A Framework for Domestic Violence Service Provision to Women and Children in Ireland

2015
About SAFE Ireland

SAFE Ireland is a young, innovative and strategic national organisation.

We work with 40 specialist domestic violence member organisations across Ireland. Together we provide a range of services to support the safety and well being of 12,000 women and children annually. Through this work we understand the complexities, impact and pervasiveness of domestic violence in Ireland. We believe that Ireland has the potential to become one of the safest countries for women and children.

We work to centre stage the needs and experiences of women and children who are impacted by domestic violence. Through bringing a deeper understanding of women and children’s needs and experiences we develop awareness and interventions to prevent domestic violence and to transform the state services and social responses to domestic violence. We lead research and disseminate good practice to our members, other professionals and statutory bodies.

We work in collaboration with our members, government departments, state agencies, relevant stakeholders and international partners to progress a change agenda. We want society to take responsibility for the eradication of violence against women.
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Overview: This report examines the work of domestic violence services within a “social and emotional well-being” framework. It first elucidates how domestic violence negatively impacts women’s and their children’s well-being, and which factors have been shown to restore this well-being over time. It then describes the Theory of Change that is at the foundation of domestic violence services’ work, and details how domestic violence services creatively engage with women and their children to influence the factors known to promote their well-being. It concludes with a review of the empirical evidence examining the extent to which domestic violence services have been effective in achieving their desired outcomes.

The Policy Context

Cosc is the National Office for the Prevention of Domestic, Sexual and Gender Based Violence. The office was set up under recommendations from the Task Force on Violence Against Women (1997) and developed the National Strategy on Domestic, Sexual and Gender Based Violence (2010-2014). The overall strategic objective of the strategy was “developing a strong framework for sustainable intervention to prevent and effectively respond to domestic, sexual and gender based violence” (Cosc, 2010). From this overall strategic objective, key objectives of specific relevance to this framework document were developed, such as:

- To raise awareness among young people of domestic, sexual and gender based abuse.
- To increase confidence in service provision for those affected by DV and SV
- To promote high standards in service provision
- To strengthen intra- and inter-organisational co-ordination to improve service effectiveness and consistency
- To improve protection and support for victims
- To ensure that policy development and service provision planning are evidence-based and take account of the experience of victims
- To ensure greater coordination between relevant organisations
- To provide a solid foundation for future actions on domestic and sexual violence (Cosc, 2010).

Work is currently being carried out to review the achievements and challenges of the strategy.

On January 1st 2014 responsibility for domestic, sexual and child abuse services was transferred from the HSE to the newly established Child and Family Agency (Tusla). The Agency became an independent legal entity, comprising HSE Children & Family Services, Family Support Agency and the National Educational Welfare Board as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender based violence. Tusla, The Child and Family Agency is now the dedicated State agency responsible for improving wellbeing and outcomes for children.
The Agency operates under the Child and Family Agency Act 2013, and included within its remit is a statutory duty to:

"Without prejudice to the generality of subsection (1), in supporting and encouraging the effective functioning of families pursuant to subsection (1)(c), the Agency shall provide-

(a) preventative family support services aimed at promoting the welfare of children,
(b) care and protection for victims of domestic, sexual or gender-based violence, whether in the context of the family or otherwise, and
(c) services relating to the psychological welfare of children and their families."

(Taken from Child and Family Agency Act 2013, Section 8).

The Agency is responsible for the majority of funding to specialist domestic violence services, as well as rape crisis centres and other family support services. Tusla, the Child and Family Agency published a suite of documents in 2013 providing guidance around implementation of its family support framework. As the national commissioning body for family support services the intention is to set up local Child and Family Support Networks (CFSNs) to provide a continuum of support, from universal support, to targetted and specialist services, (including specialist domestic violence services), applying a progressive universalist approach. The National Practice Model – Meitheal (Child and Family Agency, 2013) will facilitate the delivery of needs based, integrated and preventative support to families and will form one avenue through which parenting support may be delivered. The approach is needs led and building a therapeutic alliance with a family is a key component of providing help. The level of intervention is assessed in respect of the level of risk to children and parental capacity.

Setting forth the framework of specialist domestic violence services is timely in the light of two European legal instruments which significantly strengthen the human rights of women, highlight the problem of violence against women and domestic violence and make clear the political imperative to eliminate gender based violence and discrimination. Ireland has opted into the Victim’s Rights Directive of the European Parliament and of the Council (2012) establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA. The directive enshrines the rights of victims and must be transposed into law by November 2015. The Directive requires every Member State to implement legislation to give all victims of crime minimum rights, support, and protection, regardless of where the crime was committed in the European Union, where the victim resides in the EU or the victim’s nationality or citizenship. The Directive aims to ensure that all victims within the Member States of the EU receive the same information, support and protection e.g. receiving information from a competent authority on first contact with that authority, to have specific needs assessed and protective measures to respond to these specific needs.

The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (2011), also known as the Istanbul Convention, is a new landmark treaty which creates a legal framework at pan-European level to protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence. The Convention acknowledges that domestic violence affects women disproportionately, while allowing for its provisions to be applied to all victims of domestic violence. The Convention defines and criminalises various forms of violence (including forced marriage, female genital mutilation, stalking, physical and psychological and sexual violence). Signatories are legally bound to set standards to prevent and respond to gender based violence, protect victims and punish perpetrators.
The Convention also establishes a specific monitoring mechanism ("GREVIO") in order to ensure effective implementation of its provisions by its member state signatories. To date, it has been signed by 37 Member States of the Council of Europe. The Irish government is committed to signing this convention and has announced that work is being carried out to change legislation to enable Ireland to ratify the Istanbul Convention. This would strengthen the rights of victims of domestic violence in this country, and would also necessitate commitment to change policy and practice responses from the Irish Government.

The Problem: Domestic Violence and Its Consequences

Domestic violence is a serious and pervasive social problem with devastating physical, emotional, psychological, and economic consequences for victims. Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. In some regions, 38% of women have experienced intimate partner violence; globally as many as 38% of all murders of women are committed by intimate partners (WHO, 2013). Across Europe, one in four women experience domestic violence over their lifetimes and it is the major cause of death and disability for women aged sixteen to forty-four years, accounting for more death and illness than cancer and road accidents (Council of Europe, 2002). The European Union Fundamental Rights Agency (FRA, 2014) conducted an EU wide prevalence study on domestic violence and found that one in three European women had experienced physical or sexual violence since the age of 15 years old by a partner or non-partner. Fifteen percent of Irish women participants reported physical and/or sexual violence by a partner since the age of 15 years old, with almost one in three Irish women (31% or 470,157 women) having experienced some form of psychological violence by a partner. The study looked at the services women contacted for help. Responses from Irish women varied considerably with 21% of women stating they went to the police, while 20% went to hospital and 24% of women went to a doctor or other health care professional. Only 8% of women went to a women’s refuge. The survey then asked respondents to cite the reasons that they did not contact the police for assistance following the most serious incident of physical or sexual violence by a partner. Over half (53%) of Irish women stated that they dealt with it themselves/ involved a friend/ family member. The percentage of women who cited this as a reason was considerably larger than the EU average of 39%. Ireland had the second highest response rate to this reasoning. The reason for such a response may be connected to the shame and embarrassment which 16% of Irish respondents cited as reason for not reporting. Similarly 22% of Irish women said that they did not want anyone to know and wanted to keep it private as a reason for not reporting compared to the EU average of 14% of women.

In England and Wales, there are 13 million separate incidents of physical violence or threats of violence against women from partners or former partners. Women are much more likely than men to be the victims of multiple incidents of abuse (representing 89% of those experiencing 4 or more incidents of domestic violence) and of sexual violence. Further, over half of UK rapes are committed by a woman’s current or former partner (Walby and Allen, 2004). The most recent national survey in the United States found that one third of women have been physically assaulted, sexually assaulted, and/or stalked by an intimate partner (Black et al., 2011). One in four men also reported experiencing some form of domestic violence, although stark gender differences were found in the types of abuse experienced as well as the impact of abuse on victims. For example, 65% of the men reporting domestic violence said that the experience had NOT negatively impacted their lives, and only 5% said the violence had made them afraid. Nearly four times more women were injured by the domestic violence, and nearly five times more women needed medical care.

