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Emily Riddle Jacobs
How Our Service Systems
Impact Resiliency and
Recovery of Domestic
Violence Survivors: Clinical
Perspectives

ABSTRACT

This qualitative research study explores clinicians' perceptions of how current social service systems impact domestic violence survivor resiliency and recovery from abuse. The study utilizes a narrative analytic approach examining semi-structured interviews gathered from nine clinicians working in the trauma field. Through using the theoretical frames of intersectionality, trauma theory, and post-traumatic growth theory, the study focuses on the potential for growth and resilience among trauma survivors. This study found that survivors experienced more nuanced post-traumatic growth with ambivalence around new self-development, resiliency, and feelings of empowerment. The research suggests that the current social service systems re-traumatize survivors and replicate tactics of abuse similar to those existing in relationships with interpersonal violence. Participants discussed feelings of unpredictability, manipulation, and disempowerment that survivors experience in IPV and within service system interactions, which were exacerbated for survivors holding marginalized identities. Implications for social work practice, policy, and future studies are also discussed.

**HOW OUR SERVICE SYSTEMS IMPACT RESILIENCY AND RECOVERY OF
DOMESTIC VIOLENCE SURVIVORS: CLINICAL PERSPECTIVES**

investigation,
the requirements
Work.

A project based upon an independent
submitted in partial fulfillment of
for the degree of Master of Social

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2017

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CHAPTER 1

Introduction

This study explores clinicians' perceptions of how current social service systems impact domestic violence survivor resiliency and recovery from abuse. The study utilizes a qualitative approach examining semi-structured interviews gathered from clinicians working in the trauma field. Through using the theoretical frames of intersectionality, trauma theory, and post-traumatic growth theory, the study focuses on the potential for growth and resilience in trauma survivors. There is a growing body of research focused on the impact of domestic violence on survivors. Many researchers are rejecting the focus on the detrimental effects of abuse and choosing to redirect the research conversation towards the growth and the development of resiliency that can occur in the aftermath of surviving violence and abuse (Harvey, Mondesir, & Aldrich, 2007; Hernández, Engstrom, & Gangsei, 2010). The following information explores general research findings on domestic violence and the theoretical underpinnings of intersectionality, trauma theory, and post-traumatic growth theory.

Research Overview on Domestic Violence

Defining domestic violence. Domestic violence is a broad term that encompasses many forms of violence and abuse that occur in a broad range of relationships. Domestic violence includes intimate partner violence, which occurs between partners and ex-partners. These traumatic experiences are distinguished as a gendered form of oppression (Howard, Feder, &

Agnew-Davies, 2013). Domestic violence can include physical violence, sexual abuse, and psychological abuse (Howard, Oram, Galley, Trevillion, & Feder, 2013). Psychological abuse includes verbal abuse and aggression, threats to the individual, the partner, and the relationship, intimidation, demeaning criticism, hostile behaviors, and destruction of property (Howard, Oram, et al., 2013). One key component in domestic violence is the element of coercion and control. Such behavior can be defined as acts of manipulation that can break down a victim's ability to leave an abusive situation. This cycle of abuse and control can threaten a survivor's support systems, take away financial independence, create difficult housing situations, and destroy the sense of autonomy. Controlling behaviors can include isolation from friends and family, requiring permission for all activities, and controlling what a survivor is allowed to do (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006).

Theoretical Underpinnings of Study

There is a growing body of research surrounding the relationship between domestic violence and the trauma of abuse and violence. This relationship has led to the development of theories surrounding the influence of trauma on survivors. Trauma can impact an individual through psychological, physiological, and behavioral reactions (Van der Kolk, Weisaeth, & McFarlane, 1996). *Trauma* can be defined as the reactionary response when internal and external resources are insufficient to navigate an external threat (Van der Kolk, 1989). These reactions can be categorized as negative or maladaptive responses that impede or impact ability to function, through changes in processes like cognitive thinking, memory, and physiological arousal (Herman, 1997).

With the recognition that trauma can have lasting and powerful impacts on the mind and body, research began to explore the ways in which individuals can develop in spite of detrimental experiences. Moos and Schaefer (1986) developed a framework to explore stress-related growth that they deemed positive adaptation. As this concept has developed, other researchers have defined this process as *posttraumatic growth*, described as a positive change as a result of trauma (Cadell, Regehr, & Hemsworth, 2003; Tedeschi & Calhoun, 1995). Posttraumatic growth is a theoretical model that can be utilized to explore the factors that contribute to positive changes and growth. This study will utilize both trauma and posttraumatic growth theory as the theoretical framework to inform this research about domestic violence. There is a scarcity of research exploring clinician perspectives on their own personal interactions and survivor experiences within social service systems.

Methodology

This study addresses the gap in the research mentioned above by exploring clinician perspectives about the impact of the larger social services system on survivors of trauma and post-traumatic growth. The overall research question asks: *How do clinicians perceive the influence of social service systems on the resiliency and recovery of domestic violence survivors?* This study's qualitative research methodology is based on a narrative approach to data analysis. Participants were asked to explore their perceptions of how social service systems influence survivors as they leave their abusive partners and move into a process of recovery. In addition, participants explored their own intersubjective process of being clinicians working within the systems that interact with survivors. Finally, this study focused on the development of resiliency and post-traumatic growth among people overcoming adversity from abuse.

The participants for this study were recruited through non-probability sampling methods. I used purposive, snowball sampling to focus on clinicians involved in the antiviolence professional network in Massachusetts. This study recruited 9 individuals who met all inclusion criteria and consented to a narrative interview. Inclusion criteria included clinicians of any background who work with trauma survivors, a significant portion of which are domestic violence survivors. These clinicians included social workers, counselors, psychologists, and any mental health professional with at least two years' experience working with trauma survivors. Participants were recruited by utilizing professional groups for licensed clinicians working with trauma survivors in greater Boston and surrounding areas. To avoid centering the researcher's voice, interviews utilized a narrative approach for in-person interviews.

Personal Interest and Importance for Social Work

I was drawn to this research topic through my work in emergency shelters. Specifically, I gained a deeper appreciation for the complexities within individual resiliency and interactions with the larger social systems while at a field placement in a domestic violence shelter. My experiences impacted the way I view the issue of gender-based violence and the services available to survivors.

I watched individuals work to regain control of their lives, while struggling with systems that continued to take away any semblance of autonomy. Legal backing for survivors still requires explicit documentation and proof. Police reports and hospital discharge papers are vital to request restraining orders and overturn a wrongful eviction. Even then, I watched many women in the shelter receive restraining orders to be renewed every year, forcing them to choose between returning annually to unsafe locations or risk leaving themselves legally unprotected.

Despite having legal protection, I watched many women moving throughout the world in fear as limited resources meant many abusers evaded police custody. Many women avoided the legal system because they felt it would make their abuser more violent or they feared the police would treat them unfairly. Limited housing options meant that individuals and families could become trapped in the shelter system. This meant shelter space was limited for those fleeing from active domestic violence situations. This housing cycle seemed to create helplessness for survivors, never knowing how long they would be without housing or where they might be shuffled next. It is difficult to begin to regain a sense of control when the decisions and the process are decided for you. This experience left me with significant opinions and experiences that motivated this research. I engaged in close work with a thesis advisor to stay aware of the ways in which my biases interacted with this research.

Therefore, it is important for the field of social work to look at the ways in which systems impact survivors. For example, it is vital to look at how racism, sexism, and classism interact within the social service systems. These forms of discrimination can impact the different ways survivors utilize and are treated within the systems. Discrimination can act as barriers to accessing care, as well as create new or re-traumatizing experiences for survivors. Clinical perspectives can work to legitimize the experiences within these social service systems and reflect on potential compounding impacts. With a larger discussion focused on examining the strengths and gaps in provider treatment, incremental changes can continue to be conceptualized.

Conclusion

This study explores clinician's perceptions of how survivors of domestic violence are impacted by social service systems created to help them. The following section more thoroughly

examines the growing body of research on domestic violence. It also explores the ways trauma theory and post-traumatic growth theory relate to survivors and interact in social service systems. Chapter III explains in detail the methodology for this study and details the narrative approach to interviewing. Chapter IV presents and interprets the data collected through interviews with clinicians. This section will draw themes from the collected narratives presented in detailed findings. Chapter V summarizes these findings and discusses opportunities for future research. This final section also explores the implications for the field of clinical social work and the potential impact on clinical practice.

