advocates
and/or social workers accompanying police officers on domestic violence calls (or shortly after a domestic violence arrest is made). The goal of such teams is twofold: to send abusers the message that there are legal consequences for their violent behavior and to inform victims of community services and resources available to them. Limited evaluations of this intervention suggest it may be meeting its intended goal of providing supportive services and information to survivors of domestic violence. The most rigorous evaluation of this service utilized an experimental design and took place in a public housing complex in New York City (Davis & Taylor, 1997). This six-month longitudinal study found that, although those receiving follow-up contact did not report any less abuse over time, victims were more willing to call the police if violence occurred.

*Longer-Term Victim Services*

While first response teams and shelters focus on providing crisis intervention and immediate safety to victims, as well as informing them of their rights and options, a number of longer-term domestic violence victim service programs are available across communities as well. This is in response to the reality that domestic violence is a pattern that too often spans years (Stark, 2007) and frequently continues even after the relationship ends (Fleury, Sullivan, & Bybee, 2000).

*Transitional housing programs.* Batterers often use finances as a means of controlling women, during and after the relationship. Some batterers deny their victims access to money, or prevent them from working outside the home (Adams, Sullivan, Bybee, & Greeson, 2008). Others harass their victims at work until they are fired (Fawole, 2008), or they damage their homes, causing women to be evicted (Baker, Cook, & Norris, 2003).
One result of these tactics is that some battered women either have no credit or their credit is so badly marred that it represents too large a risk to landlords. The long-term results for many battered women include being unable to secure and maintain permanent, affordable housing, independent of their abusers. Transitional housing programs for survivors of domestic violence were designed to offer an important alternative to living with an abusive partner, and are a vital resource for many poor battered 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 battered women in every state in the nation. All offer women housing in which they can live for a set period of time (usually one to two years), or until they can obtain permanent housing. Women 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 (National Council of Juvenile and Family Court Judges, 1998).

Melbin and colleagues (2003) interviewed women who had participated in one of six different transitional housing programs in a Midwestern state. Many women 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.
*Counseling services.* The vast majority of domestic violence victim service programs offer counseling (individually or within groups) as one of their core services. Typically, programs engage in “empowerment counseling,” a process through which one party helps the other gain or regain her sense of personal power (Gutiérrez & Lewis, 1999; Parsons, 2001). Experiencing domestic abuse frequently results in a loss of trust as well as a loss of one’s sense of control. Empowerment counseling involves helping women recover their personal sense of power and control. It can also be useful to women to learn about the typical dynamics endemic to domestic abuse, which can help women feel less isolated by their experience.

Not all domestic violence counseling services are empowerment based, of course, and many also incorporate a variety of therapeutic approaches (e.g., cognitive-behavioral, solution-focused, art therapy) tailored to the individual needs and desires of clients. To date there are few evaluations of domestic violence counseling services, and those that exist tend to involve examining client change over time without benefit of comparison or control groups. However, these limited evaluations are at least promising in that they have found improved well-being and coping (Howard et al., 2003; McNamara et al., 2006) as well as increased self-esteem and self-efficacy (Mancoske et al., 1994). One study involving abused women with PTSD reported decreases in PTSD, depression, and anxiety three months after the women received counseling services (Foa et al., 2006). Taken together, these studies suggest that short-term, trauma-focused counseling may be helpful in alleviating some of the mental health sequelae that typically result from domestic violence.

*Support groups.* While support groups were initially created by shelter programs to provide women with a supportive atmosphere through which to discuss their experiences and to share information about resources with other survivors, such groups have expanded in breadth
and scope over time. Now many groups are available that either target specific populations of abused women (e.g., African American women) or that focus on particular circumstances (groups for women still in the relationship, for example, or for women who are no longer being abused, but who still seek support with dealing with the aftereffects). While evaluations of such groups have been quite limited, there is some evidence that they are helpful to women. For example, Tutty, Bidgood, and Rothery (1993) evaluated twelve “closed” support groups (i.e., not open to new members once begun) for survivors. The 10-12 week, closed support group is a common type of group offered to survivors, and typically focuses on safety planning, offering mutual support and understanding, and discussion of dynamics of abuse. Tutty et al.’s (1993) evaluation involved surveying 76 women before, immediately after, and 6 months following the group. Significant improvements were found in women’s self-esteem, sense of belonging, locus of control, and overall stress over time; however, fewer than half of the original 76 women completed the 6-month follow-up assessment (n = 32), and there was no control or comparison group for this study.