The first national survey of domestic violence in Ireland, ‘Making the Links’ (Kelleher and O’Connor, 1995) found that 18% of women reported that they had experienced domestic violence by a partner. Mc Gee et al, (2002) showed that almost a quarter of women who were abused as adults were abused by their partner or ex-partner. The National Crime Council (2005) found that 15% of women and 6% of
men had experienced severe emotional and physical abuse by a partner at some point in their lives. Women were seven times more likely to suffer sexual abuse by a partner, twice as likely to experience severe physical abuse and three times more likely to experience severe emotional abuse. Of those experiencing abuse, 93% of the women reported being very frightened and distressed (compared to 62% of men) and 80% of women said the abuse had a lasting impact on their lives. National research carried out in 1999 found that between 1% and 6% of domestic violence offenders in Ireland receive a prison sentence (Kelleher & O’Connor, 1999). In 2012, 42% of Barring Orders and 45% of Safety Orders applied for nationally were granted (Court Services Annual Report 2013).

Although some couples engage in mutual or low-level violence that does not alter the power dynamics within their relationship, the larger social problem of domestic violence includes a pattern of behaviour, generally committed by men against women, which aims to gain an advantage of power and control over their victims (Bancroft, 2003; Johnson, 1995; Stark, 2007). Such behaviour includes physical violence and the threat of continued violence, but also includes psychological torment designed to instill fear or confusion in the victim, and to make her question her abilities. The pattern of abuse also often includes sexual and economic abuse, coerced or forced illegal activity, coerced or forced substance misuse, social isolation, and threats against loved ones (Adams, Sullivan, Bybee, & Greeson, 2008; Bancroft, 2003; Black et al., 2011; Pence & Paymar, 1993). Domestic violence as defined by the Irish government task force (1997), while offering a gender neutral description, includes the use of or threat of use of physical, sexual and emotional force and adds that domestic violence ‘goes beyond actual physical violence. It can also involve emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone’.

The Health Consequences of Domestic Violence

There are serious, chronic, and even lethal health consequences for victims of domestic violence. In Ireland, since 1996, 63% of murdered women (i.e. 130 women) have been killed in their own homes. In the resolved cases, 84 women (55%) were officially found to have been murdered by a partner or ex-partner. (Women’s Aid Female Homicide Media Watch, March 2015). There is a greater prevalence of depression and anxiety worldwide as well as in Ireland for women who experience violence in their relationships (Kelleher et al 1995; HSE Mid-West 2005; Women’s Health Council, 2005). One study of Irish general practices found that 67% of women who were depressed had experienced domestic violence and/or sexual violence as compared to 33% who had not (Bradley, 2002). Women who have experienced domestic violence are at an increased risk of depression and suicide attempts; physical injuries; psychosomatic disorders; unwanted pregnancies; HIV and other STD’s; and being killed by a partner (WHO, 2002). A study conducted by the Rotunda Maternity Hospital found that in a sample of 400 pregnant women, 12.5% (1 in 8) had experienced abuse while they were pregnant (O’Donnell et al, 2000). Minority ethnic women are over represented among women who attend for support from gender based violence organisations, and make disclosures of violence and abuse to either hospital staff, General Practitioners, Public Health Nurses, or Sexual Assault Treatment Units (Women’s Health Council, 2005). Domestic violence has been found to relate to Post Traumatic Stress Disorder (PTSD), depression, and suicide ideation (Carlson, McNutt, Choi, & Rose, 2002; Coker et al., 2002; Pico-Alfonso et al., 2006; Zlotnick, Johnson, & Kohn, 2006). Further, many women turn to alcohol or other drugs to cope with their victimisation (Cunradi, Caetano, & Schafer, 2002; Fowler & Faulkner, 2011; Kilpatrick et al., 1997; Martino, Collins, & Ellickson, 2005).

1 In 2013, there were 13,375 applications under the Domestic Violence Act (1996). 2,738 Baring orders were applied for and 1,167 were granted (42%); 5,334 Safety orders were applied for and 2,381 were granted (45%); 4,529 Protection orders were applied for and 4,142 were granted (91%) and 674 Interim Barring orders were applied for and 522 granted (77%). [Court Services Annual Report 2013]
Saint Arnault & SAFE Ireland (2014) in a research study to address the trauma impacts on women of domestic violence post-separation found that even though all the women had been out of their relationships for five years or more and were physically safe, they did not feel safe and that connecting to their daily life was difficult. The study highlighted a direct correlation between the effects of domestic violence on women’s health and their help-seeking capacity such that trauma effects impeded women’s capacity to avail of and benefit from support.

Ethnic Minority Women’s Experiences

In 2013, over 8,000 women and just under 3,500 children accessed support from domestic violence services in Ireland. This represents a 70% increase since 2007 when national statistics began (SAFE Ireland Annual Statistics 2013). These figures are believed to be only 20% of the overall number of women experiencing domestic violence in Ireland. Within these figures, disproportionate numbers of ethnic minority and Traveller women are represented, and the additional barriers that they face when accessing services must be acknowledged and addressed. Census figures (2006) estimate that 12 per cent of the Irish female population are members of minority ethnic groups, comprising a diverse range of women who may be asylum seekers, refugees, migrants, Travellers, foreign students, or members of new and established communities. The special needs and challenges for ethnic minorities generally in accessing health services is acknowledged (HSE National Intercultural Health Strategy, 2007-12). The Istanbul Convention (2011) defines and criminalises practices such as forced marriage, female genital mutilation, discrimination on the grounds of migrant, refugee or other status (Article 4, (3)) and also frames the eradication of prejudices, customs, traditions and other practices which are based on the idea of the inferiority of women and girls or on gender based stereotyped roles as a general obligation to prevent violence (Article 12,(1)).

A study of gender based violence (GBV) and ethnic minority women in Ireland (Women’s Health Council, 2009) found that 13% of users of GBV organisations were non-indigenous ethnic minority women (the majority were on spouse dependent visas or migrant worker visas or asylum seekers or refugees) yet these correspond to only 5% of the Irish population over 15 years old (CSO, 2006). Domestic violence was found to be the most common form of GBV experienced by ethnic minority women (including Traveller women) in the research. Barriers to ethnic minority womens’ access to services included legal status and Habitual Residency policies, poverty issues, social isolation, racial prejudice and discrimination, and lack of inter-culturally competent services. Allen (2012) explored the added difficulties Traveller women face where they experience domestic violence. The issues of primary concern to Irish Traveller women were poverty, social isolation, racism by the police and some service providers, as well as literacy issues that make it difficult for women to access the legal system and the lack of appropriate longer-term housing options for women who wish to leave an abusive relationship.

In 2013, SAFE Ireland completed a Report on the impact of the Habitual Residence Condition on women seeking protection and safety for themselves and their children from a domestic violence perpetrator. This research consultation was commissioned in order to collate and document the range of issues that were emerging from SAFE Ireland members relating to the Habitual Residence Condition (HRC). A person must satisfy certain criteria to be seen as a habitual resident, in order to make an application for the following: Blind Pension, Carer’s Allowance, Child Benefit, Disability Allowance, Domiciliary Care Allowance, Guardian’s Payment (Non Contributory), Jobseeker’s Allowance, One Parent Family Payment, State Pension (Non Contributory), Supplementary Welfare Allowance, and Widow(er)’s Non Contributory Pension. Overall the research found that the HRC places unacceptable barriers for women seeking protection and safety from an abusive and violent perpetrator with whom they have an intimate relationship. Women may not meet the right to reside criteria through no fault of their own. Her partner
may have refused to re-apply for her visa, may withhold information from her or may seize and hold her travel and visa documents. A woman may not meet the HRC requirements and therefore be excluded from accessing Child Benefit, One Parent Family Payment etc. A lack of English comprehension, family and support networks and familiarity with immigration and social welfare systems in Ireland, is also being leveraged by abusers to further marginalise their victims.

As mentioned earlier, the Victims’ Directive (2012) requires every E.U. Member State to implement legislation to give all victims of crime minimum rights, support, and protection, regardless of where the crime was committed in the European Union, where the victim resides in the EU or the victim’s nationality or citizenship.

**Economic Abuse Factors**

Domestic violence often includes economic abuse as well, including preventing women from working or attending education or training, sabotaging their employment or housing, or ruining their credit (A. Adams et al., 2008; Alexander, 2011). The National Crime Council (2005) concluded that the likelihood of severe abuse by a partner increases dramatically (seven times for women and 2.5 times for men) where one partner controls decisions about money. Internationally there is recognition of the link between the protection, support and empowerment of women victims and economic independence (Istanbul Convention 2011, Article 18, (3)).