CHAPTER II

Literature Review

Domestic violence is marked by subtle and overt forms of manipulation and domination, which can range in frequency from a single event to continuous occurrences across a lifetime. For the purpose of this study, the term domestic violence (DV) will be used interchangeably with intimate partner violence (IPV). Both terms will be utilized to acknowledge the historical use of DV, as a term that brought awareness to violence against women, and the inclusivity of IPV, as a term that acknowledges non-heteronormative identities who are victimized. Condrey (2012) notes that in reviewing literature around IPV, the term seems to be utilized when the studies are focusing on lesbian, gay, bisexual, and transgender individuals. The remainder of this chapter presents the theories that inform multidimensional approaches to understanding domestic violence and the empirical research relevant to the issue.

Intersectionality. Intersectionality describes a theoretical framework that examines the ways in which systems of power and oppression interact and impact social contexts and identities (Bograd, 1999). These systems of power can include such identity markers as race, gender, class, and sexual orientation, while systems of oppression can be expressed through prejudice, class stratification, and gender inequality, to name a few. The intersection of these systems with domestic violence can create complex experiences of victimization and isolation, which can interact on intrapersonal, interpersonal, and systemic levels (Condrey, 2012). For example,

Crenshaw (1993) notes that the experiences of battering and rape for women of color often occur at the intersection of racism and sexism, though the nuances of their experiences are often left out of theoretical discussions. It is important to acknowledge that the intersections of sexism and racism are only two aspects of an identity that work together to construct an experience. These intersections of identity are important because they expand the experience of domestic violence beyond that of white women, on whom the literature historically focused. Therefore, intersectionality facilitates the inclusion of a range of individuals while also recognizing that each individual experience includes their own unique factors. This is vital when looking at the many ways traumatic experiences can impact and affect a person.

Trauma theory. Trauma can be described as an “emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience that shatters the survivor’s sense of invulnerability to harm, rendering him acutely vulnerable to stressors” (Figley, 1995, as cited in Basham, 2008, pp. 415). Trauma theories were developed to help understand the impact of and reactions to trauma. Herman (1997) notes that many survivors have difficulties processing these traumatic events. This can result in survivors failing to remember full accounts of the event or to splitting off parts of the self from the experience. These reactions work to keep thoughts and memories out of consciousness. Trauma can involve feelings of powerlessness, fear, and helplessness. Many individuals struggling to process trauma can experience symptoms like hyperarousal, intrusive thoughts, constriction of affect (Herman, 1997). Individuals can feel distanced from others, isolated because of their experiences or their change in behavior. Therefore, treatment of trauma can be focused on regaining a sense of power and control over the experiences and memories.

Trauma can be experienced on individual and collective levels. Through reviewing the literature, it appears that an individual level trauma is an experience of trauma from one perspective. Individual trauma can develop into collective trauma with the development of an understanding that others experienced the trauma as well. Collective trauma involves the damage done to the social ties and bonds that create a sense of community (Erikson, 1976, as cited in Ostertag & Ortiz, 2013). The understanding of collective trauma can be aided by the concept of cultural trauma. Cultural trauma reflects the creation of a joined narrative of the collective traumatic experience. Cultural trauma theories acknowledge the ways in which those who develop the narrative influence the understanding of the collective experience. This can be seen through the depictions of disasters in the media, the racialized lenses which can demonize and essentialize groups of people. This suggests that such creations of narratives have the capacity to mobilize entire communities and nurture recovery through the creation of meaning from traumatic events

Post-traumatic growth theory. Research suggests that traumatic events can have positive effects on individuals who survive them (Moos & Schaefer, 1986). This phenomenon is conceptualized as traumatic events that impact an individual, who does not return to their pretrauma state but develop to new states of self-understanding and well-being (Ickovics & Park, 1998). This theory explores the elements that allow individuals to adapt in positive ways through trauma and adversity (Woodward & Joseph, 2003). Post-traumatic growth occurs across any range of traumatic experiences from caregivers for loved ones with AIDS to survivors of rape (Burt & Katz, 1987; Cadell, Regehr, & Hemsworth, 2003). For example, literature reviews show that post-traumatic growth in survivors of life threatening illness showed multiple themes of

positive growth. Reports have shown survivors developed an increased appreciation for their bodies and new focus on experiences in the present (Hefferon, Grealy, & Mutrie, 2009). For individuals who had experienced childhood abuse, Woodward and Joseph (2003) found that positive change occurs through inner drive toward growth, external vehicles of change, and internal psychological changes. This suggests the post-traumatic growth occurs through individual and systemic mechanisms. There is evidence that distress levels can be related to positive growth after trauma. The findings suggest specifically that those who experienced very low or very high levels of distress experienced the greatest levels of growth (Kleim & Ehlers, 2009). Cadell, Regehr, and Hemsworth (2003) found that positive post-traumatic growth is impacted by connection to spiritual beliefs, strong social support, and experience of high levels of distress. Research suggests that a sense of self advocacy plays a significant role in posttraumatic recovery and growth (Benight & Bandura, 2004). This research has identified that personality and environmental factors may play an unexplored role in positive recovery from trauma.

These theories are vital in the creation of a framework that looks at the experiences across populations. Trauma theories, like cultural trauma and collective trauma theories, reflect the expansiveness of community impacts from natural disasters and mass killings. This can help explain how cultural narratives have the potential to create community divides and/or foster community recovery. This creation of meaning out of trauma points to the prospect of posttraumatic growth and the strength that can be found in adversity. These multidimensional understandings of trauma are important as they provide a more inclusive framework to examine the interaction between survivors, in particular survivors of intimate partner violence, and social

service systems in this study. The following section describes the relevant literature on domestic violence and explores potential causes and impacts of such experiences.

Research on Domestic Violence

Definition. Domestic violence or intimate partner violence can be defined as a “range of sexually, psychologically, and physically coercive acts” (Ali & Naylor, 2013, p. 374) used against an intimate partner. The insidious nature of and destructive patterns within abusive relationships have led some researchers to deem domestic violence as a form of domestic terrorism (Pain, 2014). The movement historically has been focused on marital discord for white, heteronormative individuals. The historical definition of battering was structured around role and rule enforcement to hold women to particular places on the gender hierarchy (Epstein, 2007, as cited in Hattery, 2009). While this focus brought attention to the prevalence and impact of domestic violence, the idea of marital conflict and violence stemming from incompatible goals (Bradbury, Rogge, & Lawrence, 2000) within a relationship does not reflect the repeated patterns of humiliation. These patterns are utilized and intended to dominate and control another person. The Power and Control Wheel, developed by the Domestic Abuse Intervention Project in Duluth, MN, established a framework reflecting the intersections of violence and coercive control tactics (Yllo, 2005). This model depicts the overlap of physical, sexual, and emotional violence, connecting minimization, intimidation, denial, isolation, threats, manipulation, and legitimizing financial abuse and the assertion of male privilege. When combined with past research focusing on women and their batterers, patterns of creating or exploiting vulnerabilities and exerting domination become visible (Yllo, 2005). It should be noted, however, that IPV can occur between two female partners, two male partners, and perpetration by women against men.

Within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), domestic violence is often related to trauma and stressor-related disorders. These disorders are defined as reactions to exposure to traumatic or stressful events. Within the diagnostic criterion explanation, some of the first mentioned traumatic events included in the criterion are threatened or actual physical assault, threatened or actual sexual violence, being kidnapped, being taken hostage, and tortured. Forced sexual penetration, alcohol/drug facilitated sexual penetration, abusive sexual contact, non-contact sexual abuse, and sexual trafficking are included under sexual violence. Witnessed events include observation of physical or sexual abuse of another person due to violent assault, domestic violence, etc. This definition is important because it simultaneously speaks to the impact and the prevalence of physical and sexual abuse and domestic violence, while leaving out language legitimizing the power and impact of emotional abuse and violence that is often present within domestic violence situations.

Prevalence. Intimate partner violence is prevalent in all countries around the world. It is identified as predominately impacting female individuals, though it is present in same sex couples across different gender identities. Perpetration can occur across genders and all forms of relationship, such as marriage, committed partnerships, friendships, acquaintances, and within family relationships (Ali & Naylor, 2013). Domestic violence rates may be underestimated as it continues to be difficult to quantify less overt forms of abuse to reflect the levels of control and coercion. It can also be challenging to determine accurate prevalence of domestic violence as many individuals may not report such occurrences due to intrapersonal, interpersonal, and/or societal influences. A comprehensive study conducted by the World Health Organization (2006,

as cited in Garcia-Moreno et al., 2006) looked at experiences of intimate partner violence against women across 15 sites in 10 countries. The study found that for the women (aged 14 to 59) surveyed, 15% to 71% had experienced physical and/or sexual violence. It is important to note that 21% to 90% of the women reported one or more acts of controlling behavior by a partner. According to the National Intimate Partner and Sexual Violence Survey (NIPSVS, 2010), about one in six women have experienced sexual violence other than rape, defined as sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences, by an intimate partner in her lifetime.

