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EXPLORING THE CORE SERVICE DELIVERY PROCESSES OF AN EVIDENCE-BASED COMMUNITY ADVOCACY PROGRAM FOR WOMEN WITH ABUSIVE PARTNERS

Nicole E. Allen
University of Illinois Urbana Champaign

Sadie Larsen
Milwaukee VA Medical Center and Medical College of Wisconsin

Jennifer Trotter
Adler School of Professional Psychology

Cris M. Sullivan
Michigan State University

Once an intervention has been found to be effective, it is important to examine the processes and factors within the program that led to its success. The current study examined survivors' reflections on the Community Advocacy Project, an empirically supported intervention for women with abusive partners. The study examined the service delivery processes that survivors affirmed or identified as core components of the intervention. Qualitative analysis of interviews with 51 survivors indicated that 3 main service delivery elements contributed to positive outcomes: orientation to the whole person, unconditional validation and acceptance, and an orientation to information provision and action. These overarching themes are described and implications for domestic violence services and dissemination are discussed. © *2012 Wiley Periodicals, Inc.*

A critical component of program evaluation is to examine not only whether interventions are effective but also how they work. Attending to the latter typically involves "process" or "formative" evaluation and often focuses on *how* interventions are delivered, including how they are experienced by participants (Patton, 1990, 1997). This may be especially important with regard to services to women with abusive partners, in which there is evidence that *how* services are delivered seems as important as *what* services are provided

Correspondence to: Nicole E. Allen, 603 East Daniel Street, Champaign, IL, 61820. E-mail: allenne@illinois.edu

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(e.g., Stenius & Veysey, 2005; Weisz, 1999, 2005; Zweig & Burt, 2007). The current study examines the specific service delivery processes employed in the implementation of the Community Advocacy Project (CAP), an empirically supported, community-based advocacy intervention for women with abusive partners. While CAP has long been established as an effective advocacy program (Bybee & Sullivan, 2002; Sullivan & Bybee, 1999), the specific service delivery processes associated with its success have not been fully explored. Attention to specific service delivery processes, or the contents of the "black box," is an important part of maintaining the fidelity of implementation in dissemination and encouraging the incorporation of effective service delivery elements into related programs (e.g., advocacy provided through shelter programs).

Indeed, there is a long tradition of attending to (and critiquing) the specific processes by which human services are delivered (Knitzer, 2000; Schorr, 1988; Stroul, Blau, & Friedman, 2010). For example, by examining service delivery processes, many critiques have been levied against the human service system, including that it tends to be deficit-focused (i.e., service providers tend to focus on what is wrong with clients rather than what is right) and unresponsive to the complex and unique needs of individuals (i.e., needs are addressed in "categories" driven by service specialties rather than by clients' needs; Knitzer, 2000; Schorr, 1988).

Citing similar challenges in the response to domestic violence survivors, Goodman and Epstein (2008) carefully chronicled the history and evolution of the advocacy response, documenting a move toward professionalism in which women with abusive partners began to be understood as "clients" and "a woman's internal psychology as key to change" (p. 41). Along the same lines, 10 years earlier, Davies, Lyon and Monti-Catania (1998) bemoaned service-defined rather than women-defined advocacy, noting that the former is driven by a predetermined set of services that is simply available (the essence of the critique of categorical rather than individualized services). In their pioneering books, Davies and colleagues (1998) and Goodman and Epstein (2008) called for a return to "survivor-centered" (or woman-defined) advocacy that is characterized by a unified and coherent set of services centered around each individual's needs, and the ability to be flexible in one's approach to services (Davies, Lyon, & Monti-Catania 1998; Goodman & Epstein, 2007). Goodman and Epstein (2008) specifically cite CAP as an exemplar of a survivor-centered approach (see p. 43), making this program an excellent case for the study of key service delivery processes.

The CAP was originally developed in collaboration with domestic violence survivors in the mid-1980s, in response to the void of services available to women after they exited shelter (Sullivan, 2003). Explicitly survivor-centered, it was developed to respond in an individualized way to women's needs as defined by them. As part of this project, paraprofessional advocates work one-on-one with domestic violence survivors. Advocates spend 6 to 8 hours per week over a period of 10 weeks, working with women on whatever needs they deem most important. Generally, this means mobilizing a variety of community-based resources, including employment, financial assistance, housing, legal assistance, health care, material goods, transportation, childcare, services for children, and/or social support. Yet the specific array of resources mobilized will vary from one survivor to another (Allen, Bybee, & Sullivan, 2004) and there is no set agenda regarding a set of needs that must be addressed or a set of services that must be accessed.