**Children’s Experiences of Domestic Violence**

Children’s rights are now enshrined in the Irish Constitution (2012) with the state having clear responsibility for the safety and welfare of children where parents fail in their duty to protect their children. The views of children are also to be solicited, where practicable, in relation to any legal proceedings affecting them. In Ireland, the state’s vision for ensuring the well-being of children has been about investing in those who take care of them (HSE, 2002, Child and Family Agency, 2013). This involves a strategy of working in partnership with parents where their actual and potential expertise on their children’s well-being is acknowledged. Better Outcomes, Brighter Futures: The Irish National Policy Framework for Children and Young People (2014-2020) includes principles of being child centred and family oriented, upholding children’s rights as well as equality and diversity, evidenced based policies and services and accountability. Building on the National Children’s Strategy (2000-2010) the new policy framework emphasises the need for integrated and coordinated delivery of services to children and families. Tusla, the Child and Family Agency has as its mission to put the child at the centre, and design and deliver supportive, coordinated and evidence-informed services that strive to ensure positive outcomes for children. Tusla operates under the Child and Family Agency Act, 2013, which places the best interests of the child as the paramount consideration. The legislation views families as the foundation of strong healthy communities where children and young people can flourish and achieve their potential. Working in partnership with families is seen as essential, using a strengths based approach and facilitating access to community and specialist services (Department of Children and Youth Affairs Task Force Report, 2012).

The framework of family support operating under Tusla is underpinned by a set of interrelated theories i.e. social ecology, local support, resilience, social capital and attachment theory. These theories are elaborated in “What works in Family Support” (2013). Factors associated with resilience include a sense

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1 While all those being victimised by a partner deserve effective advocacy, protection, and support, the overwhelming majority of adult domestic violence survivors seen by local services are women. Intimate partner violence is a gendered social problem, with women being disproportionately targeted and harmed by male partners. For that reason, adult survivors are referred to as “women” and “she/her” throughout this document. This is not meant to minimise the experience of men abused by male or female partners, nor to ignore the experiences of men served by domestic violence services.
of self-esteem and confidence, a belief in one’s own self efficacy and an ability to deal with change and adaptation, and a repertoire of problem solving approaches’ (p.20). The ecological perspective recognises that how the family functions as a system is important and also that families are socially situated and affected and influenced by their surrounding environment. Relevant ecological factors that must be considered when supporting children and their families include the family members, institutional, local, workplace environments and wider social influences relating to norms, beliefs, laws and culture. Social capital is concerned with the mutually supportive relations and resources within a community that contribute to individual and collective growth and activity.

Just under 3,500 children accessed support from a domestic service in 2013 (SAFE Ireland Annual Statistics 2013). In reality more children are admitted to refuge than women. There is now recognition that children are also victims of domestic violence either through being directly abused or through witnessing their mothers or other family members being abused. Growing up in a household where there is domestic violence can have a significant impact on a child’s development. Children may react differently to domestic violence depending on their age, sex, the frequency and extent of the violence and the types of role models that surround them. Increasingly services in Ireland are encountering women, who had been with the service as a child, coming into refuge because they are now in an abusive relationship. This pattern of cyclical presentation underlines the importance of providing strong child focused supports and interventions. When children come to domestic violence services they are offered services such as safety planning, counselling and play therapy. Unfortunately and inevitably there is evidence that services to children have suffered as a result of funding cut backs to services in recent years (SAFE Ireland, 2014a).

The link between child physical abuse and domestic violence is strong, with estimates ranging between 30% to 66% depending upon the study (Hester et al, 2000; Edleson, 1999; Humphreys & Thiara, 2002). Research suggests that 30% of domestic violence starts when women are pregnant. (Lewis and Drife, 2001; 2005; McWilliams and McKiernan, 1993). Millions of children worldwide are exposed to the violence perpetrated against their mothers (Graham-Bermann, Howell, Lilly, & DeVoe, 2011; McDonald et al., 2007), and many of these children are directly abused by the perpetrator as well (Appel & Holden, 1998; Edleson, 1999). A growing body of literature indicates that children who witness abuse against their mothers, even when they themselves are not the targets of violence, are at risk for psychological and behavioural disturbance when compared to children who have not been exposed to such violence (see Kitzman, Gaylord, Holt, & Kenny, 2003, for a review). Children’s emotional and behavioural reactions to witnessing domestic violence can be severe and pervasive, and include somatic complaints, behavioural problems, withdrawal and depression (Grych et al., 2000; Kitzman et al., 2003). Not all children, of course, respond in the same way to witnessing abuse against their mothers, and some children are more adversely affected than others (Graham-Bermann, Gruber, Girz, & Howell, 2009). Research internationally indicates that four-fifths of children and adolescents who disclose sexual abuse, are also living with family violence (Kellog & Menard, 2003). In Ireland, high profile child protection cases reveal the serious consequences for young people e.g. Kilkenny Incest Investigation (McGuinness, 1993) and the West of Ireland Farmer Case (North Western Health Board, 1998). The recently published Report of the Independent Child Death Review Group (2012) found that there was a history of domestic violence in thirty of the one hundred and ninety six cases examined.

Studies carried out on the impact of domestic violence on children in Ireland such as Listen to Me! Children’s Experience of Domestic violence (2006) and Listening to Children: Children’s Stories of Domestic violence (2007) have also identified significant negative effects on the lives of children who bear witness to domestic violence. Children gave accounts of the anxiety, fear and dread they endured in their childhood and teenage years, how they were bullied at school, felt burdened with responsibility
to their parents and their siblings and their regrets about their lost childhoods and opportunities (Buckley, Whelan & Holt, 2006). Hogan & O’Reilly (2007) conducted interviews with 22 children, 19 mothers and 22 professionals on children’s experiences of domestic violence. The children spoke of the distress of overhearing their mothers being abused and some spoke of the experience of being assaulted themselves. They also acknowledged the medium to long term impacts of domestic violence on their lives such as unplanned pregnancy, drug and alcohol abuse, behavioural problems, physical health problems, and dropping-out of school. While identifying common outcomes for children in relation to their behavioural and emotional development, depression and strained relationships with parents, both studies stress that the impacts of domestic violence on children are extremely diverse and each child’s needs and circumstances must be considered in determining responses.

Both the Istanbul Convention (Articles 26, 31) and Victims’ Rights Directive (e.g. sub-sections 14, 19) strengthen the rights under law of children affected by crime and violence in relation to having their voices heard by court and other authorities and protective measures in place to respond to their assessed needs.

**Services and the Social Context**

From the research and victims’ direct experiences, clearly the social context from which and within which difficulties like domestic violence occur needs to be a key consideration in devising any framework to understand and respond to the difficult experiences of people lives. A broad range of supports for the thousands of women and even more children who experience domestic violence in Ireland have developed, including refuge services, support and information services, accompaniment and advocacy, transitional housing, support groups, supervised visitation centers, outreach, and counselling services. SAFE Ireland member services have never limited themselves to focusing solely on the abuse a woman and her children might have experienced before seeking assistance. They clearly care about service users’ immediate and long-term safety, but also realise that physical safety is not sufficient to ensuring women’s and children’s long-term health and well-being. Domestic violence services to women and children are built on a principle and philosophy of “empowerment,” or helping adult and child service users achieve personal, interpersonal, and social power (Sullivan, 2006; SAFE Ireland National Framework and Quality Standards 2015). This is why domestic violence victim services consult with their clients and why services are individually tailored to women and children’s needs, and span the range from crisis intervention to intensive advocacy (SAFE Ireland 2011). It is also why a key component of domestic violence work is systems change and social change: people’s well-being is directly impacted by the level of supports and opportunities available in their environments (SAFE Ireland 2003). Again the intended ratification by the Irish state of the Istanbul Convention will reinforce the relevance of and requirement to undertake complementary approaches in respect of policies and measures to respond to experiences of violence against women alongside policy responses towards gender equality and the reduction of gender based discrimination (Article 1(b) and Article 4).
A theory of change is an evidenced based articulation of how and why one expects a desired change to occur (Anderson, 2005; Hernandez & Hodges, 2006). It involves identifying the desired long-term objectives (e.g., what are we hoping to accomplish?), and then working backwards to identify how specifically to achieve measurable outcomes tied to the goals (e.g., how do we get there?). It is quite similar to using a logic model to guide one’s work, but differs in that it intentionally and explicitly incorporates established theories as well as scientific evidence to create an empirically justified conceptual framework (Hernandez & Hodges, 2001, 2006).

Conceptual frameworks are basically “road maps” designed to connect how we think about a problem to the activities and practices we are involved in to address the problem and our desired outcomes from these activities. Examining domestic violence work with women and their children within a conceptual framework helps services define and communicate what they do and why they do it. It is also a way to continually examine one’s own accountability: How well is a service meeting its goals? Is a service engaging in practices and activities that are likely to lead to their desired goals? Should staff be doing anything differently?

The Social and Emotional Well-Being Promotion Framework, hereafter abbreviated as the Well-Being Framework, is an ideal structure to use to describe the goals and practices of domestic violence services because this framework: (i) accurately represents domestic violence services’ goal of helping women and their children thrive; and (ii) recognises the importance of community, social, and societal context in influencing individual social and emotional well-being.