Domestic violence does not discriminate who is impacted by abuse, violence, or harassment. All individuals may find themselves affected, regardless of race, age, gender identity, socioeconomic class, HIV-status, religion, or sexual orientation (National Coalition of Anti-Violence Programs (NCAVP), 2011). While there are no specific demographic factors or characteristics that are associated with domestic violence, some research notes that intimate partner violence has exceptionally high rates in communities that have fewer available resources (Pickett & Wilkinson, 2009, as cited in Howard, Feder, et al., 2013). Women are also statistically more likely to experience domestic violence during pregnancy (Howard, Oram, et al., 2013). Research has found that violence occurs at similar rates in same sex relationships as in heterosexual relationships (Elliot, 1996). Other research has found that similar patterns of coercion and control are found in both heterosexual and same-sex partner relationships (Murray, Mobley, Buford, & Seaman-DeJohn, 2006). According to NIPSVS (2010), 35% of heterosexual women, 44% of lesbian women, 61% of bisexual women, 26% of gay men, 29% of heterosexual men, and 37% of bisexual men experienced rape, physical violence, and/or stalking by an

intimate partner in their lifetime. These statistics exemplify the many forms of intimate partner violence. Unfortunately, there is also overlap between those reporting intimate partner violence and any combination of rape, physical violence, and stalking. For example, 63.8% of women reporting disclosed one form of violence by an intimate partner, while approximately 12.5% experienced all three forms of IPV. Meanwhile, for men who reported, 92% experienced only physical violence, while 6.3% experienced both physical violence and stalking by an intimate partner. Despite inconsistencies in reporting, which are particularly high for men, this study estimates that sexual violence other than rape by an intimate partner has been experienced by almost 1 in 12 men in the United States (NIPSVS, 2010).

According to a study examining research around IPV in civilian and non-civilian samples, about 22% of active duty military women experienced abuse (O'Campo, Woods, Jones, Dienemann, & Campbell, 2006). The literature also suggests that domestic violence is perpetrated by 13% to 58% of male active duty service members. The rates of DV in military persons is difficult to gauge, however, as active duty service members can experience barriers and experience personal detriments to their careers or relationships. Therefore, accurate rates can be difficult to find. For example, one study suggests that military IPV occurs at almost three times the rate as that within civilian populations (Marshall, Panuzio, & Taft, 2005).

Impact. Previous research has found that domestic violence has physical, reproductive, and psychological impact on survivors. A meta-analysis of 42 studies found that the research suggests a high prevalence of domestic violence victimization in psychiatric patients (Oram, Trevillion, Feder, & Howard, 2013) It is important to note that in one Australian study, intimate partner violence was the leading cause of death, disability, and injury for women 15 to 44 years

old (Vos et al., 2006). Violence experienced during pregnancy is associated with preterm labor, low birth weight, fetal death, maternal mortality, and subsequent child behavioral problem (Howard, Feder, et al., 2013; Howard, Oram, et al., 2013). There is also an association between domestic violence and mental disorders, like depression, anxiety, eating disorders, and psychosis (Howard, Oram, et al., 2013).

Studies also suggest that survivors in same-sex relationships have unique challenges, like increased difficulties accessing services and high rates of complex trauma (Stile-Shields & Carroll, 2015). The efforts to address and intervene around IPV from the medical community has often neglected the needs of lesbian, gay, bisexual, and transgender persons (Ard & Makadon, 2011). Shelter options have historically been, and continue to be, focused on female identified persons, which can leave gay men with few options for services (NCVC & NCAVP, 2010). Systemic and institutional barriers can also limit accessibility. This can be in the form of laws or policies that do not acknowledge nuances within abuse between non-heteronormative male and female partners (Simpson & Helfrich, 2008). This can also be present in non-inclusive, heterosexist language, lack of understanding and resources within an agency, and complexities around HIV status disclosure and treatment (Merrill & Wolfe, 2000). These types of barriers can impact a survivor's ability to leave a partner or find supports in transitional periods.

Difficulties in reporting and accessing care can occur across populations. Military service men and women can face unique challenges when experiencing partner abuse, exacerbated by the military culture. It is important to note that higher levels of mental health symptoms were reported in female veterans who had also experienced DV (O'Campo et al., 2006). Some findings suggest that reported spouse abuse is correlated with child abuse, specifically physical

and sexual abuse, not reports of neglect (Rumm et al., 2000, as cited in Zolotor, Theodore, Coyne-Beasley, & Runyan, 2007). This data suggests that it is vital to examine the factors that contribute and correlate with victimization and perpetration of violence and abuse. Studies show that IPV offenders in general populations and military populations have co-occurring disorders like PTSD, substance abuse, and depression (Tinney & Gerlock, 2014). Mobility, physical and geographic separation, potential for multiple deployments, and medical and psychological impacts of deployments can uniquely impact military families and rates of IPV.

Etiology. It is important to examine the elements that attribute to victimization and perpetration of intimate partner violence. One study reviewing the literature found that across these levels, contributing factors included the young age of the perpetrator, alcohol consumption, marital instability, economic stress, supportive social norms, traditional gender norms, ineffective legal protections for victims, low social capital, and poverty (Hamzeh, Farshi, & Laflamme, 2008). Some findings suggest that such factors occur across individual, family, societal, and community levels.

There is some evidence of a connection between childhood abuse and intimate partner sexual victimization (Craft & Serovich, 2005). Studies suggest that secondary education, high SES, and formal marriage are considered protective factors against IPV (Abramsky et al., 2011). Abramsky and colleagues (2011) found that risk factors such as alcohol abuse, cohabitation, young age, outside sexual relationships, experiencing childhood abuse, growing up with domestic violence, and perpetrating or experiencing other forms of violence in adulthood are considered to increase the risk of IPV. This research also suggests that IPV risks increase when both partners have associated risk factors. DV offenders in general populations and military

populations have co-occurring disorders like Post-Traumatic Stress Disorder, substance abuse, and depression (Tinney & Gerlock, 2014).

Mobility, physical and geographic separation, potential for multiple deployments, and medical and psychological impacts of deployments can uniquely impact military families and rates of IPV. Another study collecting narratives from married women in Iran noted that their participants did not draw connections between prior victimization and IPV (Hamzeh, Farshi, & Laflamme, 2008). These women identified individual factors, such as unpleasant public conversation and unsuitable clothing in public, and community factors, such as pervasive victim blaming perspectives, as triggers for abuse. It is important to note that this study found individual factors were the most commonly and strongly agreed upon. This suggests that more abstract, systemic factors may be difficult to identify within an individual perspective.

Interactions with social services. The focus on the potential for growth in the face of trauma requires an acknowledgement of the traumatic nature of seeking social services. Therefore, there is a growing body of research questioning the ways in which the social work profession and social service systems can replicate forms of coercion, similar to that experienced within domestic violence relationships (Keeling & Wormer, 2012). Social service systems include government funded organizations and private organizations enacting public policy. This can include survivors interacting with organizations focused on housing assistance, government benefits, income support, food assistance, health care services, education systems, child care, job training, and mental health services.

Therefore, this study has identified how these services interact with the population of DV survivors as a vital area of interest for further research. There are also gaps in the research that

leave out a clinical perspectives and what specific personal and environmental factors impact post-traumatic growth for DV survivors. This study also identifies a need for more research around the personal and systemic factors that contribute to post-traumatic growth for survivors of IPV.

Conclusion

In conclusion, research shows that domestic violence is a problem which impacts significant numbers of individuals around the world. Unfortunately, IPV can affect any person regardless of identity, though each population and intersectional identity impacted can have unique experiences and needs around recovering from abuse. Theoretical explorations have shown that trauma can have significant impacts on individuals, some of which can spark positive change. Through reviewing the literature, it became apparent that continued research conducted through the lens of the adaptability and resiliency of survivors is needed. Furthermore, the limited conversation around the complex role our current social service systems plays in a survivor's path to recovery from abuse discounts the power and influence of systemic oppression. The need for this study is therefore informed by these gaps in the literature. Thus, this current study examines how post-traumatic growth, trauma theory, and intersectionality can be applied to understanding factors that influence IPV survivors. This study also explores how clinicians perceive the influence of social service systems on the resiliency of survivors. The following chapter will explore the research design and methodology utilized in this study. Data collection and analysis, ethical implications, reliability, and validity will also be presented in the following discussion.

