

Survivor-Defined Practice in Domestic Violence Work: Measure Development and Preliminary Evidence of Link to Empowerment

Journal of Interpersonal Violence

2016, Vol. 31(1) 163–185

© The Author(s) 2014

Reprints and permissions:

sagepub.com/journalsPermissions.nav

DOI: 10.1177/0886260514555131

jiv.sagepub.com



Lisa A. Goodman,¹ Kristie Thomas,² Lauren Bennett Cattaneo,³ Deborah Heimel,⁴ Julie Woulfe,¹ and Siu Kwan Chong¹

Abstract

Survivor-defined practice, characterized by an emphasis on client choice, partnership, and sensitivity to the unique needs, contexts, and coping strategies of individual survivors, is an aspirational goal of the domestic violence (DV) movement, assumed to be a key contributor to empowerment and other positive outcomes among survivors. Despite its central role in DV program philosophy, training, and practice, however, our ability to assess its presence and its presumed link to well-being has been hampered by the absence of a way to measure it from survivors' perspectives. As part of a larger university–community collaboration, this study had two aims: (a) to develop a measure of survivor-defined practice from the perspective of participants, and (b) to assess its relationship to safety-related empowerment after controlling for other contributors to survivor well-being (e.g., financial

¹Boston College, Chestnut Hill, MA, USA

²Simmons College, Boston, MA, USA

³George Mason University, Fairfax, VA, USA

⁴REACH Beyond Domestic Violence, Waltham, MA, USA

Corresponding Author:

Lisa Goodman, Department of Counseling and Developmental Psychology, Lynch School of Education, Boston College, 140 Commonwealth Ave., Chestnut Hill, MA 02467, USA.

Email: Lisa.goodman@bc.edu

stability and social support). Results supported the reliability and validity of the Survivor-Defined Practice Scale (SDPS), a nine-item measure that assesses participants' perception of the degree to which their advocates help them achieve goals they set for themselves, facilitate a spirit of partnership, and show sensitivity to their individual needs and styles. The items combined to form one factor indicating that the three theoretical aspects of survivor-defined practice may be different manifestations of one underlying construct. Results also support the hypothesized link between survivor-defined practice and safety-related empowerment. The SDPS offers DV programs a mechanism for process evaluation that is rigorous and rooted in the feminist empowerment philosophy that so many programs espouse.

Keywords

intimate partner violence, domestic violence, evaluation, service delivery, advocacy, survivor-defined practice, survivor-defined advocacy

Survivor-defined practice, characterized by an emphasis on client choice, partnership, and sensitivity to the unique needs, contexts, and coping strategies of individual survivors, is an aspirational goal of the domestic violence (DV) movement, assumed to be a key contributor to empowerment and other positive outcomes among survivors. Despite its central role in DV program philosophy, training, and practice, however, our ability to assess its presence and its presumed link to empowerment has been hampered by the absence of a way to measure it from the perspective of survivors. As part of a larger project designed to create measurement tools for DV program evaluation, this study had two aims: (a) to create a measure that captures variation in DV program participant perceptions of survivor-defined practice, and (b) to assess the extent to which participants' perception of survivor-defined practice is related to their sense of empowerment, specifically in the domain of safety. Next, we discuss the origins and definition of survivor-defined practice, and review indirect evidence of its relationship to empowerment.

Survivor-Defined Practice

Over the course of a lifetime, 3 out of 10 women in this country experience violence at the hands of an intimate partner (Breiding, Chen, & Black, 2014). As recognition of the pervasiveness and emotional, social, and economic costs of this social problem has grown, so too has the public response. Over the past four decades, hotlines, DV shelters, and community-based programs

for intimate partner violence (IPV) survivors have sprung up in communities across the country (Macy, Giattina, Sangster, Crosby, & Montijo, 2009), accessed by up to half of all survivors at one time or another (Du Mont, Forte, Cohen, Hyman, & Romans, 2005).

However, as these programs have proliferated, scholars and practitioners have expressed growing concern over the degree to which they have become professionalized, and one-size-fits-all. When DV first emerged as a social problem, advocates responded to women's stories in the collaborative spirit of "sisters helping sisters" (Schechter, 1982). In the absence of professional organizations or protocols to guide them, advocates partnered with IPV survivors to help them find safety, support each other, and achieve their goals as they defined them, taking care to avoid imposing their own definitions of success or timetables for change (Goodman & Epstein, 2008). However, as DV programs grew more prevalent and standardized, this spirit of partnership was often replaced with a menu-based approach where a survivor is offered a set of options for assistance based primarily on the availability of services or the mission of the organization rather than on the survivor's unique circumstances and hopes for the future (Davies & Lyon, 2013). The resultant "one-size-fits-all" approach may be experienced as disempowering to survivors whose preferences do not match neatly with available services (Kulkarni, Herman-Smith, & Ross, 2015). As a result, a growing number of DV scholars, policy-makers, and practitioners are calling for a return to what they call a *survivor-defined* approach to services (also called *victim/survivor/woman-centered* or *feminist relational advocacy*¹; Davies & Lyon, 2013; Goodman & Epstein, 2008; Goodman, Glenn, Bohlig, Banyard, & Borges, 2009; Kulkarni, Bell, & Rhodes, 2012; Kulkarni et al., 2015; Nichols, 2013).

The premise of a survivor-defined approach is that survivors' situations, and thus the goals they want to pursue and the support they need, vary enormously—by virtue of culture, class, sexual orientation, immigration status, degree of social connectedness, family situation, and many other factors. Survivor-centered practice is tailored to take this complexity into account (Davies & Lyon, 2013). Crystallizing this premise, several core principles cut across scholars' characterizations of survivor-defined practice: Support must be (a) shaped by clients' goals for themselves, (b) offered in the spirit of partnership, and (c) sensitive to the unique needs, contexts, and ways of coping of individual survivors and their families (e.g., Goodman et al., 2009; Kulkarni et al., 2015; Davies & Lyon, 2013).