Importantly, training emphasizes a strengths-based and survivor-centered approach to intervention (Sullivan, 2011). In strengths-based approaches, advocates assume that domestic violence remains pervasive because it is tolerated by society and that women with abusive partners are active help seekers who go to great lengths to protect themselves

and their children (Gondolf, 1988). Thus, advocates are trained to notice and build upon women's strengths rather than deficits and to identify the many ways women cope with very difficult situations. This does not imply that women's complex needs (e.g., mental health needs, substance abuse) are ignored, but they are addressed in a way that makes sense for a given survivor. Being survivor-centered means that the survivor, not the advocate, guides the intervention, in both what needs are to be met and how to go about meeting them. Consistent with a strengths-based approach, advocates assume that survivors have existing capacities that can be built upon to support their pursuit of their goals. Thus, advocates may offer information and assist in the problem-solving process, but survivors make their own final decisions based on their own values and priorities.

Taking a strengths-based and survivor-centered approach ensures an individualized intervention because no two survivors' circumstances are the same. In addition, this intervention focuses on preparing advocates with broad knowledge of community resources—making them ready and able to mobilize resources rapidly—and also on providing emotional support as it emerges naturally in the relationship.

Sullivan and colleagues have demonstrated the effectiveness of CAP (e.g., Allen et al., 2004; Bybee & Sullivan, 2002; Sullivan & Bybee, 1999). A true experimental design was used to compare women who participated in CAP with a control group who received "services as usual" from the community, and women were interviewed every 6 months for 2 years after the intervention was over. Two years after the intervention ended, survivors who had worked with advocates over a 10-week period had significantly higher levels of social support and quality of life, were more able to access community resources, and were less likely to experience abuse (Sullivan & Bybee, 1999).

The findings from this study suggest that the advocacy intervention accomplished what it intended: actively engaging the survivor in all aspects of the work and transferring the knowledge and skills of the advocate to the survivor so that positive change would continue even after the program itself ended. Although Sullivan and colleagues have also always contended that the strengths-based, survivor-centered approach to the intervention was critical to its success (Sullivan, 2000, 2003), they lacked the data in the original study to empirically examine this assertion and to closely examine *how* survivors experienced services. Thus, the current study is not concerned with establishing the effectiveness of the intervention (indeed, this is already well-established), but rather aims to explore the processes by which the program was effective.

The current study was designed to examine, from the point of view of survivors themselves, which aspects of the service delivery process were viewed as especially relevant and useful. If, indeed, it is important to examine not just *what* is delivered but *how* it is delivered to understand service effectiveness (Dunst & Trivette, 1994; Early & GlenMaye, 2000), then hearing from survivors themselves about their experience with CAP was expected to shed important light on which components of the service delivery process were most salient for and important to women.

While on the one hand we expected this study to be a check of fidelity with regard to strengths-based and survivor-centered processes, it was also meant to be a way to more fully conceptualize the service delivery mechanisms that facilitated changes in survivors' lives from their perspective. Specifically, the current study was guided by the following questions: (a) How do survivors describe advocates' strengths-based approach, survivor-centered processes, knowledge and access to resources, and emotional support provision as key service delivery components?; and (b) What other core service delivery processes do survivors describe as key service delivery components?

METHOD

The CAP was first implemented at Michigan State University by the fourth author and her colleagues. It was replicated at a Midwestern university by the first author in 2004, where it has been in place since. Training was based on the same manual and model, and the evaluation focused on whether certain central elements of the program were in place in the replication program. The current study involves data collected across the first five years of the program. During that time, 54 students were trained as advocates and worked with women for between 10 and 14 weeks. Pre-comparisons and post-comparisons revealed that the replication of CAP resulted in similar outcomes to the original implementation (Allen & Larsen, 2008). Specifically, women who worked with advocates reported less violence, greater quality of life, and improved mental health outcomes over time (e.g., less depression, fewer symptoms of PTSD). Further, an examination of the specific nature of the intervention revealed that CAP was implemented with high fidelity to the original model.

The program was supervised by the first author and coordinated day-to-day by the second and third authors, sequentially. Between 10 and 13 undergraduate students were chosen to be advocates each year. Most were Caucasian, in line with the general makeup of undergraduates on this campus. The first ten weeks of the course involve an intensive training program based on the training manual from the Michigan State University program. Advocates were expected to spend 6–8 hours per week working with or on behalf of participants, including at least two in-person meetings per week. Meetings took place where—and when—convenient to participants, whether in their homes (when safe) or in other community locations. Advocates worked on mobilizing whatever resources were most relevant for participants, as well as providing emotional support.

Participants

Participants for the CAP were recruited from a local domestic violence shelter and from the community more broadly, using widely placed fliers advertising free assistance for women in abusive relationships within the past six months. Generally, around half of participants were referred from the shelter and started working with advocates immediately upon leaving there, and about half were self-referred from the community. Participants were eligible if they (a) self-identified as having been in an abusive relationship within the past 6 months and (b) planned to stay in the county for the next few months. Women who agreed to participate completed several questionnaires before being assigned to an advocate, and then completed questionnaires and a brief in-person interview after the program ended.

Overall, advocates completed interventions with 72 women between 2004 and 2009, 51 of whom were reached for both pre-intervention and post-intervention interviews. We compared women who completed a T2 interview to those who had not, and there were no significant differences in terms of age, income, number of children, violence, quality of life, depression, or PTSD at T1. Women of color were slightly less likely to have a follow-up interview compared with White women; we lack the data to make definitive statements about why this difference emerged.