CHAPTER III

Methodology

This qualitative research study is an exploration of the following question: *How do clinicians perceive the influence of social service systems on the resiliency and recovery of domestic violence survivors?* The purpose of this qualitative study is to examine how diverse survivors of partner abuse are positively and negatively impacted by trauma and how social service agencies may have similar influences. This study focuses on the potential for growth and the development of resiliency that can occur in the aftermath of surviving violence and abuse. Emphasis on growth in the face of trauma also acknowledges the challenges and possible trauma of seeking social services. There is a growing body of research questioning the ways in which the social work profession and social service systems can replicate forms of coercion, similar to that experienced within domestic violence relationships. As examined in Chapter II, a search of the literature suggests that the field would benefit from an exploration of how social service systems serve this population and influence the growth of survivors in both positive and negative ways.

Qualitative methods, an inductive approach to research, analyze data in search of themes and connections between concepts and potential theories that explain experiences (Thomas, 2003). Qualitative research delves into the perspectives of those studied, to examine how their perspectives are influenced and changed by physical, social, and cultural contexts (Maxwell, 2013). With the complexities involved in recovery and resiliency in the face of trauma, adopting

a narrative qualitative approach allows for deep and expansive insight into an individual's experiences, relationships, and situations that impact them. Narrative approaches to qualitative research focus on how life experiences are understood and interact with social contexts to create a storyline that reflects a sense of self (Frost, 2013). A narrative approach also can provide rich data that speaks to complex interactions between many factors (Knowles, Niven, & Fawkner, 2012). Narratives provide insights into individual, school-level, and societal-level interactions to create a more nuanced perspective of how someone makes meaning of their environment and lived experiences (Frost, 2013). The open platform can allow individual and relational strengths to shine through in the results.

In this study, the narrative approach reflects first person accounts of experiences, one of the characteristics of narratives (Fortune, Reid, & Miller, 2013). Narratives are reflective of storytelling, which hold the capacity of meaning making, empathy creating, and community building. In reviewing the literature around narrative qualitative approaches, Labov's (1982) narrative analysis is referenced by numerous qualitative researchers. A Labovian narrative revolves around single interview questions and brief, specific stories in response (Reissman, 2013). Labov's definition of a narrative sets the stage for the narrative approach of this research, which asked specific questions along the themes of individual involvement in the field, impact of trauma, and experiences of interactions of social service systems.

Ethical Considerations

This study was reviewed and approved by the Human Subjects Review Board at Smith College. HSRB approval letter is included in this thesis (see Appendix A). The changes to expand the recruitment protocol was approved through the HSRB during the study (see

Appendix B and Appendix C). Informed consent forms were utilized to ensure thorough participant understanding of the expectations, roles, and purpose of this study (see Appendix D). Consent forms were emailed ahead of time to each participant after the initial phone call or email conversation, so that participants had time to read the forms before the interview. This researcher utilized a professional transcriber to assist in the transcription of the interviews. The transcriber agreed to respect the confidentiality of each interviewer (see Appendix E). All research materials including recordings, transcriptions, analyses and consent/assent documents were stored in a secure location according to federal regulations. All electronically stored data was password protected during the storage period. Signed informed consents form were kept secure in a location separate from other research materials. The physical transcripts were also stored on a confidential flash drive that is locked away in the same lock box.

Confidentiality was ensured for clinicians as their names and places of work were not included in this study or data collection. When clinicians discussed clients, the clinicians and I engaged in active and collaborative work to maintain confidentiality about clients during the interview. Before the interview, clinicians and the researcher reviewed the goals of this study and reasserted that specific identifying information, such as names, ages, and physical location, were not to be included.

Participants

The participants for this study were recruited through non-probability sampling methods. I used purposive, snowball sampling to focus on clinicians working in the antiviolence field and with survivors of domestic violence/intimate partner violence in the Massachusetts area. I looked for 12 individuals who met all inclusion criteria and consented to a narrative interview.

Inclusion criteria allowed for interviews of licensed clinicians, who have worked for at least two years in their licensed position. Licensed clinicians included social workers, psychologists, counselors, and mental health professionals working with survivors of intimate partner violence. The sample parameters allowed individuals working in shelters, housing agencies, government assistance services, residential and inpatient care facilities, and any other social service agency. Such social service agencies could be private or government funded. Clinicians were considered as working with domestic violence survivors if their program, professional function, or funding was focused on, designated for, or widely accessed by such survivors. These criteria were developed to be more inclusive of a broad range of experiences regarding clinician, client, and social system interaction.

While this study was intended for 12 individual participants, this researcher faced significant challenges in recruiting. Only 9 clinicians were found to participate, though this researcher expanded the criteria in an attempt to find more clinicians. Criteria was expanded outside of licensed clinicians to all levels of practitioners working with survivors. It was also expanded from the greater Boston area to surrounding areas around Boston, including Western Massachusetts. Procedural changes were also made to expand from only in-person interviews for the allowance of recorded phone calls and skype sessions. It is this clinician's belief that the 12 participants desired would have been found if the timeline for this study could have been expanded.

Data Collection Procedure

I recruited participants by utilizing professional groups to identify licensed clinicians working with trauma survivors in the greater Boston and surrounding areas. Individual providers, as well as identified point people for agencies, were contacted asking permission to interview appropriate staff members on this research topic (see Appendix F for recruitment email). Once agency contacts agreed to participate, emails were sent to the agencies including a brief description of the research purpose and interview and the email and phone number of the researcher. Agency contacts agreed to bring awareness of this opportunity to clinicians with whom they work. Once young adults expressed interest, individuals were contacted and scheduled for 60-minute periods for in-person, audio-recorded interviews.

Physical consent forms were hand signed and completed during the in-person interviews with clinicians. Interviews were collected with two recording devices, one tape recorder and one audio recorder on an iPhone 6. Flexibility was provided so that interviews could run under or over the 60-minute timeframe. To avoid centering my voice as the researcher, interviews were semi-structured and included five prompts given to participants during the 60-minute allotted time. Once interviews were completed, participants were asked to refer any other qualifying individuals they knew who might be interested.

Each interview was transcribed by this writer. Recordings were numbered and no identifying information was kept with the audio recordings. The audio transcripts were stored on this writer's computer and saved on a password secured flash drive, stored in a lock box. The audio recordings were then destroyed after being imported into my computer.

Narrative Interview Questions

The narrative interview guide used in this study focused on centering the voices of participants and allowing individuals to control flow of the interview (see Appendix G). Prior to collecting data, these interview questions were tested through a pilot interview with a licensed professional working in the domestic violence field. The first prompt in the interview guide asked participants to describe what motivated them to work in the field of domestic violence/intimate partner violence. The second prompt asked clinicians to explore the positive and negative ways in which they have witnessed survivors being impacted by trauma. The third prompt asked participants to reflect on the ways trauma impacts survivors of different identities. The fourth prompt asked clinicians to reflect on how they interacted with social service systems in service of their clients. The final prompt examined how social service systems impacted the survivors with whom clinicians work. These questions were open-ended to allow for individual interpretation. Clarifications were given as needed, with specific probe questions to explore how trauma theory, post-traumatic growth theory, and intersectionality impacted the experiences of clinicians and their clients.

Qualitative Data Analysis

A multiple case study qualitative approach was utilized in this study. Each narrative interview was treated as a single case and voice recorded. This writer transcribed each narrative interview from notes and audio recordings. Written transcripts of the narrative interviews were then analyzed by this researcher, using Atlas ti software, qualitative analysis software that organizes and facilitates the coding of the data.

The first stage of the coding process consisted of identifying the narratives based on Labov's approach to narrative analysis. Labov (1982) posited that narratives are created from an abstract, orientation, complicating action, evaluation, resolution, and coda. The abstract is a summary of the story and the orientation positions the listener to the time, place, and situation. The complicating action is the retelling of the actual event and the evaluation allows the storyteller to apply meaning. The resolution is the final piece of the story and the coda brings the listener back to the present. In this study, I analyzed the responses of the participants by searching for the six elements of Labov's narrative analytic method. It is important to note that Labov's original approach to the narrative was to identify the function of individual parts of the narrative, to determine the "communicative work it accomplishes" (Reissman, 2013, p.3). After whole or partial narratives were identified among the transcripts, I analyzed each one to identify the primary theme evident in the narrative. An open coding process also was utilized to label individual concepts that felt salient within each narrative. These concepts were then examined to create further overarching themes. Common themes were drawn across the interviews based on the number of interviews in which they appeared.