Providing this kind of support may seem straightforward, but in fact, it is often extremely complex: At the level of the individual, survivors present with a broad array of goals that fall not only within the domain of safety, but also within the domains of housing, employment, social connection, and the

well-being of children—with improvements in one domain sometimes triggering setbacks in others (Goodman, Cattaneo, Thomas, Wolfe, Chong, & Smyth, 2015). Even when two survivors articulate the same goal, a broad array of contextual factors may dictate different paths toward achieving it. Some survivor goals may be short-term and relatively manageable whereas others might be longer term and multifaceted, requiring persistent effort and coordination (Lyon & Davies, 2013). For many survivors, the devastating effects of trauma on sense of self and agency might make goal identification itself a significant piece of work (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). At the level of the system, a paucity of resources, time, and community-wide collaboration may challenge advocates' capacity to support survivors' goals; and some systems, including police departments, the justice system, and child protective services, may actually thwart them (Nichols, 2013). This may be especially true for marginalized survivors—for example, immigrants, homeless survivors, those suffering mental illness, women of color, or gay, lesbian, bisexual, transgender, or queer survivors—for whom mainstream responses are unsuitable at best and sometimes even harmful (Goodman & Epstein, 2008). Survivor-defined work may therefore require considerable sophistication, sensitivity, and systemic support. For these reasons, such an approach may be variably implemented, even in DV programs that adhere to its underlying philosophy.

Despite potential variable implementation, however, indirect empirical evidence hints at the strong benefits of a survivor-defined approach to services. For example, when survivors report greater control over the help-seeking process, they are more satisfied with systems ranging from the police and justice system to residential and community-based DV programs, expressing or evidencing a greater likelihood of using those options in the future (Cattaneo, 2010; Kulkarni et al., 2012; Zweig & Burt, 2007). Furthermore, they report fewer depressive symptoms and greater quality of life over time, even accounting for repeat abuse (Cattaneo & Goodman, 2010).

Although these studies lay important groundwork, the concept of sense of control does not capture the degree to which participants experience practice as survivor-defined. Indeed, whether survivor-defined practice results in a greater sense of control remains an open question, as the absence of a direct measure of survivor-defined practice impedes research on its prevalence and relationship to relevant outcomes. Recently, Kulkarni and colleagues (2015) developed a measure of survivor-defined practice from the perspective of advocates; this is a valuable contribution, which will enable an assessment of advocates' experience of their work—but there remains a need for a measure of the same concept from survivors' perspectives. The first aim of this study was to develop such a measure.

Survivor-Defined Practice and Empowerment

Despite inconsistency in its definition, facilitating empowerment remains a central aspiration of many DV programs (Goodman & Epstein, 2008; Kasturirangan, 2008; Macy et al., 2009; McDermott & Garofalo, 2004; National Coalition Against Domestic Violence, 2011); and empirical work suggests that empowerment serves as a key mechanism for the achievement of outcomes such as mental health and safety (Cattaneo & Goodman, 2010). Research demonstrates, for example, that among survivors living in a shelter, global sense of empowerment moderated the relationship between IPV severity and posttraumatic stress disorder (PTSD) symptoms, above and beyond access to resources (Perez, Johnson, & Wright, 2012). Furthermore, in a randomized trial, an empowerment-oriented shelter-based intervention was related to less severe PTSD symptomatology and greater safety over time (Johnson, Zlotnick, & Perez, 2011).

At a theoretical level, the concepts of survivor-defined practice and survivor empowerment seem strongly linked. At the very heart of survivor-defined practice is the work of eliciting a survivor's own priorities and then supporting her efforts to reach them; whereas empowerment at its core reflects the degree to which an individual feels that she can indeed articulate her own goals for herself and move toward them with the support of others (Cattaneo & Chapman, 2010). Indeed, pointing directly to the tight link between the two concepts, Nichols (2013) noted,

survivor-defined advocacy is derived from the empowerment model of early grassroots feminist advocacy, which holds that survivors gain autonomy and consequent protection from further abuse by controlling their own choices. (p. 1404)

Because an individual may experience different levels of empowerment in various domains of life, the parent research from which this study draws highlighted the need to focus on DV survivors' empowerment with respect to specific domains rather than as a general and overarching construct. It further underscored the domain of safety as a key arena in which to explore survivors' sense of empowerment, given its high priority among survivors seeking residential and community services (Lyon, Bradshaw, & Menard, 2011). Safety-related empowerment can be defined as the experience of power and control in relation to keeping safe from physical and emotional abuse (Goodman, et al., 2015). Given that survivors prioritize safety in their work with programs, we would expect that survivor-centered practice would be associated with safety-related empowerment. However, given the absence of a measure of survivor-defined practice, this link has not been empirically tested.

A second aim of this study was therefore to explore this relationship. Specifically, we anticipated that survivors who perceived more survivor-defined practice would also report higher levels of safety-related empowerment. We further expected that this relationship would hold generally and across each of the three dimensions of safety-related empowerment: (a) internal resources (the extent to which the survivor has developed a set of safety-related goals and a belief in her ability to accomplish them); (b) expectations of support (the extent to which the survivor has knowledge about and access to useful support from people in her informal and formal networks); and (c) trade-offs (the extent to which the survivor perceives that her efforts to achieve safety will trigger new difficulties). These subscales were developed based on the *Empowerment Process Model* (Cattaneo & Chapman, 2010), applied to DV survivors through a rigorous collaborative process among researchers, service providers, and survivors (see Goodman, et al., 2015 for the scholarly and practice-oriented underpinnings of the concept of safety-related empowerment).

Furthermore, supporting the strength of this link, we hypothesized that the relationship between survivor-defined practice and each dimension of safety-related empowerment would remain even after controlling for other key contributors to positive outcomes for survivors, including financial stability (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012; Goodman, Dutton, Vankos, & Weinfurt, 2005; Perez et al., 2012) and social support (Adkins & Kamp Dush, 2010; Bybee & Sullivan, 2005; Goodman et al., 2005; Kocot & Goodman, 2003).