The Well-Being Framework

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

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

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1 Throughout this document the word ‘staff’ refers to both paid employees and volunteers working within domestic violence services, as most services rely on at least some trained volunteer labour to achieve their goals.
Protective factors are conditions or variables located within a person, family, situation or community that reduce the likelihood of negative outcomes occurring. Having supportive family and friends protects service users from being trapped with an abuser. It is not a guarantee that such support will protect a woman and her children, but it is more protective in general than having unsupportive friends and family.

Promotive factors are conditions or variables located within a person, family, situation or community that contribute to positive outcomes. When a mother understands the impact of domestic violence on her relationship with her child, this can promote a more positive mother-child bond. When a staff member advocates with or for a woman and her family to obtain stable housing and access to community support services, this can promote many other positive changes in their lives, including an increase in social support and a greater sense of overall well-being.

Domestic violence services do reduce risk factors and enhance protective factors that have been linked to re-victimisation and impaired well-being. However, they are interested in more than preventing a negative event (e.g., abuse, PTSD) from occurring. The primary focus of domestic violence services is to enhance promotive factors that contribute to women and their children’s well-being. Article 1(b) of the Istanbul Convention on the Purposes of the Convention reinforces the significance and necessity of including promotive factors in a comprehensive framework so that those affected by violence are not just safe and emotionally and psychologically well but can re-build their lives. National policy in respect of supporting families is also focused on prevention and attending to the evidence base of what works for families and delivers the best outcomes in meeting the range of their needs (Child and Family Agency, 2013).

Predictors of and Pathways to Well-Being

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

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

The COR theory asserts that psychological distress following traumatic or highly stressful life events is strongly influenced by “resource loss,” in that trauma often results in individuals losing economic, social, and interpersonal resources central to their well-being (Hobfoll, 1989, 1998, 2001). For women with abusive partners, this could include consequences such as having to relocate and leave family and friends, in addition to experiencing physical injuries, depression, and/or a reduced sense of self. The theory proposes that if this trauma-induced ‘resource loss’ is followed by resource gain, psychological distress will be reduced and well-being will be increased. For example, if safety is re-established, justice is achieved, and skills are enhanced, these resource gains would counteract the resource losses and reduce the negative impact of the trauma. There has been considerable empirical support for this theory across numerous populations (e.g., Hobfoll, Johnson, Ennis, & Jackson, 2003; Hobfoll & Lilly, 1993; Hobfoll, Mancini et al., 2011; Hobfoll, Tracy, & Galea, 2006; Wells, Hobfoll, & Lavin, 1999).

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

The following sections briefly review seven predictors of well-being that are typically targeted by domestic violence services. At the intrapersonal level, these are (i) self-efficacy and (ii) hope. Predictive factors at the interpersonal and social levels include (iii) social connectedness and positive relationships with others, (iv) being safe, (v) good physical, emotional and spiritual health, (vi) possessing adequate resources, and (vii) social, political and economic equity.
Intrapersonal Predictors of well-being.

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

**Self-efficacy**

Self-efficacy is the belief that one is competent and able to perform the actions needed to achieve a goal (Bandura, 1977). Across many studies and numerous populations, self-efficacy has been found to influence one’s social, physical and emotional well-being (Boehmer, Luszczynska, & Schwarzer, 2007; Hack & Degner, 2004; Hampton, 2004; Hochhausen et al., 2007). A woman who is experiencing domestic violence is often diminished not only by the abuser’s pattern of ridicule, control and domination, but also by prior community responses that have not only failed to help her but that may have re-victimised her or made the situation worse (SAFE Ireland 2014; Arnault and SAFE Ireland, 2014; R. Campbell, 2006, 2008; Rivera, Sullivan, & Zeoli, 2012).

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

**Hope**

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

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

It is essential to remember that one’s ability to be “well” is socially situated. It is often not enough to simply change the way an individual thinks and feels – factors at interpersonal, community and societal levels need to be addressed as well. This section reviews the evidence behind the following predictive factors of well-being that are typically targeted by domestic violence services: (i) social connectedness and positive relationships with others; (ii) being safe; (iii) having good physical, emotional and spiritual health; (iv) possessing adequate resources; and (v) social, political and economic equity.

Social Connectedness and Positive Relationships with Others

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

Safety

Safety involves not just physical safety but emotional and economic safety as well. People who are experiencing violence or the chronic threat of violence report lower quality of life compared to those not under such siege (Arnault and SAFE Ireland, 2014; Evans-Campbell et al., 2006; Ramos & Carlson, 2004; Sagi-Schwartz, 2008; Williams et al., 1997). Women and their children deserve to be free of physical and sexual abuse, but also of threats, intimidation, stalking, economic abuse, coercion, and isolation. Domestic violence service staff work extensively and creatively to assist women in maximising their own and their children’s safety, while recognising that the abuser is ultimately responsible for his abusive behaviour (Davies, Lyon, & Monti-Catania, 1998).

Emotional, Physical and Spiritual Health

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

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

Staff work diligently and creatively with women and their children to maximise their emotional, physical and spiritual health. To address physical health concerns domestic violence services have strong partnerships with local general practices and health clinics. Spiritual well-being is facilitated and attended to as well through community engagement and partnerships. Emotional well-being is attended to both informally and formally. Informally, all organisational activities are designed to maximise emotional well-being (e.g., through empathic listening, being respectful, and being caring and encouraging). Formally, many staff have counselling and social care skills and qualifications, provide referrals to domestic violence informed therapists and also assess for mental health needs that may require additional supports (e.g., psychiatric intervention). Increasingly, SAFE Ireland members are becoming trauma sensitive and informed and SAFE Ireland has published practice based research on healing from domestic violence related trauma (Arnault and SAFE Ireland 2014).

Possessing Adequate Resources

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

Social, Political and Economic Equity

There is clear evidence that social inequities lead to poorer health and well-being outcomes for children and adults (Braveman & Gruskin, 2003; Ferguson, 2006; Flores, 2010; Galea et al., 2002; Hobfoll, 2001, 2003; Norris et al., 2002; Raphael, 2006; US Department of Health and Human Services, 2000). In addition to inequities that impact people related to their gender, race or ethnicity, refugee or migrant status, education or income, disability, geographic location, or sexual orientation, women affected by domestic violence and their children experience system injustices specifically related to their victimisation. Often referred to as “secondary victimisation” by the system, women are often blamed for the abuse they have experienced or denied the help needed to protect themselves and their children (SAFE Ireland, 2014b; R. Campbell, 2006, 2008; Rivera, Sullivan, & Zeoli, 2012). Further, some women are discriminated against by landlords, or in the workplace, either because of the abuse they have experienced or because of their marginalised status in society. Domestic violence staff work creatively, at the individual as well as systems levels, to maximise women and children’s access to the supports they need and to reduce the social, political and economic inequities that they face. This approach is strongly supported in the Istanbul Convention soon to be ratified by the Irish government (2011).
Additional Predictors of Children’s Well-being

Domestic violence services recognise that children exposed to abuse against their mothers are at increased risk for physical, emotional, behavioural, social and cognitive problems (Hogan & O’Reilly, 2007; Buckley, Whelan, & Holt, 2006; Gewirtz & Edleson, 2007; Kitzmann et al., 2003). While children are a heterogeneous group with distinct and varied experiences and needs, services focus on ameliorating negative effects of exposure and building children’s strengths and capacities. The seven predictors of well-being just reviewed are relevant for children as well as adults, and are the focus of change for both adult and children’s services. However, in addition to these well-being predictors, services for children also work to improve those factors that have been shown to enhance children’s resilience.

Resilience

The most consistent factor cited as promoting children’s resilience post-trauma is a secure attachment to the non-abusive parent or other significant adult caregiver (Graham-Bermann et al., 2006; Kliewer et al., 2004; Mullender et al., 2002; Osofsky, 1999; Pedro-Carroll, 2001). The repair of attachment bonds between mothers and their children weakened and ruptured by domestic violence is a key focus of all domestic violence services. Staff work to support mothers to understand the impact of domestic violence on their children, their relationship with their children and on their parenting capacity. Enhancing children’s self-concept (Daniel & Wassell, 2002), social/relational competencies, and support networks (Pedro-Carroll, 2001) have also been identified as important to enhancing their social and emotional well-being, and all are directly targeted by domestic violence services. Children’s services include developmentally-appropriate educational and support programmes and activities designed to help them understand the trauma they have experienced and provide them with coping and problem-solving skills. Services also engage in age-appropriate safety planning with children and help them deal appropriately with their anger, fears and confusion.
Domestic violence services engage in a wide range of activities designed to positively impact the intrapersonal, interpersonal and social predictors of well-being for both women and their children. Specifically, they work to (1) increase women’s and children’s sense of self-efficacy as well as their hope for the future, and (2) directly increase their access to community resources, opportunities, and supports (including social support). Consistent with Conservation of Resources theory, these improvements create a positive spiral in the lives of women and children, resulting in more positive social and emotional well-being over time.