Rigor and Trustworthiness

Some critiques on the construction of research outline strategies that ensure research results in valid scientific evidence (Rolfe, 2006). Rigorous adherence to scientific strategies can create a sense of trustworthiness in the data and findings. Trustworthiness demands that the research holds elements of credibility and rigor of procedure for understanding and analyzing qualitative data. Studies are considered trustworthy when the information gathered and reported reflects participant experiences as closely as possible (Lincoln & Guba, 1985). Lincoln and Guba

(1985) felt that establishing this accurate reflection required a return to participants after analysis, creating a sense of reliability of the data collected. Other researchers have suggested that repeated data collecting is not necessary in qualitative approaches because “reality is assumed... to be ‘multiple and constructed’” (Sandelowski, 1993, as cited in Rolfe, 2006).

Therefore, looking to force a confirmed answer takes away from the meaning of the findings. This suggests that assessing validity or trustworthiness in qualitative data is vital, as these assert the legitimacy of diversification in response. As this concept reinforces the idea that individual experiences and interpretations will differ within any one set of qualitative data, the current study will not return to participants for confirmation.

Reflexivity is an important influence to consider in the case of this study, as the concept for this study was created out of professional experience of the researcher. Reflexivity refers to the idea that researchers influence the research process and outcome, through individual characteristics and available theories and resources (Mruck & Breuer, 2003). Therefore, the researcher’s interactions with the participants held the potential for influencing the results. Hamdan (2009) created the concept of reflexivity of discomfort, which applies to the use of reflexivity to consider difficult and uncomfortable elements within the researcher/researched dynamic. When examining difficult narratives, this perspective on reflexivity asks the researcher to examine complex elements to the dynamics, like power equations between the researcher and the researched (Berger, 2013). In this study, these dynamics played out in intricate ways, as the participants held higher credentials and more experience in the field than the researcher. It is important to acknowledge how the participants are being defined in this study. They are clinicians who are both represent their own experiences and reflect on the witnessed experienced

of their clients. Therefore, this study is only gaining a limited perspective on the impact of trauma and social service systems.

With the understanding that this study is impacted by the researcher's reflexivity, steps were taken to maintain awareness and limit bias. I continually reviewed research construction and progress with my thesis advisor. I also utilized field notes and journal entries to assist my awareness of my interpretations and biases. Chapter V includes an analysis of how reflexivity impacted the analysis of the data and my understandings of my role as a social worker.

Conclusion

This qualitative study utilizes a narrative approach to better understand the constructed perspectives of clinicians working with survivors of domestic violence and/or intimate partner violence. Narratives were collected and analyzed by theme to create a storyline of experiences highlighting the potential growth and traumatization in the aftermath of trauma. The following chapter reports the findings of these collected narrative interviews and the themes represented within them.

CHAPTER IV

Findings

This chapter represents the findings from the study examining the following question: *How do clinicians perceive the influence of social service systems on the resiliency and recovery of domestic violence survivors?* The nine participants who participated in this study reflected on their experiences working with domestic violence survivors as they navigate the social services systems. This study examined how clinicians witnessed trauma impacting survivors of domestic violence and the ways in which social service systems impact the path to recovery from abuse. This researcher asked questions about the participant's personal journey into the field, the positive and negative ways in which trauma impacts survivors of domestic and intimate partner violence, the ways that social service systems can re-traumatize survivors, and how identity interacts with these experiences.

Using Labov's (1982) narrative analysis, this research identified complete and partially complete narratives. Narratives were grouped into multiple categories that focused on the impact of trauma on survivors, barriers to help, elements of clinician, types of trauma, forms of intervention, growth out of trauma, system interactions, re-traumatization through systems interactions, and elements and impacts of trauma at large and domestic violence specifically. Through the grouping of narratives, four dominant themes emerged.

The four themes that emerged from the interviews are the following: (1) while trauma can negatively impact most elements of a survivor's life, there is also the potential for positive

growth; (2) social service systems replicate tactics of abuse and can further exacerbate the impact of trauma; (3) transparency, accountability, and empathy are central to care, for survivors and their interactions with systems; and (4) marginalized identities compound experiences of trauma and increase barrier to accessing care. The chapter begins with a description of the participants, then presents reflections of the researcher, and ends with description of the themes found in this research.

Description of Participants

This sample of nine participants was fairly homogeneous, in part due to the sampling strategies used, geographic restrictions created to focus on the Massachusetts area, and time restrictions. Two participants were recruited through a list serve for therapists around Massachusetts. The other seven participants were recruited through personal and professional referrals into the network of domestic violence shelter systems in and around Boston.

Every participant interviewed identified as female. The participants had a range of positions within the anti-violence field, though the largest majority (3 of 9), were independently licensed social workers. While three participants were independent licensed social workers (LCSW), there was also one licensed mental health counselor (LMHC), two general licensed social workers (LCSW), one participant with a doctorate of psychology (PsyD), another with a masters of education (ME), and another who was an unlicensed counselor (C). Two participants worked in private practice, while the other seven were associated with private and public agencies focused on serving survivors of violence. These agencies included community programs, shelters, and victims' resource centers. Two of the nine participants identified as clinicians of color and two participants identified as members of the LGBTQ community. Since

demographic questions were not asked specifically to participants, these demographic distinctions were established by participant self-identification only during the interviews. Five of the nine participants discussed the ways in which their identities impacted their experiences in the field.

For the purpose of discussing the findings, researchers will not be identified by their name; instead they have been assigned letters (Participant A, Participant B, etc.; P-A, P-B, etc. for shorthand). Location identification and program names were also omitted to maintain anonymity.

Reflexivity of Researcher

This study affected this researcher more than anticipated and had a few unanticipated impacts. First, the information gathered in the initial first few interviews shaped the conversations that occurred in the later interviews with clinicians. This meant that as the researcher, I was speaking more directly about the themes that were already identifying themselves after the first few interviews.

Second, I was greatly moved and shaped, both as a researcher and an emerging clinician, by the conversations this study provided me. The concerns that participants identified allowed me to see that I was not alone in my frustrations with our current social service systems. I was able to feel supported and understood as each clinician indirectly validated the challenging experiences I had in my short time in the field. These participants also provided me with an insurmountable amount of hope. Their experiences and creative approaches to clinical and advocacy work expanded my understanding and capacity for dedication and empathy in the face of these systems. It showed me what type of work was possible in alliance and in spite of these

systems. Each clinician presented a multifaceted ability to provide care while navigating the complexities of private and public agencies, all while considering the greater impacts of community and society.

I found these participants to be insightful and compassionate clinicians, and I am thankful to have been privy to their sharing of experiences. The time spent speaking with these clinicians also left me with an unexpected perspective. While it is not required that a clinician have experiences of trauma or hold marginalized identities, these characteristics were discussed as creating powerfully compassionate clinicians. The clinicians who identified these characteristics within themselves spoke to the strength of understanding just how expansive the lens of trauma can be. These interviews validated the importance of access, not only for survivors to access healing services but also for survivors to become part of the field of healing. To imagine that clinicians are not also mental health clients is to deny the reality of humanity. I acknowledge that the reflexivity I experienced while interviewing these participants inevitably influenced the following presentation of narratives about the participants' clinical work.

Description of Themes

The four major themes that emerged from these narratives will be described with the aid of the participants' own words. The original design of this research was to label narratives from interviews and code them for general themes. These general themes were then to be discussed to present an overview of the findings. Through coding, however, it became clear that the complexities of this topic and the responses of the participants could not be captured through general statements without the direct quotations of the participants. Therefore, the words of the participants will weave through the description of the themes found.

One of the themes that emerged was trauma's capacity for negative and positive impacts on survivors' lives. Participants reflected on the patterns of abusive behavior and the types of abuse that could be experienced within a domestic violence relationship. Each clinician identified the multiple facets of a survivor's world that were altered due to experiences of trauma, including intrapersonal, interpersonal or relational, and ecological levels. Of note, participants also identified the prevalence of compounding experiences of trauma. Multiple participants described those with compounded trauma as individuals whose abusive relationship was not the only traumatic experience occurring across their lifetime.