Measures

Demographics and relationship information, including race/ethnic background, age, income, education, number of children, and current relationship status, were assessed at both T1 and T2.

A semistructured qualitative interview protocol was used to examine the specific issues worked on with advocates, what survivors' relationship was like with their advocates, what impact (if any) the program had on their lives, and what they perceived to be the most important parts of the intervention. First, we elicited un-primed statements and probed generally regarding experiences survivors described. Second, if they were not mentioned spontaneously, then we followed up by probing for a priori components we believed to be important based on the program model. We also asked what could be done to improve the program.

Highly trained interviewers conducted the interviews. Participants were informed that their responses would remain confidential and would not be shared with their advocates, in an effort to elicit honest responses. Interviews took approximately 1–2 hours to complete.

Analysis

All interviews were transcribed and analyzed using QSR N5, a qualitative data analysis software program. First, the interviews from 2004–2007 were coded to identify themes. After a coding scheme was established, the interviews from 2007–2009 were read to see if they suggested any new themes or modifications to old ones. The content analysis of interviews aimed to identify prominent themes that explained how and why the advocacy intervention was effective. Initially, nine first-order themes were identified. A theme was identified as such when it introduced a unique response to our guiding question that was not encapsulated or contained within another theme. The coding task was completed by the second author in regular consultation with the first author.[1]

As a second step to encourage parsimony and to identify overarching or meta-themes, first-order themes were organized into meaningful clusters and are presented here as three second-order themes. The data were then considered in light of the final set of meta-themes to see if this schema was adequate to capture the prominent themes present in women's narratives. This is consistent with an open-coding approach (Berg, 2004) in which multiple iterations of analysis take place. In addition, negative cases, or those that would disconfirm the themes identified, were explicitly sought in both the first and the second set of analyses (Guba & Lincoln, 1989).

RESULTS

Most participants were African American (49%) or White (38%), with another 13% being Asian, Pacific Islander, Latina, or other. Average age was 35 years (standard deviation [*SD*] = 10.67). While most (about 81%) participants had graduated from high school or earned a GED, those who were employed (about 36%) were primarily working low-paying jobs in the service sector. The average income at pre-intervention was $677/month, compared to $880/month at post-intervention. Women had been with an abusive partner,

[1]The third author had analyzed earlier years of data for a separate project, obtaining very similar first-order themes to those obtained with the full dataset.

on average, 4.5 years, and 92% had ended or were ending the relationship at T2. They had an average of two children.

Critical Components of the Intervention

Women discussed a variety of reasons why they believed CAP helped create positive change in their lives. The main reasons clustered into three overall themes that seem to capture the essence of the advocacy approach: orientation to the whole person, unconditional validation and acceptance, and an orientation to information provision and action. Below we report whether one, two, a few (3–7), some (7–20), half (21 or more), or most (32 or more) of the women supported a particular theme. We describe each major theme that emerged with attention to subthemes that were captured within.

Orientation to the whole person. One important foundation of the intervention is for advocates and survivors to be able to see each other as whole people; almost all participants talked about this theme in some way. First, the program assumes that it is not possible to develop a comprehensive plan for meeting a person's goals without knowing the full context of their lives. A few women commented, unprompted, that because they could share anything and everything with their advocates, the advocates were able to understand what they really needed and to work from there:

> There was a working relationship with her, but most people counsel, most people that I've tried to deal with, they don't really take the time to listen or to understand what you need. Either you fit into the right little holes, if you're a square peg not fitting into a round hole, they don't wanna come up with a square peg set or a square hole somewhere for you. It just . . . doesn't work that way.

This quote points out that without a full understanding of the woman's situation (as well as the flexibility to provide an individualized solution), often the wrong solution may be posed. Women mentioned other benefits as well; for instance, a few noted (without prompting) that it was nice to have already told their advocates everything, so that when new developments came along, they did not have to start over by telling someone the whole story again. As one woman put it, she appreciated that her advocate could work with her on "anything, and it didn't even have to be with finding resources."

Second, the orientation to the whole person seemed to lay a foundation for genuine caring and connection to form between advocate and survivor. Indeed, over half of participants mentioned, unprompted, that this sense of caring was a crucial part of the intervention. Rather than the intervention simply being about emotional *or* material needs, advocates gain a sense of both a woman's "needs and, also my emotional state of mind." For instance, one woman appreciated the fact that her advocate would help her visit an old friend, in addition to working on financial needs. Participants noticed attention to both material and emotional needs and often noted that it led to the very important sense that their advocates truly cared about them (which was often different from how they perceived other service agencies).