While the actual range of activities may vary across agencies (e.g., refuge, support services, outreach, counselling, advocacy, accompaniment, transitional housing, children’s services, support groups), services for both women and their children tend to share eight key features. In partnership with the women and children, domestic violence services staff engage in the following activities:

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

SAFE Ireland members often refer to the constellation of these eight components as engaging in “empowering practice.” Article 12 of the Istanbul Convention (2011) seeks measures that promote the empowerment of women, place victims rights at the centre and meet their specific needs. Empowering practice involves interacting with service users in ways that increase their power in personal, interpersonal and political arenas (R. Adams, 2008; Gutiérrez & Lewis, 1999; Sullivan, 2006). It is a helping relationship through which the staff member shares power with the woman, and is a facilitator, not a director, of services. This echoes the highly participative manner of intervening in families described under the Meitheal model of practice (Child and Family Agency, 2013). The staff works to facilitate each woman’s access to knowledge, skills, supports and resources. Direct outcomes of these activities can be documented at intrapersonal, interpersonal and social levels. Intrapersonal changes include both cognitive (e.g., increased knowledge and skills) and emotional (e.g., feeling more hopeful) improvement. Interpersonal changes would include such things as increased safety and social support, while social-level changes might include increased access to community resources. Figure 1 on the following page illustrates the Theory of Change underlying how service activities are expected to impact the factors that influence well-being. The eight key features of domestic violence services, illustrated in the left column of Figure 1, are described in more detail next.
Eight Common Features of Domestic Violence Services

1. Provide Information

Knowledge is power. Therefore, a key objective of domestic violence services is to increase adult and child service users’ knowledge about a variety of topics important to their long-term well-being. Empowerment for women and children involves being informed about rights and available community resources. All women, regardless of their backgrounds, must be able to access information about the legal and support systems necessary for their safety. The Victims’ Rights Directive (2012) highlights the right to receive information in a number of sub-sections (including sub-sections 21, 23, 24, 26, 27, 31) from the first contact with a competent authority and indicates the manner in which information should be conveyed as well as the necessity to ensure that victims understand the information as well being understood themselves. Specialist services offer support and information in relation to the range of abuse a service user and their children may have experienced. Services provide verbal and written accessible information on the services available to women and their children and how to access them, in plain English and other languages and formats, as appropriate. Services also raise women’s consciousness about the dynamics of domestic violence and other forms of violence they may have experienced e.g., child abuse, sexual assault, prejudice and discrimination. They offer information about how the children might be responding to the violence, and help women think through their next steps. In short, they provide any and all information service users might need to understand their experiences within the larger sociopolitical context, to make well informed decisions for themselves, and to heal emotionally from the abuse.

2. Safety Plan

A core activity of every domestic violence victim support service is to engage in safety planning with women and their children (SAFE Ireland Standards 2015; Victims Directive 2012; Istanbul 2011; Davies, Lyon, & Monti-Catania, 1998). Services take appropriate action in response to identified risk of harm by providing appropriate information, assessing for risk factors and child protection and welfare concerns, conducting safety planning with women and children and working with other agencies to provide support and advocacy services to manage the risk. It is understood that these efforts may or may not be successful, given the individual circumstances surrounding each incident of abuse and that the perpetrator is ultimately responsible for his decision to be violent or not. Services recognise that safety strategies must prioritise the protection of children, be varied and flexible and individualised to each woman and family’s experience, and that women decide for themselves what might reduce future risk of abuse. These strategies generally centre on having plans for immediate escape should violence occur (e.g., having a predetermined location to flee to, having clothing and important documents assembled and hidden), but conversations also include risk reduction strategies (e.g., obtaining a protective order, changing locks, changing phone numbers). Staff support women to think through both abuser-generated risks (e.g., the abuser’s prior behaviours, threats, access to her and the children) as well as life-generated safety risks (e.g., neighborhood safety, access to help from various systems, level of supportive networks) and, together, staff and individuals generate plans for addressing each. The protection and welfare of children are generally best served through promoting the protection and support of the non-abusing parent. Staff also engage in age-appropriate safety planning with the children, to help reduce their risk of future harm and to help them determine appropriate exit strategies if needed.
Important contextual factors impacting work and success

**SERVICE ACTIVITIES**

- Common elements of service activities:
  1. Provide information (about rights, options, domestic violence, trauma, sociopolitical setting)
  2. Safety plan
  3. Build skills (e.g., coping, emotion regulation, problem solving, parenting, resource attainment)
  4. Offer encouragement, empathy and respect
  5. Supportive counselling
  6. Increase access to community resources and opportunities
  7. Increase social support and community connections
  8. Community change and systems change work

**SERVICE OUTCOMES**

- Intrapersonal changes:
  1. Cognitive changes: increased knowledge, skills, critical consciousness
  2. Emotional changes: sense of self, emotion regulation

- Interpersonal and social changes:
  1. Increased access to community resources
  2. Strong mother-child bond
  3. Effective coping strategies
  4. Increased support, community connections
  5. Enhanced justice

**FACTORS PREDICTING WELLBEING**

- Intrapersonal predictors of wellbeing:
  1. Self-efficacy
  2. Hopefulness

- Interpersonal and social predictors of wellbeing:
  1. Social connectedness
  2. Positive relationships with others
  3. Adequate social and economic opportunities
  4. Economic stability
  5. Safety
  6. Positive physical, emotional and spiritual health behaviours

**SOCIAL AND EMOTIONAL WELLBEING**

- Extent to which community supports victim safety, offender accountability, equality and diversity and provides resources and opportunities
- Community wellbeing

*Figure 1.* Theory of change underlying how domestic violence services activities impact adult and child service users’ wellbeing.

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*20* A Framework for Domestic Violence Service Provision to Women and Children in Ireland
3. Building Skills

Knowledge is critically important, but having the skills to put knowledge into practice is crucial to enhancing self-efficacy. The explanatory notes to Article 18 (3), of the Istanbul Convention states that victims’ services need to instill in victims a sense of control over their lives which includes financial security and economic independence. Domestic violence service staff use a variety of strategies, including building skills, modeling, and role playing, to help women and their children enhance the skills they say they need. These skills will differ across individuals but for adults might include writing a CV, browsing the web, how to prepare for and conduct themselves in court, parenting skills, repairing the mother-child bond that may have been intentionally weakened by the abuser, and developing more positive coping skills (e.g., handling flashbacks). Staff also work with children on a number of skills that have been shown to relate to youth well-being, including problem solving, coping, and social and emotional regulation (Graham-Bermann et al., 2007; Johnson et al., 2002; Liebman et al., 2006). For example, they may help children develop self-soothing skills for when they waken from nightmares, and/or help them better regulate their emotions and social skills with others.

4. Offer Encouragement, Empathy and Respect

Across all services, domestic violence staff are expected to treat women and children with empathy, encouragement and respect. Observing commitments in relation to confidentiality and sharing of information provided by women supports trust-building, disclosure and engagement in continuing to seek support and access resources. In talking about the gendered dynamics of domestic violence, and its roots in issues of male power and control, staff support women to become less self-blaming and to identify the commonalities in their experiences. Staff are trained to be nonjudgmental, respectful of differences, and to be culturally competent. Cultural competence involves employing specific knowledge, behaviours and policies to effectively work to challenge and reduce barriers to safety and service for ethnic minority women and children. These philosophical underpinnings guiding the work are key, not just because they represent a courteous way to treat other human beings, but because they are attributes of empowering practice and have been found to increase people’s sense of self and self-efficacy (Maton et al., 2004; Saleebey, 2006). Self-efficacy is influenced not just by prior experiences of success, but by encouragement from others (Bandura, 1977; Bandura & Cervone, 1983; Hyde, Hankins, Deale, & Marteau, 2008). Significantly these philosophical underpinnings of respect, dignity, a rights based approach, sensitivity to the impacts of gender based violence and inequality on victims well-being and behaviour are now enshrined in the recent European legal instruments. Staff members’ encouragement, empathy and respect enable those availing of their services to recognise their skills and strengths. Staff also take into account the effects of domestic violence on a woman’s confidence and capacity to meet her own and her children’s needs and engage in a collaborative process to undo and mitigate these effects and enhance her self-efficacy. Staff also address the physiological factors that can impact one’s ability to engage in new behaviours (Hyde et al., 2008). For example, staff may be called on to help adult and child service users recognise signs of anxiety (e.g., “butterflies in the stomach,” fear, trembling), to normalise this as a coping reaction, and to offer strategies for self-regulation.