Method

For the parent research, of which this study is a part, we collected data from a convenience sample of survivors seeking DV services at 17 urban and suburban organizations in three states in the Northeastern United States. All the programs provided safety planning, counseling, and information and referrals in person and over the phone to DV survivors living in the community. Thirteen programs also provided emergency shelter to survivors and their children, with stay lengths of several weeks to approximately 6 months. Shelter sizes ranged from small (i.e., 5 families) to medium (i.e., approximately 15 families) to large (i.e., approximately 50 families), although most were medium in size. Five of the programs that provided emergency shelter also provided transitional living programs (TLP), with stay lengths of up to 2 years. An additional two programs provided TLP only. All programs were “mainstream” in that they did not focus services on one particular population nor did they strive to match staff demographics with any one client demographic (i.e., sexual orientation).

Participants

Eligible participants were (a) aged 18 or above and (b) English-or Spanish-speaking. From the original sample of 309, we first eliminated data from the four men who participated in the study, and from four participants who responded to less than 50% of the entire survey. Then, we excluded 46 participants who had more than 50% of unusable responses within at least one of the measures in this study either due to their endorsement of “not applicable” or a lack of response.

The final sample of 255 women had a mean age of 36.1 with a racial and ethnic composition of 37.6% White, 26.7% Black/African American, 24.7% Hispanic/Latino, and 11% other. Most of the sample (69.8%) was born in the United States. Participants’ socioeconomic status was mixed, with about half (55.7%) reporting they attended at least some college or graduated college, 53.7% reporting that they were unemployed, and three fourths (71.4%) receiving some type of government assistance. Regarding relationship and family characteristics, the majority (88.6%) identified as heterosexual; 22.4% reported being in a relationship, 31.6% of whom reported the relationship was with their abusive partner. Most women (89.8%) had children; of those, 43.7% reported that their abuser was their children’s father.

The sample was evenly divided between community-based program (51%) and residential program (49%) participants. Among community participants, 35.4% reported contact with the program about once a week; the next most frequent responses were a few times a month (13.8%) and every few months (9.2%). Among residential participants, 29.6% of the participants had been at the shelter or TLP for less than 1 month; 42.4% for 1 to 6 months; and 19.2% for more than 6 months.

This final sample of 255 differed significantly from the original sample of 305 (without the four men) in that participants who reported being born outside the United States and having no children were overrepresented among the 50 participants dropped from the final sample.

Procedures

For the parent study, participants were recruited through program staff at each participating program. They posted flyers describing the study (as an investigation of survivors’ experiences with DV and seeking help) at client meetings, and scheduled times for group survey administrations (with baby-sitting provided). Depending on the number of expected participants, anywhere from one to four members of the research team administered the surveys to participants in groups of up to 15 people. No program staff member was present during survey administrations. The survey administration

team included the first, second, and sixth authors, along with 11 trained graduate students who were pursuing degrees in either mental health counseling or social work. Research team members administered the informed consent form orally and answered questions while participants filled out the survey. For administrations with Spanish-speaking participants, a bilingual member of the research team was present and all instructions and materials were offered in Spanish. To prevent anyone with literacy issues from feeling uncomfortable, we offered to read the survey to any participant who “did not feel like” doing the survey on her own; and we stressed that no survey information would be shared with program staff. Snacks and childcare were provided and all participants received a US\$20 TARGET gift card. Survey administrations lasted between 60 and 90 min.

Measures

The following measures are a subset of those asked for the parent study, which also included measures of violence history and mental health.

Background questions. As reported in participant characteristics, we asked about demographics and use of DV services within the past year.

Survivor-Defined Practice Scale (SDPS). Potential items for this measure emerged from a university–community partnership called the Domestic Violence Program Evaluation and Research Collaborative (DVPERC), composed of researchers and representatives from 17 DV programs across the northeast dedicated to improving links between research and practice in the DV field (for a fuller discussion of the DVPERC, see AUTHOR CITATION). Over the course of a 12-month period, DVPERC members reviewed and discussed scholarly literature on the concept of survivor-defined practice, conducted seven focus groups with program staff and one with survivors and had many additional informal conversations with survivors to identify key aspects of the concept and generate items for the scale. This process resulted in a draft 21 item SDPS meant to tap the extent to which survivors experienced DV program support as being guided by client goals (e.g., *Staff help me to shape goals that work for me*), offered in the spirit of partnership (e.g., *Staff here offer choices; Staff here support my decisions*), and sensitive to the unique needs, contexts, and coping strategies of individual survivors and their families (e.g., *Staff here respect the way I deal with things, whether or not they agree with it*). We purposely included more items than we wanted on the final scale so that we could eliminate items for which there were too many *not applicable* or blank responses, indicating less universally applicable

questions. Respondents answered on a 4-point Likert-type scale (from *strongly disagree* to *strongly agree*) with the option of “not applicable.” We included the following instruction:

If you only work with one advocate at this organization, please just keep that person in mind as you answer these questions. If you work with more than one person, please give one response that represents a general sense of the staff here.

Financial support. Level of financial support was measured by creating a composite variable using three items asked in the parent study. The first, “How would you describe your current financial situation?” asked participants to select one of five responses ranging from “I simply can’t pay my bills” to “I do not worry about paying for things I want and need.” The other items, which are from the 30-item Family Resources Scale (FRS; Dunst & Leet, 1987), asked participants to rate the adequacy of two types of resources (i.e., “money to buy necessities” and “clothes for your family”) along a 5-point scale ranging from *not at all adequate* to *almost always adequate*. Responses were grouped into one of three categories: “low,” “moderate,” or “high” financial support. Cronbach’s alpha for this sample was .75.