> She had feelings too, she has feelings too. . . . She wasn't just straight with the paperwork; she also had feelings, too. You know, she act like . . . she cared. . . . It was different from [other service providers], even the services that the [community agency] provided. . . . Um, 'cause the [agency], you know, you ask them for

> somethin', it'd be 3 or 4 days later before you'd get the information, so if you ask [my advocate] and she didn't have it then, she'll call ya back an hour or 2 later with the information and she seemed like she really . . . cared about, you know, victims of domestic violence . . . . And some of the [agency] staff seemed like, hey, they do this stuff every day, you know, so you just another victim to them . . . . She didn't treat me like I was just another victim.

Overall, it seemed that advocates and survivors seeing each other as whole people contributed to a strong sense that advocates *cared* about the women (e.g. "she really cared about what was happening to me, what was happening in my life, and I appreciate that every second of the day."). This sense of caring pervaded women's responses to all the questions. While some women actually said that it was the most important ingredient in the intervention, others simply mentioned it at various points throughout the interview. Women sometimes reported that the other things their advocates did were important *because* they showed that they cared, or that without knowing that their advocates cared, they would not have been open to the program.

Additionally, it was important to women to see their advocates as whole human beings too, who shared, showed their feelings, and let them know what they were thinking. Indeed, most women commented that it was important that they knew their advocates or saw them as friends (over half of participants raised this idea unprompted). Relationships were certainly not entirely mutual, in that more emphasis was placed on women sharing than on advocates sharing about themselves. However, what was important was that the intervention was not rigidly professional, but appeared to live somewhere between friendship and business.

> [I became more comfortable with her] 'cause she talked about her life a little bit, too . . . . [Our relationship was] nothing like anything I had with any other service providers. Usually, they're just professional and there is no connection or friendship or anything between them.

This sense of caring was in turn extremely important for the intervention to be effective, and so that women felt comfortable opening up to their advocates. One woman explained this in terms of being treated like a person rather than a project.

> I felt like I could trust her . . . I gave her [personal information], stuff that you just don't give to people, but since I knew . . . what she was doing, I don't know, I felt comfortable. . . . Because she talked to me like a person rather than a project. . . . She's caring; she actually cares about the details. She wants to know the details. She wants to know what's going on and she wants to help.

Indeed, more than half of participants commented unprompted on the fact that this had the feeling of being about more than just "*a number*" or a school project (e.g. "It wasn't just a job for her. She was sincere, she loved what she was doing."

> If I ever needed to talk she was always there, even if I needed to call her, you know, if she was free and I wanted to talk and sit down, she would come and, you know, things like that. . . . I just felt that she was always there for me. . . . She told me I could call her on her cell phone any time, you know, and that, I think, is going farther than the program. . . . I wouldn't call her at 1 o'clock in the morning, but,

> you know, you know, it's not like I have to stop calling her at 5 o'clock. If I needed to call her at 7 or 8 or something and talk 'cause I just needed to talk, she said I could do that.

Unconditional validation and acceptance. The ability to see each other as whole people directly contributed to the second theme: advocates' ability to accept and validate the women with whom they worked. Again, almost all participants talked about this theme as reflected in one of three core components of the advocacy model: emotional support, a nonjudgmental, strengths-based approach, and a survivor-centered intervention. At their core, all three of these approaches are important because they convey to women that they are strong, capable, and worthy—of respect, of fair treatment by others, and of achieving their dreams.

Emotional support. Acceptance was most often conveyed by explicit emotional support. Most women said such support from their advocates was a crucial part of their intervention (in fact, almost all noted this without prompting). Women defined such support in different ways: some women commented without prompting that most crucial was the advocate's ability to simply listen effectively, which helped women feel understood.

> If I just wanted to talk she would just listen. She would be there. She didn't have to say nothing. I just wanted to talk. And I know I could talk to her and it would be okay and she'd listen and understand.... She's just there for me and ... sometimes you have to vent and she was there for me. It just made me feel like she cared and I know she did.

In addition to listening, some participants said without prompting that advocates provided emotional support by being a source of validation and encouragement.

> I also ... found her to be incredibly affirming, telling me that I was doing a good job, that I was a strong person, and ... just ... keep doing what I was doing, and it's gonna be okay, which is something I wasn't finding elsewhere, and really needed.

As this last comment suggests, such support was important for women primarily because it was often something they were not receiving elsewhere. Even when they did have someone they could talk to, such people were often not supportive or women felt they could not be trusted:

> [To have emotional support,] it means everything.... I mean I can feel free and live again or ... that I'm not crazy.... Even though most of the people were against everything I said ... I feel free to be me and knowing that I'm not wrong ... I am okay.... It's alright for me to not want nobody hittin' me. It's alright ... regardless of what everybody else is thinking. That I don't have to be nobody's stepstool you know.

Thus, receiving emotional support from advocates often helped women to start to see their own viewpoints as valid. This, in turn, allowed them to start to believe that they were capable and worthy:

> Well, she kind of like reinforced the fact that, that I deserve like a good life, that I deserve positive things to happen to me for a change, and that I don't deserve all the crap that's been happening to me for the last years. She just kind of . . . helped with my self-esteem a little bit by giving me an idea of, you know, that I'm basically worthy of happiness because, honestly, a lot of the times it doesn't feel like it.

