

# In the Spotlight: The Impact of Domestic Abuse Victim Services on Survivors' Safety and Wellbeing: Research Findings to Date

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■ By Cris M. Sullivan, Ph.D.

More and more, funders and others are asking if victim service programs are engaging in “evidence-based practice.” To help domestic violence programs answer that question, I have reviewed the current research and summarized what we know about the evidence that our services make a difference for survivors. It can also be helpful to programs to know what research studies have found about the effectiveness of our efforts, so that we can feel confident we are measuring the appropriate *short-term outcomes* that will lead to desired *long-term outcomes* for survivors. It is not realistic for non-profit programs, with little money devoted to evaluation, to measure the long-term impact of their work – that’s what research is for. We can, however, examine the short-term changes that have been found to lead to long-term success.

**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; Gordon, 1996; Sullivan et al., 2008; Tutty, Weaver, & Rothery, 1999). For example, Berk, Newton, and Berk (1986) reported that, for women who were actively attempting other strategies at the same time, a stay at a shelter dramatically reduced the likelihood they would be abused again.

One research study used a true experimental design and followed women for two years in order to examine the effectiveness of a community-based **advocacy** program for domestic abuse survivors. Advocates worked with women

4-6 hours a week over 10 weeks, in the women’s homes and communities. Advocates were highly trained volunteers who could help women across a variety of areas: education, employment, housing, legal assistance, issues for children, transportation, and other issues. Women who worked with the 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 four (24%) of the women who worked with advocates experienced no physical abuse, by the original assailant or by any new partners, across the two years 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 (Sullivan, 2000; Sullivan & Bybee, 1999).

Close examination of which short-term outcomes led to the desired long-term outcome of safety found that *women 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 short, then, there is evidence that if programs improve survivors’ social support and access to resources, these serve as protective factors that enhance their safety over

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time. While local programs are not in the position to follow women over years to assess their safety, they *can* measure whether they have increased women's support networks and their knowledge about available community resources.

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. These findings are promising but given the lack of a control group they should be interpreted with extreme caution.

Another research study examined domestic abuse survivors' safety planning efforts (Goodkind, Sullivan, & Bybee, 2004). Survivors were asked what strategies they had used to stop or prevent the abuser's violence. For every strategy mentioned, women were asked if it made the abuse better, worse, or had no effect. Not surprisingly, for every strategy that made the situation better for one woman, the same strategy made the situation worse for another. However, the two strategies that were *most likely to make the situation better* were contacting a domestic violence program, and staying at a domestic violence shelter. These results provide strong support for the

importance of domestic violence programs.

It is also important, though, that women who were experiencing the most violence and whose assailants had engaged in the most behaviors considered to be indicators of potential lethality were the most actively engaged in safety planning activities, but remained in serious danger, despite trying everything they could. These findings highlight the importance of remembering that survivors are not responsible for whether or not they are abused again in the future. For some women, despite any safety strategies they employ, the abuser will still choose to be violent.

Evaluations of **support groups** have unfortunately been quite limited. One notable exception is Tutty, Bidgood, and Rothery's (1993) evaluation of 12 "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. Hence, these findings, too, should be interpreted with extreme caution.

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Tutty's findings were corroborated by a more recent study that did include an experimental design (Constantino, Kim, & Crane, 2005). This 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.

These research studies are presented to provide you with some evidence supporting the long-term effectiveness of the types of services you offer. If programs can show that they have had positive short-term impacts on women's lives that have been shown to lead to longer-term impacts on their safety and well-being, this should help satisfy funders that the services being provided are worthwhile.

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