Social support. The 12-item Social Support Network Scale (SSN) from the Chicago Women’s Health Risk Study (Block et al., 2000) measures informal social support, hypothesized to be positively correlated with safety-related empowerment. The scale, developed specifically for adult women challenged by abuse or poverty, assesses three aspects of informal social support: acceptance and support (5 items), emergency help (4 items), and access to resources (3 items). We chose to use the first two of these subscales only because the third did not fit the situations of participants living in a shelter who had temporary access to resources they might not normally have. Participants responded to each item with either “agree” or “disagree.” The SSN has been shown to have high reliability and construct validity with abused women (Block et al., 2000). In this sample, Cronbach’s alpha for the first two subscales combined was .83.

Client satisfaction with services. To test the convergent validity of the SDPS, we administered the Client Satisfaction Questionnaire–8 (CSQ-8; Attkisson & Greenfield, 2004), a measure of satisfaction with the program that participants were recruited from. Participants responded to items (e.g., “How would you rate the quality of services you received?”) on a 4-point scale depending on the nature of the question (e.g., “poor” to “excellent” versus “quite

dissatisfied” to “quite satisfied”). Scores range from 8 to 32, with higher values indicating higher satisfaction. The CSQ-8 has been studied extensively and has been shown to have high internal consistency and predictive validity in a variety of samples, including inpatients and outpatients in mental health settings. Cronbach’s alpha for this scale for this sample was .94.

Safety-related empowerment. The 13-item Measure of Victim Empowerment Related to Safety (MOVERS), developed as part of the parent study (Goodman et al., 2015), was used to measure survivors’ level of safety-related empowerment. MOVERS assesses three domains of safety-related empowerment: Internal Tools (a general assessment of the extent to which the survivor has developed a set of safety-related goals and a belief in her ability to accomplish them); Trade-Offs (the extent to which the survivor feels that her efforts to achieve safety trigger new difficulties); and Expectations of Support (the extent to which the survivor has knowledge about and access to useful support from people in her informal and formal networks). Participants responded to a 5-point Likert-type scale (from *never true* to *always true*), and were encouraged to think broadly, if applicable (i.e., “When you are responding to these questions, it is fine to think about your family’s safety along with your own if that is what you usually do”). MOVERS has high construct validity and high internal consistency, with Cronbach’s alpha for the entire scale at .87 and for each subscale at .88, .82, and .74, respectively.

Spanish translation. All measures were translated and back translated to ensure their appropriateness for use with monolingual Spanish-speaking participants. In our analyses, results based on a sample without the Spanish-speaking participants ($n = 38$) were very similar to those based on the full sample. Given that our interpretation of either result is the same, we report results for the full sample here.

Results

Aim 1: To Develop SDPS

Consistent with the first aim of this study, we examined the factorability, validity, and reliability of the 21-item SDPS in a sample of survivors in DV programs. As a first step, we assessed the quality of our items by examining their inter-item correlations and the frequency of “not applicable” responses (Clark & Watson, 1995; DeVellis, 2012; Worthington & Whittaker, 2006). As a result of this process, we dropped one item due to its strong correlations and conceptual redundancy with two other items ($r = .87$ and $.85$) and we

eliminated items with “not applicable” response rates of more than 4% to ensure item relevance. These items included five negatively valenced items (e.g., *I feel judged by staff here; staff here are rude*); three items that referred to sensitivity to culture, class, or sexual orientation, and three others (e.g., *I feel comfortable disagreeing with staff here without worrying about losing services; I have the right to refuse services here; I decide how often I meet with staff here—by phone or in person*). This process left nine items for the EFA (see the appendix for list of items and contact first author for a copy of the final measure in English or Spanish).

The next step was to conduct an exploratory factor analysis (EFA).² The Kaiser–Meyer–Olkin index (.91) indicated good sampling adequacy and Bartlett’s test of sphericity was significant ($p < .001$), suggesting that the correlation matrix was appropriate for EFA. We then determined the number of factors to extract based on the Kaiser eigenvalue rule and the scree plot (DeVellis, 2012; Worthington & Whittaker, 2006). Both criteria supported a unidimensional solution. With principal axis factoring as an extraction method, the single factor solution accounted for 59.8% of the shared variance in the nine items. Communalities were at an acceptable level (from .39 to .80; $M = .60$), and internal consistency was high (Cronbach’s $\alpha = .93$).

Once we completed the EFA, we developed scale scores by averaging item scores. Means and standard deviations are presented in Table 1. Finally, supporting the scale’s construct validity, the scale score of SDPS was significantly correlated with clients’ satisfaction with services ($r = .77$).

Aim 2: To Explore the Relationship Between Survivor-Defined Practice and Three Dimensions of Safety-Related Empowerment

Another aim of this study was to explore the possible relationship between survivor-defined practice and three dimensions of safety-related empowerment. We first conducted basic analyses including descriptive statistics and bivariate correlations among the variables. A series of hierarchical regression analyses were then used to assess the multivariate contribution of demographic characteristics (race, immigration status, and parenting status; Block 1), financial stability and availability of informal social support (Block 2), and survivor-defined practice (final block) to the three aspects of safety-related empowerment as well as the composite of all three.

Table 1 shows the mean, standard deviations, and the zero-order correlations of the variables. On the bivariate level, financial stability, informal social support, and survivor-defined practice were all moderately correlated with each aspect of safety-related empowerment and with the MOVERS composite in the expected directions.

Table 1. Means, Standard Deviations, and Bivariate Correlations.