5. Support and Supportive Counseling

Services provide timely, proactive support interventions to service users that are non-judgemental and encourages them to exercise control over their own lives, to live without abuse, to fulfill their potential, and to make informed positive choices for themselves and their children. Whether through care planning, individual counselling, support groups, crisis intervention or casual conversations, staff help women and their children understand that they are not alone in their experience and are not responsible for the violence and abuse they have experienced. Service staff use their expertise to attend
to the unique aspects of each woman’s and child’s story and act in a way that shows they understand recovery is a personal path for each person. Staff take into account the potential (but not universal) effects on women of stress, confusion, diminished entitlement to respond to their own needs, lack of confidence, and/or the ability to assess danger due to the impacts of the domestic violence. They assist women to understand common responses to trauma (e.g., trouble concentrating, sleep problems, being easily startled) and provide them with the knowledge, skills and time they need to heal. Every person responds to trauma differently, so staff assist each service user to identify the impact that the abuse has had on them, and how to identify and cope with events that may ‘trigger’ the same physiological or emotional reactions they experienced when being abused. Services enable mothers and other adult caregivers to support and protect children and enable the regular exchange of information about children between caregivers and staff and other relevant agencies. In continuing to consult directly with women about their needs and experiences and the outcomes of support (SAFE Ireland, 2009, 2011) services can measure the benefits, changes and impacts that occur to women and children as a direct result of receiving the support of services.

6. Increase Access to Community Resources and Opportunities

Advocacy ranges from ensuring that a woman’s rights are upheld through the court process, to helping her obtain housing or financial resources. The role of the domestic violence staff is to engage in dialogue and critical analysis with the woman, reviewing all sides of the issue and determining costs and benefits of different courses of action. The staff must have the skills to actively listen and ask pertinent questions, help brainstorm potential options and strategies, and strategise how best to meet the woman’s needs. Domestic violence service staff are aware that to be effective in advocating for women and children they need to be aware of and well-connected to the local community. Staff understand the roles and responsibilities of different statutory, community and voluntary services and hold up to date information about relevant agencies and can identify and access those which meet the needs of individual service users. They also need to know relevant laws and policies, and individual people locally in frequently used agencies who are in control of needed resources. In advocating and dialogue with other agencies and professionals, domestic violence services also play a role in increasing the sensitivity of other services and reducing the risk of repeat victimisation of women through the support pathway, a concern specifically raised in article 18 (1, 3) of the Istanbul Convention. This means that a great deal of a domestic violence advocates’ work is conducted in the community – effective advocacy does not happen from behind a desk.

7. Increase Social Support and Community Connections

As noted earlier, social support is critical to the well-being of all adults and children, and is especially important for women with abusive partners or ex-partners. While knowledge about community resources and how to obtain them is extremely important, actual ability to access new resources and opportunities is highly dependent on what is available in the community. Empowerment-based practice involves working actively with women and children to help them gain access to these limited or difficult-to-access resources and opportunities. Domestic violence services staff work to increase women’s and children’s social support and community connections in two general ways. First, some services are intentionally offered in group settings (e.g., support groups, refuges), through which women and their children can talk with other service users and form new supportive relationships. Second, staff discuss the importance of social support and community ties with service users and talk about current support networks as well as possibilities for expanding support. Many women want to maintain strong ties in their communities or need to build new community networks, and staff can be extremely helpful in honoring and supporting this need.
8. Community Engagement and Social Change Work

Recognising that well-being is not independent from community-level factors, staff do not focus solely on working with individual women and family groups. They also engage in a variety of efforts to create communities that hold offenders accountable, promote justice and equality, and that provide adequate resources and opportunities for all community members. This is accomplished through inter-agency level advocacy efforts (generally targeted at the criminal justice, health care, child protection services, social protection, housing, and other systems), prevention activities, community education activities, and collaborative community actions (see Article 13, Istanbul Convention 2011). Agencies working together create the potential for a holistic response to meeting the safety and well-being needs of women, children and young people. It is necessary to create clear client pathways through the justice, health, housing and other systems.

Co-ordinated inter-agency responses to domestic violence are recognised as key to effectiveness in providing services to those affected by domestic violence (Istanbul Convention Article 15,(2) and Article 18,(2)). Services are represented and participate in relevant inter-agency fora to represent the needs of those availing of their services and promote understanding of the causes and consequences of abuse and violence in intimate relationships and promote quality responses to those affected. The goal of most, if not all, domestic violence services should be to help create communities that value all of their members and that promote individual and community well-being. This work involves a great deal of time and energy on the part of staff, who often engage in their communities at multiple levels. They likely participate in regional inter-agency fora, meet regularly with key community members to improve protocols, policies, and practices, work on related social issues (such as poverty, racism and discrimination, housing, employment, child protection and welfare), and engage in cross-trainings with other professions. These complex, time-consuming, and generally underfunded efforts are key to domestic violence services’ social change work. Article 23 of the Istanbul Convention clearly outlines this multi-dimensional role of specialist domestic violence services to provide women with safety from abuse, support to cope with trauma and leaving abusive relationships and reclaiming their self-esteem; it also states that specialist services support women to ‘lay the foundations for an independent life of their own choosing’ and ‘play a central role in networking, multi-agency co-operation and awareness raising in their communities’ (Explanatory Report 2011, section 133).

Addressing Service Users’ Needs as Mothers

The majority of service users seeking services from domestic violence services are mothers of minor-aged children (SAFE Ireland 2009, 2011; Lyon, Lane, & Menard, 2008; Tutty, 2006). In response to this, domestic violence agencies provide services and advocacy that focus on meeting the children’s needs, their mothers’ needs as parents, and the families’ needs. Services recognise that mothers’ and children’s social and emotional well-being are fundamentally intertwined, and that mothers and children have separate as well as interrelated needs. Therefore, they offer an array of services and supports to meet women’s diverse needs as parents. These needs may be of an interpersonal nature (e.g., women wanting to improve their parenting and/or to understand the emotional impact of the abuse on their children), or may be more socially situated (e.g., mothers needing help with Family Law Courts, Child Protection and Welfare Services, protecting their child at school).

Mothers continue to be concerned about their children’s ongoing safety and well-being, especially if the abuser is the children’s father and has continued contact with them. Abusers may not only pose a physical or emotional threat to the children directly, but many intentionally use the children to continue harassing, intimidating, and monitoring the mothers (SAFE Ireland, 2014b; Hogan &O’Reilly 2007; Buckley et al 2006; Beeble, Bybee, & Sullivan, 2007; Walker, Logan, Jordan, & Campbell, 2004; Mullender et
In short, mother's concerns for their children tend to heavily influence the decisions they make about staying in or leaving the relationship (Kurz, 1996; McCaw et al., 2002; Tutty, 2006) as well as all other decisions (e.g., employment, re-locating, seeking counselling). Domestic violence services recognise that, unless the children's and family's needs are considered as a whole (with family often including extended family and support system), mothers' social and emotional well-being will not be achieved.

Domestic violence services staff also work creatively to repair the mother-child bond that is so often intentionally damaged by the abuser (Bancroft, 2003; Beeble et al., 2007; Peled, Davidson-Arad, & Perel, 2012). It is common for abusive individuals to undermine their victim's parenting and to attempt to turn the children away from their mothers as part of the abuse, and it is critical for the well-being of both mothers and children to have this bond healed.
What empirical evidence exists that domestic violence services are impacting the well-being of domestic violence women and their children? Unfortunately, few studies have examined the long-term impact of domestic violence services on service users over time. However, the studies that have been conducted have consistently found such services to be helpful. Refuge services, for example, have been found to be one of the most supportive, effective resources for women with abusive partners, according to the residents themselves (SAFE Ireland 2009, 2011; Chanmugam, 2011; Few, 2005; Goodkind et al. 2004; Itzhaky & Ben Porat, 2005; Lyon, Lane, & Menard, 2008; Tutty, 2006; Tutty, Weaver, & Rothery 1999; Wettersten et al., 2004). While many of the studies examining refuge impact to date have been relatively small and/or qualitative, three large-scale studies have been conducted that comprehensively examined women’s needs at refuge entry as well as the services they received and the outcomes of those services. One study included 368 women from ten refuges across Canada (Tutty, 2006) one involved 3,410 women from 215 refuges across eight states in the United States (Lyon, Lane, & Menard, 2008), and one involved 201 women from 18 refuges in Ireland (Safe Ireland, 2009). All three surveyed service users at refuge entry and exit, allowing for the first examinations of change over time within refuge. Findings across all three studies were quite similar, with the vast majority of service users reporting that they felt safer, more hopeful, and possessing more safety strategies post-refuge.