Nonjudgmental, strengths-based approach. More than half of participants noted that it was important to them that their advocates did not judge them and seemed to see their strengths, rather than seeing their failures (some women raised this unprompted; some were prompted). However, this was difficult to disentangle from emotional support, as many comments women made about emotional support implied a nonjudgmental stance. For instance, one woman's comment implies that a nonjudgmental attitude is a crucial component of emotional support:

> Interviewer: Anything that you think of as a key ingredient?
> [My advocate] never did ask me was I gonna go back to [the abusive ex-partner] or anything. And I think she knew that I wasn't gonna go back.
> Interviewer: And what's significant about that for you?
> Because the shelter was like, you know, since I been with him for 18 years and I had left and went back a few times, so, you know, they judge you for that. But she never did judge me for that. . . . Her main concern was to support me.

Using plain language, another women reflected on the value of a nonjudgmental stance:

> Plus, it was nice to have someone to talk to that didn't have to give you their opinion on crap they don't know anything about.

Though being nonjudgmental was often not immediately mentioned as a key process of the intervention, it was something that more than half of participants said was crucial to the intervention as carried out. A few women noted unprompted that they could only start to trust and open up to advocates in the first place because they were nonjudgmental. Thus, had the advocates judged them or their actions or seen them as failures, many of the interventions probably would simply never have developed.

> By her not judging, it made me more open to trust and just made me feel like I could say, ya know, "I had a hard time today and I called him," and to really be honest, and with other people I feel like I'm not gonna open up if they're gonna judge me. . . . You'll just not share it if you thought they're gonna be hateful, then why say it? She made me comfortable that I could say it without she's gonna criticize me and question. I mean, she could tell me it wasn't good but she said it in a way that she was just givin' me the reasons to process and see that it wasn't good, not to look at me like, *Oh you did this again, you're a failure, why you doin' this.*

In addition, a few women noted unprompted that they could start to see themselves in a different way because advocates communicated that they could understand why women had done the things they had done and to see their actions and characteristics as strengths rather than failures.

> What I've been through, so many people would judge me because of what I've been through. She didn't. She was just understanding and kept telling me it wasn't my fault 'cause I kept putting it on myself and she just, it's not your fault, you know. Those are your kids, you know, and just kept encouraging me and stuff. . . . It made you feel better about yourself. It made me feel better about myself and that's one thing I do need help with is feeling better about myself 'cause I tend to let myself down a lot.

Seeing their strengths through someone else's eyes sometimes helped women start to see themselves in that way; it also sometimes helped women start to trust other people more. It was helpful for them to see that not everyone was looking for their faults or waiting to give them advice.

Survivor-centered intervention. Along with seeing women's strengths, advocates validated women's experiences by conveying that they were the experts on their own lives and could dictate the direction of their respective interventions. Again, more than half of participants noted that it was important that advocates expected them to lead the direction of the intervention (some raised this unprompted; some were prompted). Women's comments often suggested that the intervention would not have been the same if conducted in any other manner.

> She just gave me advice and suggestions 'cause she said it was basically left up to me, I'm the one that would have to live it, and . . . she couldn't make the decisions for me; she could only give me suggestions and advice. And that's what she did.

The specific ways that the intervention was survivor-centered differed across people. Mainly, women said that they saw the relationship as one of equals, that it was a "*partnership*" or a "*collaboration.*" In some cases, this meant that the woman said what she wanted to work on and the two simply went from there. In other cases, after the woman decided what she wanted to work on, she would suggest how they might work on it and the advocate would help her think through different options. Often the advocate would be able to reinforce what she wanted to do as well as help think of how to do it more effectively. Some women saw this as an advising or consulting relationship. No matter how it worked in the specifics, the end result was that the woman again felt reinforced and supported by the advocate.

> I've never had [a service provider] like [my advocate]. She's just positive. All my other ones are just trying to get their job done. It's about them. It's not about me. It's about them getting their job done, doing what they're supposed to do, and they really don't care about me. And [my advocate] was focused on—it was about me. It was about helping me, help getting my goals, and, you know, she was there for me.

> Interviewer: Okay. What difference, if any, did it make for [the advocate] to let you direct what the two of you worked on?
> So that I could do it on my own when she wasn't around . . . so I could carry it on my own.

Overall, the fact that the intervention was nonjudgmental, survivor-centered, and supportive translated into women feeling that this was one relationship in their lives that truly was validating and accepting. For example, one woman commented on the importance of the unconditional nature of this support:

> I could do anything with her support. Just knowing that I have her in my corner and it wasn't dependent on anything that I did or didn't do, it was just there.

Action orientation. The above-mentioned components laid the groundwork for a productive and active intervention. For many women, working toward accomplishing specific goals was almost the entire work of the intervention. Indeed, almost all women commented on the active portions of the intervention. Primarily, the "action orientation" in this intervention meant helping women work toward specific goals by connecting them with relevant community resources. Without prompting, almost all women mentioned that gaining knowledge and access to resources was an important part of the intervention for them (and almost all women said that it was important when prompted directly). Women were often quite knowledgeable about local resources coming into the intervention, having had to use them in the past; still, they often found that their advocates could help them find even more.