	M	SD	Possible Range	Actual Range	1	2	3	4	5	6	7	8	9	10
1. White ^a	—	—	[0.00, 1.00]	[0.00, 1.00]	—									
2. U.S. born ^a	—	—	[0.00, 1.00]	[0.00, 1.00]	.39**	—								
3. Having children ^a	—	—	[0.00, 1.00]	[0.00, 1.00]	-.06	-.14*	—							
4. Financial stability	0.95	0.69	[0.00, 2.00]	[0.00, 2.00]	-.02	-.07	.00	—						
5. Informal social support	6.63	2.44	[0.00, 9.00]	[0.00, 9.00]	.12	.12	.10	.27**	—					
6. Survivor-defined practice	3.47	0.56	[1.00, 4.00]	[1.43, 4.00]	.19**	-.04	.12	.16*	.33**	—				
7. MOVERS (Composite)	3.88	0.73	[1.00, 5.00]	[1.92, 5.00]	.02	-.01	.08	.30**	.37**	.35**	—			
8. MOVERS (Internal tools)	3.94	0.84	[1.00, 5.00]	[1.50, 5.00]	-.02	.01	.03	.24**	.28**	.26**	.86**	—		
9. MOVERS (Expectations of support)	3.86	0.97	[1.00, 5.00]	[1.25, 5.00]	.00	-.06	.12	.25**	.35**	.37**	.83**	.62**	—	
10. MOVERS (Trade-offs)	2.2	1.12	[1.00, 5.00]	[1.00, 5.00]	-.11	-.02	-.03	-.20**	-.22**	-.18**	-.59**	-.23**	-.28**	—

^aThese displayed categories were coded 1 whereas their corresponding counterparts (i.e., non-White, non-U.S. born, having no children) were coded 0. MOVERS = Measure of Victim Empowerment Related to Safety.

* $p < .05$. ** $p < .01$.

Table 2 presents a summary of the criterion variables regressed on safety-related empowerment. Across all models, demographic variables were not significantly associated with safety-related empowerment. In Block 2, the partial effects (β s) of financial stability and informal social support on safety-related empowerment were individually significant across all models. Above and beyond the effects of demographics, financial stability and informal social support simultaneously explained a small amount of variance in Trade-Offs (R^2 Change = 4.5%) and a medium amount of variance in the other two MOVERS subscale scores (R^2 Change = 10.9% and 13.9% for Internal Tools and Expectations of Support) as well as the MOVERS composite (R^2 Change = 17.3%). The additional variances explained for these models were all significant.

Controlling for the effects of demographics, financial stability, and informal social support, the partial effects (β s) of survivor-defined practice in Block 3 were significant on Internal Tools, Expectations of Support, and the MOVERS composite but not on Trade-Offs. Above and beyond Blocks 1 and 2, survivor-defined practice accounted for a small yet significant proportion of variance in Internal Tools, Expectations of Support, and the MOVERS composite (R^2 Change = 3.1%, 6.0%, and 5.0%, respectively). The additional 0.3% of the variance in Trade-Offs explained by survivor-defined practice was trivial and not significant. The final models accounted for a total of 14.2%, 20.4%, 6.2%, and 23.0% of the variance in the three aspects of safety-related empowerment and its composite, respectively, all reaching the level of statistical significance, $F(6, 248) = 6.84, 11.88, 3.82, \text{ and } 12.36, ps < .001$.

Discussion

As DV programs have grown in size and number over the past 45 years, they have also become more professionalized, hierarchical, and standardized, often resulting in a one-size-fits-all approach to service (Goodman & Epstein, 2008). Observing this trend, DV scholars and practitioners have argued forcefully for a return to a more survivor-defined approach in which advocates provide individually tailored and highly collaborative support to survivors as they work to achieve their own goals, claiming that such an approach is necessary to facilitate survivors' empowerment and long-term safety (Davies & Lyon, 2013; Kulkarni et al., 2012). Yet, in the absence of a tool to measure survivor-defined practice from survivors' perspectives, we have been unable to evaluate systematically its presence in individual relationships, and within and across programs; nor have we been able to demonstrate its presumed link to survivor empowerment. This study set out to fill these gaps by (a) developing a measure of survivor-defined practice from the perspective of

Table 2. Multiple Linear Regressions on Survivors' Safety-Related Empowerment.

	MOVERS (Composite)			MOVERS (Internal Tools)			MOVERS (Expectations of Support)			MOVERS (Trade-Offs)		
	Block 1 β	Block 2 β	Block 3 β	Block 1 β	Block 2 β	Block 3 β	Block 1 β	Block 2 β	Block 3 β	Block 1 β	Block 2 β	Block 3 β
White	.03	.01	-.05	-.03	-.01	-.07	.02	-.01	-.07	-.12	-.10	-.08
U.S. born	-.01	-.03	.01	.03	-.07	-.03	-.05	-.07	-.03	0.02	.03	.01
Having children	.08	.04	.02	.04	.08	.06	.11	.08	.06	-.03	-.01	-.01
Financial stability	—	.21***	.20**	—	.16*	.14*	—	.16*	.14*	—	-.15*	-.15*
Informal social support	—	.31***	.24***	—	.31***	.23***	—	.31***	.23***	—	-.17*	-.14*
Survivor-defined practice	—	—	.25***	—	—	.27***	—	—	.27***	—	—	-.09
R ²	0.7%	18.0%	23.0%	0.2%	14.4%	20.4%	0.5%	14.4%	20.4%	1.4%	5.9%	6.2%
Δ R ²	0.7%	17.3%	5.0%	0.2%	13.9%	6.0%	0.5%	13.9%	6.0%	1.4%	4.5%	0.3%
Δ F	0.59	26.26***	16.23***	0.18	21.47***	19.82***	1.40	21.47***	19.82***	1.16	8.59***	1.99

Note. MOVERS = Measure of Victim Empowerment Related to Safety.

* $p < .05$. ** $p < .01$. *** $p < .001$.

participants and (b) assessing its relationship to safety-related empowerment after controlling for other contributors to survivor well-being.

Results supported the reliability and validity of the SDPS, a nine-item measure that assesses participants' perception of the degree to which their advocates help them achieve goals they set for themselves, facilitate a spirit of partnership, and show sensitivity to their individual needs and styles. The items combined to form one factor indicating that the three theoretical aspects of survivor-defined practice may be different manifestations of one underlying construct.