In the Irish study 314 women completed entry forms (58% of all women staying in the refuge during the collection period) and 201 women completed exit forms (39%). Upon entering refuge, women’s top priority needs were: staying safe (73%), receiving information and support with housing (63%), making life decisions (64%), healing emotionally (63%) and understanding the impacts of domestic violence (60%). Women received a great deal of help with their self-identified needs. For example, all of the women seeking safety had been kept safe, 85% of those seeking information and support with housing received that support, and 89% of women needing support with emotionally healing received it. Further, 92% of women looking for help understanding the impact of domestic violence had received that help and 85% of those seeking support with making their own life decisions received it. The outcomes women achieved as a result of their refuge stay were impressive. The vast majority reported increased capacity to keep themselves and their children safe, increased access to services and community resources, and increased emotional well-being for themselves and their children.

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

Finally, it is noteworthy that a number of studies have asked women what they would have done if refuge had not been available to them, and the responses have been sobering. Women’s responses included that they would have been homeless, would have continued to be beaten, or that they would...
have prostituted to support themselves and their children. Some women noted that they would have been murdered, or would have either killed themselves or their abusers (Lyon et al., 2008; SAFE Ireland, 2009; Sullivan et al., 2008; Tutty, Weaver, & Rothery, 1999). In the SAFE Ireland study, 38% of women said they would have had no other option if refuge had not been available to them, and almost 17% said they would have stayed in the abusive situation. Clearly, refuges provide not only immediate and long-term support for abused women and their children but are in some cases life-saving as well.

SAFE Ireland’s second study *Lifelines to Safety: A National Study of Support Needs and Outcomes for Women Accessing Domestic Violence Services in Ireland* (2011), identified women’s needs when accessing a range of community based domestic violence services, the degree to which they received support and the changes or outcomes evident in their lives as a direct result of receiving the services. Twenty nine domestic violence organisations who provide non-accommodation support services took part in the study which included support and advocacy, information, support groups, transitional housing court accompaniment and children’s services. Similar to the previous study carried out by SAFE Ireland (2009), the majority of needs women identified were catered for and women received the support they were seeking. The outcomes for the women receiving services were also very positive, with a high majority of women again, experiencing significant positive changes in their lives.

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

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

Court Accompaniment. Bell and Goodman’s (2001) quasi-experimental study, of a legal domestic violence advocacy programme conducted in Washington, DC., found that women who had worked with domestic violence advocates reported less abuse six weeks later, as well as marginally higher emotional well-being compared to those who did not work with a domestic violence advocates. Their qualitative findings also supported the use of paraprofessional legal domestic violence advocates. All
of the service users who had worked with domestic violence advocates talked about them as being supportive and knowledgeable, while the women who did not work with domestic violence advocates mentioned wishing they had had that kind of support while they were going through this difficult process. SAFE Ireland’s (2014b) qualitative legal research, The Lawlessness of the Home, highlighted the importance of court accompaniment for women in persisting in seeking safety and justice for themselves and their children.

Evaluations of support groups have shown positive findings as well. The 10-12 week, closed support group is a common type of group offered to women, and typically focuses on safety planning, promoting mutual support, and discussing the dynamics of abuse. Tutty, Bidgood, and Rothney’s (1993) quasi-experimental evaluation of such support groups revealed significant improvements in women’s self-esteem, sense of belonging, locus of control, and overall stress over time. These findings were corroborated by a randomised control trial of an 8-week group led by a trained nurse that focused on helping service users increase their social support networks and access to community resources (Constantino, Kim, & Crane 2005). At the end of the eight weeks the service users who had participated in the group showed greater improvement in psychological distress symptoms and reported higher feelings of social support.

Women availing of domestic violence services in Ireland experienced comparable positive outcomes as a result of accessing these types of services (SAFE Ireland 2009, 2011).

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

A few domestic violence victim services offer counselling/therapy support as one of their core services. Typically, these counselling services engage in an empowerment process through which one person helps another gain or regain their sense of personal power through the counsellor actively mediating her power and amplifying the clients control over the content and direction of the counselling process (Gutiérrez & Lewis, 1999). Empowerment involves helping service users recover their personal sense of power and control as well as learning about the typical dynamics endemic to domestic abuse, which can help women feel less isolated and less self-blaming for the abuse.

Not all domestic violence counselling services are empowerment based, of course, and many also incorporate a variety of therapeutic approaches (e.g., cognitive-behavioural, solution-focused, art therapy) tailored to the individual needs and desires of clients. To date, there are few evaluations of domestic violence counselling services and most of those that exist tend to involve examining client change over time without benefit of comparison or control groups. However, a small number of clinical trials suggest that brief counselling designed specifically for domestic violence service users can reduce depression and increase well-being. For example, Kubany and colleagues (2004) conducted one of the first clinical trials of a cognitive trauma therapy tailored specifically for women affected by PTSD due
to domestic violence. Their treatment, labeled Cognitive Trauma Therapy for Battered Women (CTT-BW), was designed in collaboration with domestic violence staff and service users. Their model included standard modalities such as psycho-education about post traumatic stress disorder (PTSD), stress management and exposure (talking about the trauma, homework, watching movies about domestic violence), but also included components to address four unique areas of concern they had identified as salient to abused women. These included (i) trauma-related guilt that many service users reported (guilt about failed marriage, effects on children, decisions to stay or leave); (ii) histories of other traumatic experiences; (iii) likelihood of ongoing stressful contact with the abuser in relation to parenting; and (iv) risk for subsequent re-victimisation. Therapy was provided in an individual format in eight to eleven 90-minute sessions for most clients. To be eligible, women had to have been free of abuse for at least 30 days, and no longer in the relationship.

Findings were quite positive: 87% of women who completed treatment no longer met diagnostic criteria for PTSD, and 83% obtained depression scores in the normal range at the conclusion of treatment. The intervention also significantly reduced participants’ guilt and increased their self-esteem. Improvements were maintained at 3 and 6-month follow-up assessments. Of additional note 80%, of this ethnically and educationally diverse group of women, who started CBT-BW completed it, and the programme worked equally well when delivered by clinicians or non-clinicians.

While Kubany and colleagues’ intervention is promising for women who are both out of the abusive relationship and no longer in danger, Johnson and colleagues created a CBT programme specifically for women experiencing recent abuse, who are likely still in danger, and who may or may not continue their relationships (Johnson et al., 2011). They intentionally designed a programme for women living in domestic violence refuges, which they named HOPE: Helping to Overcome PTSD through Empowerment. HOPE involves 9-12, twice-a-week, 60-90 minute individual sessions (over a maximum of eight weeks) that address issues especially salient to abused women. Based heavily on Herman’s (1992) multi-stage model of recovery, it involves three stages: (i) re-establishing safety and a sense of self-care, (ii) remembering and mourning, and (iii) reconnection (Herman, 1992). The treatment prioritises women’s safety needs, does not include exposure therapy, and focuses heavily on women’s empowerment. Specifically, therapists focus on women’s individual needs and choices, and help them develop any skills needed to reach their personal goals. Later sessions focus on building cognitive and behavioural skills to manage PTSD symptoms and triggers, while optional modules are available that address common co-occurring issues such as substance abuse and managing grief.

Women were eligible for this study if they met sub-threshold PTSD criteria, which involved meeting the re-experiencing criteria and either the avoidance or arousal criteria of PTSD. Additional inclusion criteria included: (i) no diagnosis of bipolar disorder or psychosis, (ii) not concurrently in individual therapy, (iii) no changes in psychotropic medications over the prior 30 days, and (iv) no significant suicide ideation or risk. Seventy women were randomised to either receive HOPE or to continue receiving standard refuge services and were then re-interviewed 1 week, 3 months and 6 months after they left refuge.

A number of positive findings were reported from this study. Compared to women in the control condition, those in the HOPE condition were less likely to experience abuse six months after leaving refuge. Further, women receiving services as usual were 12 times more likely to experience re-abuse than were women who received at least 5 sessions of HOPE. With regard to PTSD symptoms, there were no significant condition differences over time except for emotional numbing (in the desired direction). Those randomised to receive HOPE also showed significant improvement over time on depression severity, empowerment, and social support compared to women in the “services as usual” group. A similar intervention conducted in Spain reported similar decreases in depression and PTSD (Crespo & Arinero, 2010).
Mancoske and colleagues (1994) compared grief resolution counselling to feminist-oriented counselling and found both to increase self-efficacy and self-esteem. However, their study did not include a no-treatment control group, so it is unclear to what extent change was due to the passage of time or other services being received. Similarly, McWhirter (2011) compared emotion-focused therapy with goal-oriented therapy for domestic violence service users. She collaborated with homeless refuge service providers and residents themselves who had experienced domestic violence and who were mothers in designing the study. Inclusion criteria were that the women were residing in a homeless refuge, had experienced domestic violence within the prior year, and reported at least one child present during at least one of the assaults. The goal-orientated treatment used motivational interviewing and CBT principles to enhance women’s and children’s understanding of their goals and how to attain them. The emotion focused group focused heavily on understanding and expressing feelings, and exploring personal belief systems. Women and children were interviewed one week prior to the treatment, and at the end of the 5 week intervention.