> And, she amazed me, the amount of information that she would find, because . . . I thought how in the world are they going to give me an advocate that hasn't come up with all the resources that I've already come up with? But she did, and it was great, and would give me websites to check out on my own, um, so that I could pick out of it what I might find best for myself.

More important for many women, their advocates would research these resources, help them strategize about the best way to obtain resources, and accompany them to agencies. Thus, it was helpful to women just to have an extra set of helping hands, and more than half the women said, unprompted, that this helped take the stress out of finding resources. A few women also noted that accessing resources with an advocate made a difference in their attitudes as well. On reflection about what difference it made to access resources with the help of her advocate, one survivor remarked:

> I didn't feel like it was a bad thing that I needed help. I don't know how to explain it, but I didn't feel bad. I didn't feel embarrassed.

Given the centrality of mobilizing resources in advocacy interventions, it is not surprising that advocates' knowledge of and access to resources would figure prominently in explaining the value of the intervention. Yet it was not just that advocates knew where to go and how to access resources, but that they engaged in hands-on support as women navigated those resources. Overall, advocates connected women with resources in a collaborative way, such that when the intervention was over, women would be able to continue to mobilize resources on their own behalf.

> Honestly, I did not know about a lot of things that she let me know about and it made, you know, I'm coming to the point where, you know, I've got a job lined up and I should be getting my own place here in a few weeks. And, you know, when I first met her I . . . didn't know about any of the resources, and now even

> though we're not in the program anymore, I'm still taking the help she gave me and using it on my own.

Women appreciated that their advocates were persistent, both in contacting them and in researching resources to meet their needs. Likewise, they appreciated that advocates followed through, not only on projects started together but also on needs that the women mentioned in passing. Importantly, the things advocates worked on were often "outside of the box." That is, the assistance provided to women could include practical support offered in the moment (e.g., developing a resume, gathering job applications) or helping plan a low-cost vacation.

> I just know that she was just helpful to me emotionally, and . . . she constantly, constantly, constantly offered to help me. . . . I mean, if I made a comment to her about something, she, the next time I saw her, she always had something for me on that and I thought that was just really nice. . . . Like I said, my family and my friends just don't help out very much, and if they do, it's just, you know, it's very minimal, nothing that takes any time or effort. She put a lot of time and effort into everything she did.

A few women commented specifically that the combination of validation and concrete movement toward goals was very important for them. The synthesis of those two things meant that women often felt energized, motivated, and able to make changes. In part this was because advocates helped women develop new skills and, importantly, realize and believe in the strengths that they *often already thought they had.*

> Well, we worked on, uh, budgeting 'cause I . . . had never had a checkbook or paid bills. At, ya know, 36 was just . . . very hard for me, ya know, 'cause he never let me so that was very helpful to me . . . . She brought me over folders and we organized and . . . just wrote down a budget and everything and then she gave me resources in case I was struggling with . . . paying certain bills . . . . I don't think I coulda [left my abusive partner] had I not known that I could make it on my own and someone sit down with me to show me that I could pay my bills . . . .It's made me realize that I can make it on my own. . . . And no man is gonna control . . . what I do.

A few women noted that this translated into feeling like they had regained hope, inspiration, or the motivation to move forward again.

> The program, for me, gave me a window of hope. I mean, when everything seemed completely dismal and bleak and, like, there was no hope at all, it gave me a window of hope that I might be actually able to meet some of my goals.

One woman summed up how the whole process helped her to develop as a person. Essentially, through helping her attend to some of her basic needs and believing in her, the advocate facilitated a process by which the woman could focus on her own emotional growth and find strength within herself to move forward. Though this was a particular

story, the themes of resource provision, emotional support, inspiration, and growth were reflected in different ways throughout all the narratives.

> Interviewer: And did [your advocate] help you at all with the other job?
> No, I actually found that one on my own, but I think she sparked such motivation in me, that, you know "look at all these things I found for you," you know, and it just made me believe in myself . . . there was such a wide variety of things . . . that she'd bring back to me, believing that I could do these things. And I don't think I ever would've applied for the job that I applied for. I don't think I would've thought that I could have done that job. . . . Yeah, um, [my work with my advocate] allowed me to continue to get back on my feet, um, which in turn allowed me to not have to focus on that for once and be able to focus on the emotional turmoil that I was going through and just deal with the growth process that I wanted to focus on . . . .Yeah, I feel like I'm a much stronger person. I know what I want out of my life and I know how to get there. I know that I have the strength to get there. Which I think were things that were brewing before the project, but this allowed me to stay on that path and enhance that in me. . . . Yeah, otherwise those things might've gone way underground because I was so focused on just getting through each day.