The second aim of this study was to assess the extent to which those reporting higher levels of survivor-defined practice would also report higher levels of safety-related empowerment. Results indicate that indeed the SDPS was related to safety-related empowerment as a single construct (5.0% of additional variance explained) even after controlling for demographics, financial stability, and social support. Specifically, it was associated with two of the three dimensions of safety-related empowerment: participants' perception that they had the internal resources necessary to move toward safety (3.1% of additional variance explained), and that they had access to community support to facilitate safety (6.0% of additional variance explained). It was not, however, related to the third dimension, Trade-Offs; that is, participants' perception that moving toward safety would trigger new challenges (AUTHOR CITATION).

Overall, these results support the hypothesized link between survivors' perceptions of survivor-centered practice and their safety-related empowerment, but add nuance to this picture. The largest contribution of survivor-centered practice to safety-related empowerment was through Expectations of Support. When survivors experience help as oriented toward their goals and sensitive to their priorities, it appears that they have more optimism about the support community resources are able to provide. To a smaller but significant degree, survivor-defined practice was also positively associated with Internal Tools; that is, a survivor's sense that she knows what her path forward is and can do what is needed to move ahead. This aspect of safety-related empowerment is the most directly related to what survivor-defined advocates are aiming to achieve in their work with survivors. The cross-sectional nature of the study, and the fact that different lengths of interventions were aggregated in the sample, may have led to a weaker relationship between these variables than is possible under ideal circumstances. Among a sample with long-term relationships with advocates, it is possible the impact would be greater.

Although there was a bivariate relationship between survivor-defined practice and the Trade-Offs aspect of empowerment, this relationship

disappeared when the effects of demographics, financial stability, and social support were controlled for. This finding is consistent with a view shared by our practitioner collaborators in this project: Advocates can be severely limited in their ability to facilitate empowerment among survivors who lack basic resources, because for them in particular, working toward safety sometimes produces new and greater economic challenges that require a broader collaboration among community agencies. This kind of system-wide collaboration is certainly not the norm. As Davies and Lyon (2013) have pointed out in their foundational books on advocacy, a survivor-defined approach will never be entirely successful without a broad and comprehensive response to survivors that cuts across multiple systems.

When advocates are able to focus more broadly on their practice and collaborate in more comprehensive ways with community organization that support women's financial stability and social support in addition to safety, they may be able to assist survivors in reducing trade-offs. We explored this possibility through a post hoc mediation analysis (Preacher & Hayes, 2008), and found that financial stability and social support fully mediated the negative relationship between survivor-defined practice and trade-offs (indirect effects = $-.04$ and $-.09$, $SE = 0.03$ and 0.05 , $ps < .05$, respectively). In other words, it is possible that when advocacy helps improve survivors' financial stability and increases their social connections, difficult trade-offs may be diminished. Longitudinal research would be helpful in further exploring these relationships.

Limitations

Several sampling issues limit the generalizability of this study's findings. Although the sample was ethnically diverse, all participants were currently living in the Northeast, all identified as female, and the vast majority identified as heterosexual. Furthermore, although they came from a variety of types of DV programs, none was drawn from the justice system where survivor-defined practice might be experienced differently or be differentially related to empowerment. In addition, although this study includes both English and Spanish speakers and the SDPS is available in both languages, the small number of Spanish-speaking survivors in the sample made it impossible to conduct a separate EFA with this subsample. For all these reasons, it is critical that this study be replicated within specific subgroups, including men; lesbian, gay, bisexual, transgender, and queer (LGBTQ) participants; survivors from different parts of the country; and representatives of different ethnic and language communities. Yet, it is heartening in terms of generalizability to note that demographics of this sample (including race/ethnicity,

immigration status, and educational background) are almost identical to those of a national sample obtained in a study of community-based DV programs (Lyon et al., 2011), suggesting the potential generalizability of the SDPS to other help-seeking DV survivors.

Beyond sampling lie design limitations: Because this study was cross-sectional, causal direction cannot be determined. Although we have hypothesized that survivor-defined practice contributes to specific dimensions of safety-related empowerment, it is also possible that those who feel more empowered are also more likely to perceive the practice they receive as survivor-defined; or that in fact, advocates find it easier to take a survivor-defined approach when the survivors with whom they work seem to have a stronger sense of direction or have an easier time accessing resources. Longitudinal research will be necessary to clarify this question.

In terms of the validity of the SDPS, despite our efforts to reassure participants of the confidentiality of their responses, positive scores on the SDPS may to some extent reflect the need to affirm advocates' approach given the power they hold to provide or withhold needed resources and referrals. Researchers interested in conducting further validation of this measure should not only take every precaution to demonstrate and ensure the confidentiality of responses, but should also consider using a measure of social desirability to determine the extent to which participants are responding to please advocates.

In terms of specific items, the SDPS itself is limited by the absence of items that directly capture sensitivity to issues of class, culture, and sexual orientation. Although we aimed to include these items, the questions we developed (e.g., *Staff here respect my racial/ethnic background*; *Staff here respect my sexual orientation and/or gender identification*.) triggered too many *not applicable* responses to be retained. We hypothesized that this pattern might be a result of participants of majority groups (i.e., White, heterosexual, Christian) responding *not applicable* because they are not as likely to think about their own race, religion, or sexual orientation as relevant. Post hoc analysis on demographics of those participants who responded with *not applicable* revealed a significant difference in race, with more White participants selecting *not applicable* compared with participants of color; however, the effect was small (Cramer's $V = 0.15$), and there were no differences with regard to sexual orientation or religion. This suggests that these questions were not problematic across majority/minority lines and that more research is needed to understand the reasons why participants deemed them not applicable.

Finally, questions that included outright critical language (e.g., *I feel judged by advocates here*) also elicited too many *not applicable* responses

and had to be excluded. It is possible that participants were uncomfortable responding to such negatively valenced items, but instead preferred to express dissatisfaction through low scores to positively worded items.

Implications for Practice and Research

In terms of practice, although many advocates in DV programs would like to use a survivor-defined practice model in their work with survivors, they may be hampered by the considerable resources required to do so, including training, supervision, and extended time spent with individual clients. It is our hope that programs can use these data to request more of these resources to do this important work.