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

Howard and colleagues (2003) compared community-based counselling outcomes for abused women, by whether they had been sexually assaulted by their assailants as well. This study compared 357 battered women with 143 battered and raped women who participated in counselling at one of 54 domestic violence services in Illinois. Women completed self-administered measures pre and post counselling. Almost two thirds of the sample was non-Hispanic white (64%); 27% were Black, and the other 9% were Latina, Asian American or Native American. The vast majority of the women had participated in individual counselling (92%), 4% received group counselling, and 40% had been members of both individual and group counselling.

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

Transitional housing services for service users of domestic violence are a vital resource for many low-income women striving to become free from abuse (Davis & Srinivasan, 1995; Melbin, Sullivan, & Cain, 2003). All offer service users housing in which they can live for a set period of time (usually one to two years), or until they can obtain permanent housing. Tenants often pay a small percentage of their income for rent, and most transitional housing services also include support services such as counselling, housing assistance, and employment assistance. Melbin and colleagues (2003) interviewed women who had participated in one of six different transitional housing services in a Midwestern state in the U.S. Many women noted that, had the transitional housing programme not been available, they would have either returned to their abusers, been homeless, resorted to prostitution, or would be in prison. In Ireland, more recently, transitional housing policy to women and children experiencing domestic violence has moved towards offering a housing first solution whereby women and children are given long term housing with visiting support services provided as appropriate (Sonas, 2011). Given the scarcity of local authority housing, and the continued danger many women face from their ex-partners...
even after they end the relationship, transitional and specialist housing services 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 such services impact women’s economic stability, psychological well-being, or safety over time.

Unfortunately, there continues to be a dearth of studies examining the impact of domestic violence services on children’s well-being. In reviewing what works in supporting Irish vulnerable families in general, McKeown (2000) concluded that the client is the main determinant of the efficacy of support to vulnerable families rather than the worker/provider. He says this implies that interventions to support vulnerable families must be tailored to the family’s definition of need, cultivating a strong therapeutic relationship with the family, developing its social support networks and, above all, restoring faith and hope in the family’s generic strengths and resilience to solve its problems. A study of mothers experiencing parenting difficulties concluded that interventions which attend to the emotional and mental health needs of the mother are most likely not only to have direct benefits to her well-being but enhance her parenting skills and the overall behaviour and well-being of children (McKeown & Haase, 2007).

Internationally, the few studies that have examined the efficacy of either support and education groups or play therapy with children exposed to abuse against their mothers have been quite promising. Kot and colleagues (1998) created a play therapy intervention specifically for young children (aged 4-10) residing with their mothers in domestic violence refuges. Play therapy has been found to be efficacious for young, traumatised children in general (Ray, Bratton, Rhine, & Jones, 2001), but Kot modified the treatment to consider issues specific to witnessing family violence (e.g., self-blame, safety) and condensed a 10 week protocol into 45 minute sessions over 12 consecutive days to account for the brief time families are often in refuge. Using a wait-list control comparison, the study noted that children who received play therapy showed significant improvement in self-concept and overall behaviour.

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

Support and education groups for children exposed to intimate partner violence have also demonstrated promising results. One study compared a 10 week group for children (aged 6-12) to an intervention where mothers received a 10 week parenting support group while their children received the support and education group (Graham-Bermann et al., 2007). Families were recruited into the study through newspaper advert, social service organisations, and domestic violence refuges. Both intervention groups were compared to a wait list control, across eight months follow up, and both reduced children’s internalising behaviours over time. The intervention targeting both mothers and children showed the greatest improvements on children’s behavioural and internalising problems, and attitudes toward violence.
Similar findings with respect to involving mothers in programmes for children who have witnessed and experienced domestic violence were reported in a study of a Family Violence Programme (FVP) in Ireland. Between 2002 and the end of 2004, Mayo Women’s Support Service and childcare workers from the HSE ran the FVP in three locations in the county. The programme was run over a ten-week period and comprised a group for children who had experienced domestic violence and a group for their mothers, both of which were run concurrently. In total, 42 women and children participated in the programmes which operated over a ten-week period for two hours a week. The overall aim was to create a safe/trusting environment to enable children to talk about their experiences and to assist mothers in understanding the effects of domestic violence on children, develop their parenting skills and promote their own self-esteem (Lally, 2005). The evaluation included interviews with six mothers who had participated in the programme and seven of the eight programme facilitators. Secondary data in the form of information collected at the time of the FVP including work plans, facilitators’ notes, minutes of meetings and reflections from the participants (both women and children) were also used to inform the evaluation. Mothers said that, as a result of the programme, their children were more loving and more gentle, had more respect for their mother, less outbursts and physical displays of anger and better overall anger management. They found their children listened more and were easier to engage in conversation and showed more confidence and self-esteem. Mothers identified themselves as gaining in self-confidence and assertiveness, increased personal development, better stress management, and better parenting and more positive in outlook.

Sullivan and colleagues designed a 16-week post-refuge intervention that provided advocacy services to mothers while offering a 10-week support and education group to their children (aged 7-11) that was similar to that offered by Graham-Bermann (Sullivan, Bybee, & Allen, 2002). Compared to a control group of families receiving services as usual, both mothers and children noted significant improvements post-intervention and through eight months follow up. Mothers reported decreased depression as well as increased self-esteem and quality of life, while children had higher self-confidence and higher self-worth. Taken together, all of these studies suggest that the typical types of interventions provided by domestic violence services to children (support and education groups for older children, play therapy for younger children) may be effective in reducing their behavioural problems and increasing their sense of self.

This brief evidence review was presented to illustrate that there is increasing support for the long-term effectiveness of typical domestic violence services in enhancing the social and emotional well-being of women and their children over time (Macy et al., 2009; Rizo et al., 2011; SAFE Ireland 2009, 2011; Sullivan, 2010). However, a great deal more research is needed. To date a great deal of the research and evaluation in the field has suffered from a variety of methodological problems, including, but not limited to, small sample sizes and samples with limited generalisability (e.g., predominantly white populations), non-experimental designs, cross-sectional designs which preclude identifying causal relationships, high attrition, and measures lacking established validity and reliability. It is essential that services and policies be guided by sound empirical evidence in order for funds to be best utilised. It is also important to focus research and evaluation on children’s experiences, minority ethnic communities, and other traditionally marginalised groups.
Domestic violence services work not only to protect women and their children from further harm, but to promote their long-term social and emotional well-being. The Social & Emotional Well-being Promotion Framework, therefore, reflects the mission of SAFE Ireland member services, and provides a useful model for organising and articulating how the work of these services promotes the well-being of women and their children over time. It echoes national policy on supporting children and families in focusing on the comprehensive range of needs for family well-being, providing an evidence base for activities and outcomes and promoting partnership with parents in alleviating and preventing harm to children and their family members (Child and Family Agency, 2013).

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

Although few in number, the studies that have evaluated domestic violence services suggest that these services do indeed positively impact numerous factors predictive of well-being. Women, who have used domestic violence services, report positive outcomes such as feeling safer, more hopeful, and possessing more safety strategies. Both refuge and support services have been shown internationally to lead to women experiencing less violence over time, less difficulty accessing community resources, increased social support, and higher quality of life. Support groups have led to service users feeling a greater sense of belonging and higher self-esteem, while experiencing less distress. A focus on mothering can increase women’s parental self-efficacy and optimism about the future while decreasing their mothering-related stress. Counselling can lead to decreases in depression, anxiety and PTSD symptoms, while helping women feel better about their lives. Therapeutic interventions for children have been shown to improve their self-concepts and reduce their behavioural problems.

Recognising that well-being is impacted by social and community level factors, domestic violence services also engage in a variety of efforts to create communities that hold offenders accountable, promote justice and equality and that provide adequate resources and opportunities for all community members. In short, services work to make significant changes across intrapersonal, interpersonal, and social levels to promote the well-being of women and their children. While there are still more questions than answers in this field, the empirically supported framework described in this document suggests that domestic violence services are engaging in effectual practices that are likely to achieve their goal of enhancing the social and emotional well-being of women and their children. This framework reiterates the rights based approach of the Victims’ Rights Directive (2012), a focus on evidence based outcomes and, in line with the Istanbul Convention (2011), the framing of measures to combat domestic violence within a gender analysis, with measures targeted at individual, community, legal, institutional, cultural and economic levels to promote social and emotional well-being.
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