Although women were overwhelmingly positive in their reactions to the program as a whole, we did also prompt them to talk about what they would have liked to be different. More than half said that they would not change anything about the program. Some said that they would have liked the program to last longer. Some said that the program did not have a big impact on their lives, although they otherwise said positive things about the experience. One woman said that she wished the program had collaborated more closely with a particular community resource. And two said that they wished their advocates had greater knowledge of or access to resources. One woman did report a negative experience overall. Interestingly, she did not attribute this to the program as a whole, which she said could do a lot of good; she attributed this to her particular advocate not devoting enough time and not following through on her involvement.

DISCUSSION

The analysis of domestic violence survivors' experiences with the CAP indeed illustrated the importance of strengths-based, survivor-centered, emotionally supportive, action-oriented advocacy—all a priori assumptions about important elements of the service delivery process. However, examining survivors' perspectives served to expand our conceptualization of key service delivery processes both in terms of how we organized our understanding of *how* the intervention was helpful and how we understood the key processes of CAP that facilitate positive changes in survivors' lives. Specifically, a qualitative analysis of their experiences suggest three overarching themes, including an orientation to the whole person, unconditional validation and acceptance, and an orientation to information provision and action.

Links to Broader Calls for Reform

In many ways, the service delivery processes highlighted by survivors were not surprising. They affirm and echo long-standing calls to make such processes normative in the service

delivery process, generally speaking (for example, see Stroul et al., 2010, for a comprehensive overview of similar principles in the delivery of Systems of Care developed to respond to youth with severe social/emotional challenges) and in the domestic violence arena, in particular (see Goodman & Epstein, 2008). Importantly, recent research suggests that survivor-centered advocacy is more likely to result in positive outcomes for survivors. For example, Moe (2007) found that women who had received services over which they had control were less likely to return to their abusive partners, while women who were denied such opportunities were more likely to return.

Similarly, Zweig and Burt (1997) found that woman who had more control over the service delivery process were more satisfied. Thus, the service delivery processes described by survivors is not just *value-driven* (i.e., a "nice" way to engage in service delivery), but part of an emerging theory of change that centralizing women's strengths and priorities, and engaging the unique complexity of their lives, may be key to facilitating desired changes.

Expanding the A Priori Framework

While survivors' endorsed and often spontaneously raised experiences that fit with our a priori assumptions, the most salient themes offered a slightly different framework and emphasis regarding what facets of the service delivery process mattered most. Perhaps most fundamental is that survivors experienced CAP as oriented to advocacy for women as whole people rather than as solely "domestic violence survivors." For some women, the abuse they had endured was not the central, organizing experience of their lives. For others, the abuse figured prominently, and, for others, it was not even a concern any longer. Thus, while advocates must be trained in issues specific to domestic violence (e.g., legal challenges, safety planning), they must also allow for women's priorities to emerge in any and all areas of their lives. This process emerged from survivors' interviews and added another critical dimension to our understanding of how CAP may facilitate positive changes.

Unconditional acceptance was also often spontaneously cited by survivors and, while related to a strengths-based orientation (one of our a priori hypotheses), was much more firmly anchored to nonjudgment and validation. Such an approach also has a long history within the human service realm. Most notably, Rogers (1961) promoted a notion of unconditional positive regard for clients. Clearly, this approach has had broad applications in the service delivery arena. Following in Rogers' footsteps, one of the creators of Wraparound, Karl Dennis, pioneered an approach of unconditional care (Dennis, 2011). In this case, he created therapeutic residential and foster care environments from which clients *could not* be dismissed under any circumstances. Thus, perhaps not surprisingly, for survivors, unconditional acceptance and validation meant that their advocate accepted and worked with them without judgment.

Explicating a Theory of Change

Survivors' experiences with the service delivery process also point to an expanded theory of change regarding how CAP positively influences survivors' lives. Specifically, the core service delivery processes are likely critical elements because they facilitate not only the advocacy partnership and the acquisition of resources but somewhat more intangible gains (e.g. sense of invigoration, belief in self) that women viewed as contributing to a continued sense of movement after the intervention ended. Intervening in a fashion that connects women to the resources they need and validates their right and their ability

to access needed resources in the future may position them for ongoing success. This is consistent with an empowerment approach, which contends that having more rather than less control over their lives is positively associated with their well-being and that such empowerment is a *process* rather than an outcome (Rappaport, 1981).

Further, being released from an orientation to specific goals and outcomes avoids identifying particular goals as a marker of women's success or failure. For example, Weisz (2005) noted that many women did not "follow through" on referrals provided by their advocates. In the CAP approach, this would not be viewed as a failure to act. Rather, the advocate would look for additional or entirely different ways to support the woman (e.g., exploring whether the woman viewed the referral as useful, examining the specific barriers to contacting that referral, exploring entirely new goals, approaching the referral source with the women or on her behalf rather than "requiring" her to do it).