Tutty’s findings were corroborated by a more recent study that used an experimental design (Constantino, Kim, & Crane, 2005). In that study an 8-week group was led by a trained nurse and focused on helping women increase their social support networks and access to community resources. At the end of the eight weeks the women who had participated in the group showed greater improvement in psychological distress symptoms and reported higher feelings of social support. They also showed less health care utilization than did the women who did not receive the intervention.

Advocacy services. To redress the often inadequate or ineffective community responses that women with abusive partners often experience, many community-based programs engage in
various forms of advocacy on women’s behalf (Peled & Edleson, 1994). Systems-level advocacy efforts are generally targeted at changing public policy or improving institutionalized practices within the criminal justice system, the health care system, the welfare system, and other such institutions. Individual-level advocacy efforts generally involve paraprofessionals working collaboratively and respectfully with individual survivors who guide the focus of the intervention to meet their specific needs and desires. Activities identified by programs as being individual-level advocacy have ranged from helping a woman locate housing to accompanying women through the court process. Although individual-level advocacy services are a core component of most domestic violence victim service programs, the belief in their effectiveness was originally largely predicated on anecdotal evidence. In response to the dearth of empirical support for the effectiveness of advocacy for women with abusive partners, the author designed and experimentally evaluated a community-based advocacy intervention for women after they exited a domestic violence shelter program (Allen, Bybee, & Sullivan, 2004; Bybee & Sullivan, 2002; Sullivan, 2000; Sullivan & Bybee, 1999). The Community Advocacy Project (CAP) involved providing advocates to work one-on-one with women who had recently exited a domestic violence shelter, working in their communities with them 6-8 hours a week over a period of 10 weeks. Advocates were trained in helping women obtain a variety of community resources, including housing, employment, legal assistance, transportation, education, child care, health care, material goods and services, financial assistance, services for the children (e.g., tutoring, counseling), and social support (e.g., making new friends, joining clubs or groups).

A true experimental design was utilized to evaluate the impact of the Community Advocacy Project, through which women were randomly assigned to either the intervention group or the control group (services-as-usual). All 278 women, regardless of group assignment,
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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. One out of 4 (24%) of the women who worked with advocates experienced no physical abuse, by the original assailant or by any new partners, across the 24 months of post-intervention follow-up. Only 1 out of 10 (11%) women in the control group remained completely free of violence during the same period. This low-cost, short-term intervention using unpaid advocates appears to have been effective not only in reducing women's risk of re-abuse, but in improving their overall quality of life. It is important to remember, however, that although the provision of advocates reduced the risk of further violence by a partner or ex-partner, many women (76% who worked with advocates; 89% who did not) were abused at least once over the 2-year time span. No single intervention will be a panacea for this complex social problem, and many abusive men continue their violence in spite of the strategies women use to protect themselves.

In contrast to the broad-based advocacy services described above, many domestic violence advocacy programs focus on working within one particular system (e.g., welfare, housing, criminal legal). Welfare and housing advocacy services are rarer, and have yet to be evaluated. The most common type of advocacy offered throughout the country, however, is “legal advocacy,” which can help survivors navigate through civil legal procedures (e.g., divorce, visitation, custody) or criminal cases (e.g., misdemeanor domestic violence).