The second theme found that the systemic processes in social services are re-traumatizing for survivors and replicate the tactics of abuse present in DV relationships. Participants noted that these systemic processes challenged survivors' sense of worthiness, self-concept, and capabilities to manage these systems. Participants also voiced the challenge for providers to understand and manage traumatized clients, while acknowledging the humanity of those working on the ground in these systems with limited resources. The limitations were found to impact survivors, clinicians, and social service workers alike.

The third theme identified the important role that accountability, empathy, and transparency played in care for survivors and in interactions with social service systems. These three elements were utilized to supply survivors with as much information as possible, in an effort to help survivors reclaim a sense of control and competency. Participants also found that transparency around confidentiality helped to build trust and hold them accountable with their clients. These themes applied to work within systems, as participants acted as accountability

reminders to providers. This accountability was magnified through relationship building with individuals and agencies.

The fourth and final theme found in the interviews was the compounding impact that marginalized identities can have on the impact of abuse. Participants noted the increase in barriers that survivors with marginalized identities experienced throughout an abusive relationship, the process of leaving an abusive relationship, and accessing services. These survivors were also found to continue to experience abuse and trauma from societal stigma and violence. Based on narratives from the participants, the following provides an in-depth exploration of each theme.

Theme 1: Trauma has Multifaceted Negative Impacts on a Survivor's Life and Yet There is Potential for Growth in the Aftermath

In exploring the impact that trauma has on survivors, this researcher examined the types of trauma experienced by survivors, the elements of their lives impacted, and the ways in which survivors navigated through these experiences. In discussing these questions, the reoccurring theme was about trauma's pervasive negative effect and the resiliency that is shown within the process of recovery. This theme also brought to light the consistent presence of compounding traumas in the life of a domestic violence survivor.

Types of trauma. While participants gave intricate reflections on the complexities within trauma reactions, each clinician identified the importance of understanding the types of abuse and tactics of violence that is specific to domestic violence relationships. Power and control was identified as a defining factor for discerning abusive relationships, as Participant D noted,

“because what do we know about domestic violence? It’s one person having power and control.” Participants described this as a dynamic in which survivors are denied control over their lives and their decisions. Participants noted that a lack of control over a survivor’s self was impacted by the creation of a sense of unpredictability. Participant A said, “the experience of abuse or trauma can often involve unpredictability or this kind of like chaos, you know like one day this is the rule and another day it’s completely different and there’s no explanation.” This unpredictability is founded on manipulation of the survivor, the crafting of the sense that survivors can no longer trust themselves as reliable or accurate sources. This “self-doubt” is magnified through isolation, as a survivor’s life becomes more controlled by their abuser and fewer people and perspectives are allowed (P-A, P-D). The power and control can be reinforced through threats made by the abuser. Participant H provided multiple examples of this. It can impact survivors who identify as “immigrants and refugees... the abusive partner will say, ‘I’m gonna take the children away from you and you’re going to get deported... I’m gonna call the police and they’re gonna take away your green card.’” This participant also noted that the experiences of IPV for transgender, queer, lesbian, and gay clients can be challenging because there is an “additional component of abuse, of, ‘I’m gonna out you to your family... to your friends,’ or using that difference in sexual identity or gender identity as a method of abuse that somebody who’s heterosexual may not experience.”

These dynamics and tactics can appear in relationships through multiple types of abuse: emotional, verbal, financial, and physical abuse. Participant A discussed the tendency to define domestic violence by physical abuse: “there is this hierarchy around where physical abuse is at the top and verbal, emotional, psychological, and financial abuse, which is huge in DV... all of those other forms are very secondary.” The dangers of this tendency were continually noted

through the importance of understanding the prevalence and power of emotional and verbal abuse, for as Participant D noted, “physical abuse is a manifestation of emotional and verbal.” The ways in which emotional and verbal abuse interact with physical abuse are complex. Participant H discussed this complexity, “the psychological and verbal and emotional abuse was, I would almost say, worse than being hit, because it’s constant. But their view was, ‘Well, at least he didn’t hit me yet.’” While visibility of physical abuse holds the potential to be life altering and lethal, emotional and verbal abuse are shown to have equally long lasting and devastating effects. The invisibility of emotional and verbal abuse has complex impacts on survivors because “the best abusers don’t need to use violence” (P-A). It was noted to increase feelings of isolation and exacerbate the impact of self-doubt. As Participant D stated:

I think I have almost every client who if they have only experienced emotional and verbal say “I just wish it had been physical this would have been so much easier.” And for those who experienced both, they say just how much worse the emotional was, because of the longstanding impacts and that no one sees it or believes it or completely understands how bad it is.

Participant H noted how problematic this hierarchy can be, for when we as a society focus on “physical violence, not emotional, psychological, verbal, financial... It completely limits the view of domestic violence... it tells people, ‘If you don’t hit your partner, you won’t get in trouble’...It allows for more justification instead of fixing the problem.” More specifically, Participant D gave an example of how detrimental this hierarchy can be for survivors: ...when you think like what allows someone to utilize the court system, if there’s physical violence. And yet we know that so many relationships that it’s just emotional

and verbal and so then that person can't use these systems that are supposed to be there to protect survivors... but if it's just emotional and verbal it's, that's way harder than if there is physical abuse. And how much it can be harmful because there aren't then police records, or all of the things you need to prove that abuse is happening, and "prove" meaning to all these other agencies outside of the DV world.

Impact of trauma. Participants identified multiple dimensions of a survivor that could be impacted by the experiences of domestic violence. These dimensions included internal or intrapersonal, relational or interpersonal, and a larger scale layer that encompasses societal and community impact, which this study will describe as ecological. Intrapersonal, interpersonal, and ecological layers that were impacted consistently were described as a survivor's self-concept, capacity for relationships, and external presentation and perception in the world.

Participant A noted that "DV especially can really impact people's self-esteem and self-worth and self-image and really erode that." Every participant interviewed identified self-esteem as an element that was negatively impacted by experiences of trauma, specifically within abusive intimate partner relationships. This can impact survivors to distrust their own capacity to make choices, to question their intelligence and their intuition, or, as Participant C reflected it can create "an overdose of self-doubt." In addition to this, hypervigilance was described by four of the participants (P-E, P-F, P-G, and P-H) as being another impact of trauma. Participant F reflected this, describing "domestic violence survivors who have been on edge and have learned to be so in tune with body language and tone and how—interactions, because that's how they, for their safety, had to get through it and survive through it." There can also be an external impact of trauma. Participant B identified that "the cellular memory of your body changes when you

experience trauma.” As Participant I described, “physically, it can cause people to have pain, sickness. We think of it as such a mental illness – it’s really more physical than anything else.”

These individual level impacts can have external effects on a survivor’s life. Survivors can exhibit difficulties in interacting, challenges navigating relationships, and distrust of others. On an interpersonal level, one clinician described trauma, particularly experiences of childhood trauma, as impacting “peoples’ ability to establish healthy relationships because it’s hard for them to have a sense of their own boundaries or to have good models for relationships”

(Participant G). Participant A noted that experiences of relational trauma can effect relationships outside of romantic partners:

...difficulty navigating family relationships, sometimes that can precede folks who have had childhood abuse or neglect or didn’t have adults in their life who were showing them how to have healthy relationships and are kind of at a loss when they become adults for how to interact with other people in the world.

These experiences of trauma can create rippling aftermath effects. Participant B stated that “it impacts you on every level of your life... there are people who... cope very, very well and others that just their lives become a train wreck. And it leads to addiction and it leads to a cycle of abuse.” The cycle of abuse can keep survivors in their relationships and it can appear in the replication of abuse in other relationships (P-B, P-E). For example, it can impact methods of parenting and capacity to be available for and in relation to others. Participant G commented: It affects their confidence and self-esteem in so many ways, but in my case, particularly when it comes to parenting. When you’re looking at how they’re parenting, sometimes their ability to engage with their kids—they’re kind of parenting with PTSD, and that’s

hard, because then the closeness of relationship in the past can represent pain, so it's hard to connect well sometimes with your kids.