In terms of research and evaluation, the development of an empirically sound measure of survivor-defined practice will finally enable DV programs to assess the extent to which their staff members are successfully using this approach. Until now, available tools to measure the way survivors experience their work with staff have been composed mainly of one or two item measures (e.g., in the court context, *I feel that think the court considers my rights and wishes just as important as his rights and wishes* or *I got what I hoped for from filing a civil protection order*; Cattaneo & Goodman, 2010) or well-validated measures of general client satisfaction (e.g., CSQ-8; Attkisson & Greenfield, 2004; see also Goodman et al., 2015 for new measure of safety-related empowerment). Although the former may address components of survivor choice and control, they lack validity and reliability; and although the latter address an important concept, it is distinct from survivor-defined practice. For example, a survivor may indicate satisfaction with the services she received, but still wish for a more individualized response that affords her some say in which goals and services she pursues. The SDPS offers DV programs a mechanism for process evaluation that is rigorous but also rooted in the feminist empowerment philosophy that so many programs espouse (Goodman & Epstein, 2008). In addition, although the SDPS was developed for DV programs, it holds considerable promise for use in other social service programs that consider themselves to be client-centered but lack the appropriate evaluation tools.

Finally, although this study represents a significant step toward understanding the relationship between survivor-defined practice and survivor outcomes, additional research is needed to explore a broader array of potential outcomes and to establish a causal link between advocate practices and positive outcomes. To do the latter will require longitudinal research that compares outcomes for survivors who have and have not participated in a survivor-defined process. Although such an endeavor would be challenging, we have found that

when researchers partner with practitioners, a variety of new questions, methodologies, and solutions emerge that can support the work of researchers and programs, and, ultimately, improve the lives of survivors.

Conclusion

Although survivor-defined practice is an aspiration of many DV programs, it can be a challenging work. Through an ongoing university–community partnership, we aimed to provide an ecologically valid and useful assessment tool to support DV program staff as they strive to meet survivors where they are and to facilitate survivors’ movement toward their self-defined goals. Our study is the first of its kind to not only develop such a tool but also provide preliminary evidence that survivor-defined practice is an important mechanism in survivor empowerment. We hope to have laid important groundwork for future research to advance best practices and for future practice to demonstrate the impact of its efforts.

Appendix

Survivor-Defined Practice Scale Items

- I feel respected by staff in this program.
 - Staff help me to shape goals that work for me.
 - Staff here support my decisions.
 - Staff here do not expect me to be perfect.
 - Staff here support me even when things are not going well.
 - Staff here make sure that services are right for what I need.
 - Staff here offer choices.
 - Staff here believe that decisions about my life are mine to make.
 - Staff here respect the way I deal with things, whether or not they agree with it.
-

Acknowledgments

We are deeply indebted to the staff and participants of the programs that constitute the Domestic Violence Program Evaluation and Research Collaborative, including Casa Myrna, DOVE, Family and Community Resources, Health Imperatives, Jeanne Geiger Crisis Center, Journey to Safety, New Hope, Passageway, the Second Step, the Women’s Center of Rhode Island, Transition House, REACH, Renewal House, Respond, Sojourner House, Women Against Abuse, and the YWCA of Central Massachusetts. We are also grateful to the many mental health counseling MA students and social work students who supported this study through survey administration and data entry.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported in part by the Lynch School of Education at Boston College, the Simmons School of Social Work, and the Full Frame Initiative.

Notes

1. We have chosen to use the term *survivor-defined practice* rather than *advocacy*, as it is more reflective of the range of staff members that a survivor may encounter while at a domestic violence (DV) program. For example, an overnight manager at a DV shelter might not provide advocacy *per se*, but often is a source of support and crisis counseling.
2. With the “not applicable” and blank responses to the retained nine items, the exploratory factor analysis (EFA) was conducted based on a reduced sample size of 222. No significant demographic difference was noted between participants entered in the analysis and those dropped.

References

- Adams, A. E., Tolman, R. M., Bybee, D., Sullivan, C. M., & Kennedy, A. C. (2013). The impact of intimate partner violence on low-income women's economic well-being: The mediating role of job stability. *Violence Against Women, 18*, 1345-1367.
- Adkins, K. S., & Kamp Dush, C. M. (2010). The mental health of mothers in and after violent and controlling unions. *Social Science Research, 39*, 925-937.
- Attkisson, C. C., & Greenfield, T. K. (2004). The UCSF Client Satisfaction Scales: I. The Client Satisfaction Questionnaire-8. In M.E. Maruish (Ed.) *The use of psychological testing for treatment planning and outcome assessment* (3rd ed.) (pp. 799-811). Mahwah, NJ: Lawrence Erlbaum.
- Block, C., Devitt, C. O., Fonda, D., Engle, B., Fugate, M., Martin, C., . . . Walker, G. R. (2000). *The Chicago Women's Health Risk Study: Risk of serious injury or death in intimate violence: A collaborative research project*. Washington, DC: Department of Justice, National Institute of Justice.
- Breiding, M. J., Chen, J., & Black, M. C. (2014). *Intimate Partner Violence in the United States — 2010*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Bybee, D., & Sullivan, C. M. (2005). Predicting re-victimization of battered women 3 years after exiting a shelter program. *American Journal of Community Psychology, 36*, 85-96.