Legal advocacy services. “Legal advocacy” encompasses a variety of supportive services related to either civil or criminal matters. Whether offered over the telephone or in person,
trained advocates provide survivors with both information and support, while also advocating on women’s behalf with prosecutors, police, probation officers, and other court-related personnel. A common role for legal advocates is to help women obtain protection orders, and many will also accompany women through all phases of the court process as needed.

The only evaluation of a legal advocacy program to date is Bell and Goodman’s (2001) quasi-experimental study conducted in Washington, DC. Their research found that women who had worked with advocates reported decreased abuse six weeks later, as well as marginally higher emotional well-being compared to women who did not work with advocates. Their qualitative findings also supported the use of paraprofessional legal advocates. All of the women who had worked with advocates talked about them as being very 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.

*Children’s services.* Today most domestic violence victim service programs include separate services for the children in the family, as they have also been adversely affected by the abuse perpetrated against their mothers. These services most commonly include counseling, safety planning, and support and education groups, but may also include advocacy on the child’s behalf. The only published evaluations of children’s services to date are those focused on support and education groups. Groups typically run 10 to 12 weeks, and the curriculum is age-appropriate. Sessions include serious topics as well as fun activities and snacks, and children learn about labeling feelings, dealing with anger, and honing their safety skills. One evaluation of such a program revealed that children learned strategies for protection in times of emergencies and regarded their parents in a more positive light. Mothers also reported a positive change in their children's behavioral adjustment (Jaffe, Wilson, & Wolfe, 1989). Gruszinski, Brink &
Edleson (1988) conducted a similar study, based on 371 children who attended a program over a four-year period. They found that children improved their self-concepts, understood that violence in the home was not their fault, became more aware of protection planning, and learned new ways of resolving conflict without resorting to violence. While neither of these early studies included comparison groups, a later randomized control trial also found that children who attended support and education groups reported more appropriate anger responses as well as diminished sense of responsibility for the abuse over time (Wagar & Rodway, 1995).

Visitation and exchange centers. Unfortunately, for many women the abuse does not end when the relationship ends. One way that some batterers continue their abusive and controlling tactics is through access to the children they share in common with the survivor (Beeble, Bybee, & Sullivan, 2007). Perpetrators are often legally entitled to visit with their children, and they can then use those visits as opportunities to harass and abuse their ex-partners. In response to this ongoing safety risk a number of domestic violence programs have opened visitation and exchange centers through which they can minimize contact between the parents and offer protection to the women and children (Park, Peterson-Badali, & Jenkins, 1997). Such centers often have separate entrances for the custodial and non-custodial parents, and typically they have security cameras not only within the building but covering the surrounding parking lot as well. This center can be used by parents needing to exchange children for unsupervised visits, or can be used to facilitate court-ordered supervised visits. When a non-custodial parent has supervised visits with the children, a trained staff member monitors the interactions and ideally can prevent the abuser from behaving inappropriately with the children (either by behaving abusively toward them, saying negative things about the other parent, or asking the children for personal information about their mothers). While such visitation centers appear promising, the issues
around custody and visitation are complex (including the reality that some abused women become non-custodial parents and are ordered into supervised visitation) and they are in need of systematic evaluation.

How do we know it?

Much of what we believe we “know” about the effectiveness of domestic violence victim services is based on anecdotal reports, conventional wisdom, and lived practice. While valuable information can be drawn from personal practice and experience, systematic and rigorous evaluation is also needed to better understand whether programs are effective, how they are effective, and for whom they are effective.

In 1998 the National Research Council identified evaluation of domestic violence interventions as “one of the most critical needs of this field” (p. 59). Unfortunately a great deal of the existing research and evaluation has suffered from a variety of methodological problems, including but not limited to small sample sizes and samples with limited generalizability (e.g., shelter samples, predominantly white samples), non-experimental designs, cross-sectional designs that preclude identifying causal relationships, and measures lacking established validity and reliability. More funds, and larger designations of funds per study, are needed in order for more rigorous research to be conducted on the effectiveness of current interventions and programs. Conducting research involving safely locating and interviewing battered women, and including longitudinal designs, is time, resource, and personnel intensive. Only by funding additional large-scale, rigorous evaluations will our knowledge base considerably increase.
What are the next steps?