These findings suggest that experiences of trauma can lead to the continuation of traumatization. Relationships can hold the potential for replication of past traumatic experiences or hold elements of tactics of abuse (P-A, P-G, and P-H). Survivors can experience themselves as powerless, incapable, or “stupid” (P-A), which “continues to impact, over time, not permanently, their ability to form new meaningful, healthy relationships with other people” (P-H). Interactions can exacerbate this, and patterns have the potential to be reinforced. Participants A and H particularly described the “stereotypical pattern of choosing the wrong partner or choosing abusive partners” (P-A) and a belief that all relationships have the capacity to be harmful. This can further emphasize a survivor's questioning of safety, deepen isolation, or perpetuate feelings of unpredictability in their life. This can create “this process around re-evaluating their relationships in their life just in general” (P-A).

Compounding trauma. In reflecting upon the impacts of trauma for individuals, many participants (P-F, P-G, P-H, P-C, P-A) noted that trauma often does not occur in a single incident of abuse. For example, Participant F said, “there's just layers of trauma for every individual... because of what their life circumstances are.” Similarly, Participant G, reflected that “[trauma] does seem additive. It just compounds.” This “compounding” trauma was referenced in some form by all nine participants. These participants identified that for any one individual, multiple forms of trauma might be occurring simultaneously or have occurred across the lifetime. As Participant H reflected that this can look like “multi-stress situations – people not being able to pay rent, or gang violence going on in the community,” Participant A described the separation

between single incidents of trauma compared to on-going abuse, noting “recovery from interpersonal trauma like IPV and DV where the abuse is occurring... over long periods of time. I think that the path of recovery can be very different than from... even one very violent incident.”

Participants cited a range of interpersonal and ecological types of trauma, including experiences of childhood abuse, trauma experienced within a community, oppression experienced due to societal norms and holding marginalized identities, and generational trauma that can create intergenerational trauma. Every participant described these multiple forms of trauma as compounding trauma. Participant C provided an example, stating “for many of the people that come to the shelter... domestic violence is just one of the many traumas they’ve experienced... their whole life has been oriented around trauma, relational trauma, and often times community trauma and systemic oppression.” A survivors’ self-perception and interactions in the world can be impacted by compounding experiences of trauma. One survivor’s struggle was described by Participant G as follows:

It became so much of his identity to be beaten, abused—to the point that he almost abused himself with the alcohol. It just—it’s kind of, for him, it was so much of his reality that it was hard for him to imagine a reality without all of this pain. There was almost no part of him that wasn’t—that didn’t feel abused or other-ized or targeted in some way.

This all-encompassing identity can impact a survivor’s ability to recover, to function, and to break patterns. Participant B’s reflection showed this, noting that “there’s so many different ways that we can get... stuck in a place and it creates a critical identity for you that you carry

with you, in your body, and your psyche, and your soul for your whole life.” Therefore, it becomes important to acknowledge and honor the survivor identity, while seeking to continue to move towards the creation and inclusion of other identities.

The identification of compounding trauma helps to describe the insidiousness of trauma and its effects. This is exhibited in the identification of generational, societal, and community trauma by participants. For example, Participant H noted that “you can go back a number of generations... there’s a sort of mistrust of others, mistrust in the world... hypervigilance that... not necessarily causes trauma to happen, but I think makes some more sensitive to it.” Such traumatic experiences have an overarching impact, that not only impacts individuals but can also alter their environment and relationships for generations to come. This can be seen in the majority of participants (P-G, P-H, P-C, P-B, and P-F) noting that a childhood abuse history was present for most of their survivor clients. Participant G reflected on the compounding power of generational trauma in this way:

It’s hard because it’s so multigenerational... I don’t think I have a client yet who didn’t experience their initial trauma as a child in the family, from parents, and then in relationships of their own, where they’re re-traumatized. And then, therefore, their kids are suffering, too.

Similarly, multiple participants (P-H, P-G, P-D, P-C) noted that societal and community trauma can have extensive compounding impacts. Participant F reflected that “societal trauma creates a society that blames you for anything that’s wrong in your life... It’s totally the individual’s fault. Society had nothing to do with it. It’s the individual’s fault, so why should

society do anything to help?” Such perspectives can impact isolation and access to supports, resources for basic needs, and escalate the erosion of the self-concept.

Participants described societal trauma as reinforcing stigma and placing blame and responsibility onto the survivor in a manner that re-traumatizes and silences. Community trauma was described as similarly stigmatizing. Participant D described this as “ongoing oppression and trauma experience in the world and how that will never leave them,” identifying these traumas are experienced by communities as a whole. Participant C gave a recent tragic event as an example, “the shooting at the Orlando nightclub... was absolutely another trauma, legitimate trauma... even though it hadn’t been experienced personally... someone’s identity being selected just because of who they are and how they express themselves.” This was found to occur on individual levels as well. For example, Participant D described another aspect of compounding trauma: the impact of marginalized identities. Participant D noted, “how people who have marginalized identities, in particular, always have a lifelong experience of trauma. Whether it’s microaggressions, like they call them papercuts, or really like big specific moments that they remember.” The compounding impacts of trauma with identity will be discussed later in this chapter.

Healing and post-traumatic growth. An important narrative within these themes was that trauma can have both negative and positive impacts at the same time. Seven participants (PA, P-B, P-D, P-E, P-F, P-G, and P-H) noted that out of pain came examples of growth and change:

Being able to see the resilience people have... I’ve heard survivors of all kinds of trauma, and especially with domestic violence, share some pretty terrifying experiences, and to

see them still maintain hope, to still want to have a better life for themselves and for their children, to still feel like they can potentially have a healthy relationship, to decide that they are not going to be defined by what happened to them – I think I’m constantly surprised by human resiliency. (Participant H)

Five participants (P-A, P-B, P-E, P-F, P-G and P-H) specifically discussed the resiliency they witnessed in their survivor clients. Participant G noted that trauma and struggle can “prompt people to be really creative and... sounds kind of like a negative, but to see how strong they can be, what they are able to survive, what’s important to them. It can really show peoples’ strengths.”

Most participants believed that healing in the face of trauma can create opportunities for new development of “courage” (P-F), “empathy and resiliency” (P-B). Participant F reflected “I see a greater level of sensitivity, a greater level of self-awareness and empathy for people” in their survivor clients. Therefore, the positive growth that survivors gained in the aftermath of leaving their abusive relationship is important to consider and identify. Participant A was able to give a specific example of positive growth out of stressful experiences of being alone and out of their relationship:

I’m thinking of a few clients where this is part of their grief process to be like “oh the car broke down, and I just called a tow truck and, you know, and then I knew that then I needed to call my insurance company.” And they will reflect back on that and be like, “Wow! I knew how to do that. It was always my husband who did that and it turns out that like, he used to tell me I was stupid, and it turns out I’m not stupid.”

Similarly, Participant D found that survivors reflected that experiences of trauma “caused their life to go in a different way or they’ve had to make the best of it, or they feel like they have learned lessons in that time.”

The majority of participants mentioned the ambivalence survivors experience after leaving an abusive relationship. Participant H noted that “it’s so easy to get caught in that cycle of abuse... ‘How do I leave somebody that I love with all my heart, but how do I stay when they continue to hurt me?’” Participant E also reflected on this, noting that “they went into a relationship for a reason.” Therefore, even after a survivor has left a relationship, “it doesn’t mean... that the feelings are gone from that and taken away from that.” Participant A added to this concept, saying “especially if they have a child with the abuser. They all can feel so torn like ‘I love this person’ or ‘this person is the mother or father of my child’ and they feel like they are going to send them to jail.”

This ambivalence is shown in the adaptation of their trauma responses into new skills and strengths or the reframing of their traumatic situation into an opportunity for growth. Participant A noted that the process of leaving a relationship may be “the first time this person is making decisions about things, like housing or where to live, or first time they are having a credit card in their name, bank account in their name, and that can be really overwhelming.” Participant F identified that “the ability to connect with people, read the room...if you’re so accustomed to reading other peoples’ emotions for your safety, that doesn’t go away... it comes naturally to you. So it’s a strength.” Participant H summed it up the potential for “post-traumatic growth” eloquently:

There's a recognition that they have control over the next person they choose to date, that they can begin to identify the warnings signs, that they can ask for help, that can redefine their narrative – that this trauma doesn't have to become who they are, but something they experienced. And I think there can be a lot of healing in recognizing... that their low self-worth impacted their ability to recognize their strength to leave... I've seen a lot of survivors reclaim themselves, their bodies, their minds, and feel like, "I am deserving of love. I don't deserve to be abused."