- Cattaneo, L. B. (2010). The role of socioeconomic status in interactions with police among a national sample of women experiencing intimate partner violence. *American Journal of Community Psychology, 45*, 247-258.
- Cattaneo, L. B., & Chapman, A. R. (2010). The process of empowerment: A model for use in research and practice. *American Psychologist, 65*, 646-659.
- Cattaneo, L. B., & Goodman, L. A. (2010). Through the lens of therapeutic jurisprudence the relationship between empowerment in the court system and well-being for intimate partner violence victims. *Journal of Interpersonal Violence, 25*, 481-502.
- Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment, 7*, 309-319.
- Davies, J., & Lyon, E. (2013). *Domestic violence advocacy: Complex lives/difficult choices*. Thousand Oaks, CA: Sage.
- DeVellis, R. F. (2012). *Scale development: Theory and applications* (3rd ed.). Chapel Hill, NC: Sage.
- Du Mont, J., Forte, T., Cohen, M. M., Hyman, I., & Romans, S. (2005). Changing help-seeking rates for intimate partner violence in Canada. *Women & Health, 41*(1), 1-19.
- Dunst, C. J., & Leet, H. E. (1987). Measuring the adequacy of resources in households with young children. *Child: Care, health and development, 13*(2), 111-125.
- Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*, 461-477.
- Goodman, L. A., Bennett Cattaneo, L. B., Thomas, K., Woulfe, J., Chong, S. K., & Smyth, K. F. (2015). Advancing domestic violence program evaluation: Development and validation of the Measure of Victim Empowerment Related to Safety (MOVERS). *Psychology of Violence, 5*(4), 355-366.
- Goodman, L. A., Dutton, M. A., Vankos, N., & Weinfurt, W. (2005). Women's resources and use of strategies as risk and protective factors for re-abuse over time. *Violence Against Women, 11*(3), 311-336.
- Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice*. Washington, DC: American Psychological Association.
- Goodman, L. A., Glenn, C., Bohlig, A., Banyard, V., & Borges, A. M. (2009). Feminist relational advocacy: Processes and outcomes from the perspective of low-income women with depression. *The Counseling Psychologist, 37*, 848-876.
- Johnson, D. M., Zlotnick, C., & Perez, S. (2011). Cognitive behavioral treatment of PTSD in residents of battered women's shelters: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 79*, 542-551.
- Kasturirangan, A. (2008). Empowerment and programs designed to address domestic violence. *Violence Against Women, 14*(12), 1465-1475.
- Kocot, T., & Goodman, L. A. (2003). The roles of coping and social support in battered women's mental health. *Violence Against Women, 9*, 1-24.
- Kulkarni, S. J., Bell, H., & Rhodes, D. M. (2012). Back to basics essential qualities of services for survivors of intimate partner violence. *Violence Against Women, 18*, 85-101.

- Kulkarni, S. J., Herman-Smith, B. H., & Ross, T. C. (2015). Measuring intimate partner violence (IPV) service providers' attitudes: The development of the Survivor-Defined Advocacy Scale (SDAS). *Journal of Family Violence, 30*, 911-921.
- Lyon, E., Bradshaw, J., & Menard, A. (2011). *Meeting survivors' needs through non-residential domestic violence services & supports: Results of a multi-state study*. Washington, DC: National Institute of Justice.
- Macy, R. J., Giattina, M., Sangster, T. H., Crosby, C., & Montijo, N. J. (2009). Domestic violence and sexual assault services: Inside the blackbox. *Aggression and Violent Behavior, 14*, 359-373.
- McDermott, M. J., & Garofalo, J. (2004). When advocacy for domestic violence victims backfires types and sources of victim disempowerment. *Violence Against Women, 10*, 1245-1266.
- National Coalition Against Domestic Violence. (2011). *About the National Coalition Against Domestic Violence*. Retrieved from <http://www.ncadv.org/aboutus.php>
- Nichols, A. J. (2013). Survivor-defined practices to mitigate revictimization of battered women. *Journal of Interpersonal Violence, 28*, 1403-1423.
- Perez, S., Johnson, D. M., & Wright, C. V. (2012). The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters. *Violence Against Women, 18*, 102-117.
- Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods, 40*, 879-891.
- Schechter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement*. Boston, MA: South End Press.
- Sullivan, C. M. (2011). Evaluating domestic violence support service programs: Waste of time, necessary evil, or opportunity for growth? *Aggression and Violent Behavior, 16*, 354-360.
- Worthington, R. L., & Whittaker, T. A. (2006). Scale development research: A content analysis and recommendations for best practices. *The Counseling Psychologist, 34*, 806-838.
- Zweig, J. M., & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women, 13*, 1149-1178.

Author Biographies

Lisa A. Goodman, PhD, professor and director of training in the Department of Counseling and Developmental Psychology at Boston College, received her doctorate in clinical/community psychology from Boston University in 1991. Her research explores the interaction between intimate partner violence survivors and the practices, systems, and policies that aim to help them, as well as innovative mental health interventions for low-income communities. She consults extensively with local and national domestic violence (DV) organizations.

Kristie Thomas, PhD, MSW, assistant professor at Simmons College School of Social Work, has extensive practice, teaching, and research experience in the field of

intimate partner violence among marginalized populations. Additional research expertise includes homelessness, program evaluation, and community capacity building. She co-founded the Domestic Violence Program Evaluation and Research Collaborative (DVPERC).

Lauren Bennett Cattaneo, associate professor and director of clinical training at George Mason University, received her doctorate in clinical/community psychology from the University of Maryland in 2001. Her research focuses on empowerment theory, survivor-centered practice, experiences of victims of intimate partner violence, and service learning as a mechanism for social change.

Deborah Heibel is the director of Operations for REACH Beyond Domestic Violence. She holds a bachelor's degree in applied math and a master's degree in human service management. She has worked in the non-profit sector for more than a decade, including various housing and homeless services programs in Hartford and Philadelphia.

Julie Woulfe is a PhD student in Boston College's Counseling Psychology Program. Her scholarship and clinical work are focused on the intersection of oppression and interpersonal trauma and resilience; lesbian, gay, bisexual, transgender, and queer (LGBTQ) mental health; and incorporating community-based practices into research. She received her MS in counseling psychology from the University of Wisconsin–Madison.

Siu Kwan Chong is currently a master's student in mental health counseling at Boston College. He is interested in researching issues related to stigmatized groups across the life span and cultures, and examining factors that foster community building and resilience of such groups.