The past 35 years has borne witness to an explosion of interventions designed to address and eliminate intimate partner violence. Although domestic violence victim service programs strive to be effective resources to all survivors, the reality is that not all services are equally accessible, available or relevant across different populations of women. Programs that are not culturally diverse and culturally competent can lack relevance for large groups of women and may even do more harm than good (Bent-Goodley, 2005; Yoshioka & Choi, 2005). For example, many domestic violence programs promote women’s autonomy and independence as the underlying framework guiding their service delivery. While this focus may resonate for many middle class Anglo women (who, not coincidentally, are still most likely to be in leadership positions within domestic violence organizations), it may not speak to the core beliefs of women from more collectivist cultures, who value interdependence and collective well-being over self-reliance and individual gain. Many women, therefore, will refuse or abandon services if they feel pressured to make decisions that go against these values or that result in losing access to family or community.

Women with mental health problems, cognitive disabilities, substance abuse disorders and/or criminal histories are sometimes denied various domestic violence services (Zweig et al., 2002), while other women experience significant barriers to receiving help (e.g., women with physical disabilities, women who do not speak English as a first language). For most if not all survivors of domestic violence, the abuse is not the only (or even the most) pressing concern in their lives. Many service programs are now recognizing this complexity and working harder to take a more holistic response to women’s needs. National efforts are also underway to help domestic violence victim service programs with this charge. For example, the National Training...
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and Technical Assistance Center on Domestic Violence, Trauma and Mental Health (NTTAC), funded by the US Department of Health and Human Services Administration on Children, Youth and Families, is focused on providing the technical assistance and tools needed to respond effectively to battered women’s trauma-related or mental health concerns. The National Network to End Violence Against Immigrant Women is committed to building organizational capacity to handle complex immigration issues and to understand the cultural needs of various immigrant communities. A number of state domestic violence coalitions have prioritized helping local programs respond more appropriately to women with a wide range of disabilities. These are just a sampling of state and national efforts designed to make domestic violence services relevant and accessible to all women. While gains continue to be made, a great deal more work must be done.

There is some empirical evidence to suggest that at least some of the programs and interventions being offered to survivors of intimate partner violence are resulting in positive change. Unfortunately, there is still a great deal more that we do not know about what works, how it works, and for whom it works. Since the Violence Against Women Act was enacted 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. However, given the complexity of this issue it is important that research and evaluation be conducted in collaboration with practitioners, survivors and advocates who are most knowledgeable about this issue.

It is also important to focus research and evaluation in communities of color, conducted by knowledgeable researchers from within these 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 our programmatic efforts.

Similarly, more work is needed to understand the effectiveness of interventions for lesbians and gay men, for immigrants and refugees, for those with disabilities or multiple needs, and for other traditionally marginalized groups.

As our knowledge about the complex issue of domestic violence has grown, as funding has increased, and as more community members are accepting responsibility for ending intimate male violence against women and children, community-based services have developed that reflect this growth. Today most communities have at least some programs available for survivors and their children. Efforts have improved to ensure that services are culturally appropriate and respectful of the complex obstacles facing women with abusive partners. However, no community can be said to be doing enough. There are still too many survivors receiving insufficient help, and too many communities providing uncoordinated or inadequate assistance.

We have clearly come a long way, but the journey is far from over. Domestic violence victim services will continue to develop and expand to meet the changing needs of women and children. At the same time, advocates nationwide eagerly anticipate the day when such support services for women and their children are no longer necessary.
References


1 While some couples engage in mutual combat or low-level violence that does not alter the power dynamics within the relationship, the larger social problem of “battering” includes a pattern of behavior, generally committed by men against women, that results in the perpetrator gaining an advantage of power and control (Dobash, Dobash, Wilson, & Daly, 1992; Johnson, 1995). This chapter focuses on interventions that address intimate partner violence against women.