Revisiting Domestic Violence Services

There is a rising concern that advocacy services are increasingly offered in a fashion that is too similar to traditional human services: professionally driven, and espousing an apolitical, degendered analysis of domestic violence (Dobash & Dobash, 1992; Lehrner & Allen, 2008, 2009; Macy, Giattina, Parish & Crosby, 2010; ??Osmundson, L. A., n.d.; Schechter, 1982). Rather than become indistinguishable from this traditional system, the domestic violence field can revisit current service delivery practices in light of the specific process elements emphasized in the current study.

The approach to advocacy described here does not imply that domestic violence programs must be positioned to provide for all of the needs women present, but that they are positioned to link women with formal (e.g., specific services) and informal (e.g., social support, recreation) resources that will enhance their well-being and safety on their own terms. Macy and colleagues (2010) found that domestic violence and sexual assault agencies felt challenged to meet women's comprehensive needs, particularly with regard to substance use and mental health. This is consistent with cutting-edge recommendations within the service delivery system to create seamless systems of care that are not encumbered by organizational and bureaucratic boundaries (Knitzer, 2000; Schorr, 1988; Stroul et al., 2010).

Exploring the specific service delivery processes of the CAP—to illuminate the core of its fidelity—raises important questions about dissemination of this effective intervention and calls us to examine current dominant approaches to service provision with survivors. In what settings can this intervention be effectively disseminated? In the context of domestic violence programs, which often have very explicit mandates from funders regarding the services they provide (e.g., Schechter, 1982), what specific changes would be required to devote 6 to 8 hours of individualized, strengths-based, unconditional, validating, emotionally supportive, survivor-centered advocacy to survivors? How could we move from an increasingly categorical structure (with predetermined and sometimes mandated programs that clients must pursue) to a flexible one?

To the extent that domestic violence programs become more similar to typical human service infrastructures, they are likely to adopt programmatic structures that involve categories of service (e.g., legal advocacy, counseling), rather than flexible structures that are "mapped" onto women's unique and presenting needs and goals that can adapt as needs and goals evolve. Allowing for a more survivor-centered approach to domestic violence programs would require a very conscious development of internal processes

and structures. Indeed, human service delivery reform efforts have found that ensuring particular service delivery processes requires supportive infrastructure (funding and organizational policies and protocols aligned with desired processes; intensive and appropriate supervision; e.g., Stroul et al., 2010).

Sullivan's (2006) manual detailing Mission Focused Management strategies provides one important resource as it locates the work of frontline providers in the context of the organizations in which they work and provides specific suggestions regarding organizational structure and process at multiple levels. Sullivan contrasts what have increasingly become services as usual with those that would truly empower women. For example, she emphasizes that the organizational structure from the functioning of the board to the executive director to front line providers must reflect an empowerment orientation the goal is to offer empowering services to women. Thus, embodying principles that encourage survivor-centered advocacy would require careful implementation at all levels of an organizational structure.

Limitations

Some inherent limitations are involved in asking women about their experiences with a program. Although interviewers were separate from advocates, participants may have felt pressure to say that they had positive experiences with the program and those interviewed might overrepresent those who had the most positive experiences. Interviewers did attempt to elicit negative responses, but it is still possible that reports were overly positive. However, this type of concern would be most relevant had we been assessing the program's effectiveness. Given that we examined the *processes* involved in making the program helpful, a more relevant concern is whether our own hypotheses biased participants toward certain answers. Certainly, we did have hypotheses about what would be helpful before we started the study. It is worth noting that before asking about hypothesized areas, we asked women for their own thoughts. Several themes were generated from women's spontaneous reports, not in response to interviewer questions. The three broad areas that emerged, although they encompassed elements emphasized in training, were ultimately somewhat different and were influenced by women's own reports.

This study is also particular to this program. Moreover, not every woman in the program participated in the interview. Thus, it may be that other factors would rise in importance within other "alternative" programs or that women who did not participate would have had very different experiences. Future research should examine whether similar themes arise from women's experiences in other programs that are outside the service system norms. Indeed, this study raises questions about replication. This intervention was conducted with undergraduate students receiving course credit for being advocates. It is unclear whether the same type of intensive intervention would be likely, or even possible, with advocates working as volunteers or as part of an agency. Perhaps the fact that the advocates are students and not professionals may increase fidelity to the intervention model. As students, advocates have no professional norms to overcome in the delivery of an explicitly survivor-centered model.

Conclusion

The CAP provides a powerful exemplar of an effective intervention that operates in a manner consistent with the original intentions of the Women's Movement to honor

women's expertise and focus on changing the contexts of women's lives rather than women themselves. This study provides a roadmap, or guide, regarding elements of this intervention that are likely instrumental in encouraging the positive outcomes this program yields: orientation to the whole person, unconditional validation and acceptance, and an orientation to information provision and action. Each of these core components challenges implicit and explicit norms that often pervade social services as usual. While we must be committed to meeting survivors' needs as we simultaneously work to address the fundamental social changes required to end violence against women, the CAP approach invites us to do so in a manner consistent with our ideals and our ultimate vision to end violence against women.

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