In conclusion, understanding the multi-dimensional impact of trauma and the complex ways in which abuse can be experienced is vital for not only the mental health field to understand. Participants continually discussed how the societal misconceptions and lack of information around IPV have effects on the lives of survivors. It creates blame and feelings of shame for those experiencing and recovering from it. It creates silence that perpetuates the misinformation and isolation in our communities. As Participant B noted, "In order to move forward we have to remember the past, because we do remember it. Even if we have buried memories, your body remembers it." Similarly, we have to continue to remember the reality of domestic violence because the silence and misinformation also impacts the way our communities and social service system providers respond and react to IPV situations.

Theme 2: Social Service Systems Replicate Tactics of Abuse and Exacerbate Impact of Trauma

The second theme that emerged from the interviews is that social systems potentially retraumatize survivors accessing them. Participants were asked how interactions between survivors and service providers could impact survivors and their recovery from abuse.

Participants identified the ways in which systemic processes could be replicative of tactics of abuse in domestic violence situations. The systems discussed included broad systems and specific services: legal system, department of children and families (DCF), disability system (SSI and SSDI), department of transitional assistance (DTA), law enforcement and first responders, insurance systems, medical services, prison system, school systems, housing, and mental health systems and services. Participants identified the tactics of abuse that were replicated within these systems and discussed how these exacerbated the impact of trauma and could hinder recovery. All nine participants endorsed the belief that systems re-traumatize survivors. Tactics that replicate abuse and re-traumatize survivors were power and control, manipulation, instability, unpredictability, blame on survivor, and questioning of capability and worthiness. Participants discussed the ways in which well-intentioned systems could fail to fulfill the needs of survivors and perpetuate stigma of domestic violence and in utilizing social service systems.

Power and control. Participants described the power and control that systems can hold on the lives of survivors. Participants gave a multitude of examples of specific systems and the outcomes that could occur for survivors. Participants focused on the legal system, housing systems, transitional assistance, and child and family services. For example, in legal proceedings to gain full child custody, proceedings were continually postponed or continuances were granted. A survivor might have to return to the courts every year to renew their restraining order, returning to the same court, having to face their abuser year after year, continuing to tell the story of their trauma. In the search for housing, the process of applying to public housing authorities could feel equally devastating. Multiple participants (PA, PD, and PG) described this process as

re-traumatizing and reinforcing of negative beliefs about domestic violence. Participant G discussed the requirement to prove status as an IPV survivor:

They were being asked to tell the story of their trauma... They were just outraged because they felt like they were being re-traumatized, they felt like their privacy was being invaded, and then I think they didn't get it. These women were describing how they had poured out their story in a way that made them feel really vulnerable... So sometimes interacting with services can be re-traumatizing and reinforce that feeling of, "I'm worthless, I'm not worthy, nobody's gonna help me, I have to do it all by myself." This participant noted that the application processes for emergency and domestic violence vouchers, as well as housing authorities, often involved survivors having to prove their abuse. These required police reports, proof of hospital visits, copies of restraining orders, even personal references to confirm the story of the survivor.

Participant A also discussed this challenge, stating "it just seems to me that for people with a police report that talks about physical injuries it's just more clear cut for people to get services. And that's too bad." She said that non-physically violent forms of abuse are "harder to define. Or like harder to prove." Similarly, Participant C stated, "one of the ways you can qualify for shelter is proving that you lived in a place... that was not fit for humans. And how do you do that?" Participants (P-A, P-D, P-I) also expressed distress at the barriers that can deter survivors from gaining the physical documentation required to gain access to these services, even when physical abuse was present. These barriers will be discussed later in this chapter.

Participants noted that these processes were challenging for survivors, as it placed them into a situation that felt completely out of their control after escaping a relationship which continually denied them power and control over their own bodies (P-A, P-D, P-E, and P-G).

Participant D noted that court in particular “can be one of the most re-traumatizing places.” This participant reflected on the ambivalence felt within the process of restraining orders:

It’s like this other, typically man, who’s a judge who’s making decisions for this person about their life... It’s this other system that has power and control over my clients, and so they don’t have the ability to make those decisions for themselves. Someone else is telling them what’s best for them. So it can feel, I’ve heard many people say it feels like being back in an abusive relationship.

Participant G noted that particularly in DCF cases, “the family feels like, ‘I have to please you... I can’t disagree, I can’t self-advocate... you have the power to write a report about me that... may cause me to lose my kids, if I don’t agree with you.’” Whether housing needs, financial needs, legal protections, or personal and familial safety, most survivors were described as being unable to fully move forward with their lives until these issues were resolved. Many of these system processes take significant amounts of time to finalize and resolve. Participants (P-A, P-D, and P-G) noted the ways systemic re-traumatization can mimic the negative impact on selfconcept and feelings of worthlessness within IPV relationships. As Participant D noted, survivors can be caught in these processes feeling incapable, unworthy of services or support, and feeling trapped:

All those same feelings that they had in that relationship, that they are stupid, they don’t know what is going on, that they really can’t make choices for themselves, that other people are deciding what’s best for you... and that someone is monitoring them... It just so often feels re-traumatizing.

The aforementioned quotes express the difficulties within systemic responses to domestic violence. Participant F reflected that systemic processes do not reflect the needs or challenges

being faced by survivors, stating “policies essentially create all these boxes for people, and our clients’ lives never actually fit into these boxes... they blame the client ... I think they lose sight of the fact that these are people’s lives.” The lack of resources and the absence of survivor voices in the resolution mean that few people are receiving the outcomes that they desire or need. As Participant G stated in frustration:

You put peoples’ lives in chaos. In chaos. And you won’t listen when they’re trying to tell you, “Here’s what I need to put in place to do this effectively,” and you don’t listen, and then make dumb decisions. And then blame them!

Stigma. Recovery is hindered as these interactions can reinforce stigma and undermine reclamation of the self-concept. Participant E showed that survivors can leave systemic interactions feeling like, “especially if someone’s already swimming in self-doubt and negative things... ‘Oh, I am really a piece of shit, maybe I did deserve this.’” Each participant noted that it perpetuated the beliefs that survivors could be to blame for their situations. As Participant G described, these interactions can feel “dehumanizing,” and as though survivors are being blamed for not understanding these complex systems, for needing help from these systems, for not being able to figure out how to survive without these systems As Participant H noted:

There’s a lot of victim-blaming and a lot of people in the survivor’s life don’t understand why they continue to go back and there’s a lot of shame. I think, even, sometimes, social services and resources can be the ones shaming.

As the systemic processes require survivors to prove their abuse, this shaming can be reinforced for providers as well. Each participant discussed the misinformation around domestic violence and how that can impact providers and support systems in understanding the struggle

survivors are undergoing. The cycle of abuse and the internal impact that trauma has on the individual can make interactions difficult for survivors and providers. Participant F felt that “it’s definitely the stigma of... ‘Well, you shouldn’t be in this situation to begin with.’ People don’t say it, nobody ever says it, but you feel it. It’s implied in a lot of different ways.” Similarly, Participant H noted that some survivors had been told “‘Well, just don’t talk to him when he comes home and is angry,’ or, ‘You should have left him years ago or months ago.’ ...it ends up creating more shame, so then people continue to isolate and retreat.”

This stigma can be exacerbated by the effect trauma has on a survivor and their level of functioning. Multiple participants (P-A, P-C, P-D, and P-I) discussed the negative perception of survivors that can impact their treatment and their ability to manage in these systems. As Participant A reflected, trauma responses can make survivors reactive and unpredictable in their own way:

I think that some people who can be really, really traumatized, they can be really hard to get along with... there can be all of this trust stuff and a paranoia element or sense. They can be really anxious and it can be really hard to interact with someone like that. So I think that not because of anything they are necessarily doing wrong, but they are not a “good” social services client.

This good social services client was a continual theme that resonated with participants. “There’s very much this expectation that victims will be a certain way” (P-D), placing survivor clients into a double bind. Participants described survivors as needing to present as the stereotype of an abuse survivor but also being capable of presenting in a competent manner. As Participant E noted the systems can treat survivors as though “if you’ve experienced domestic violence, you

need to be this timid, tearful person. If you don't fit into that box, then it didn't happen." Such depictions required survivors to have a story with clear-cut abuse and yet be minimally impacted by such experiences. Participant H noted that all of these systems are difficult to comply with if you are also managing symptoms of trauma, experiences of depression, anxiety, or any number of trauma reactions as defined by the DSM-5. Participant I reflected on the challenges this creates for survivors interacting with providers:

...people that don't understand that this person is behaving this way because they're triggered... They're in fight or flight or freeze/collapse... Tell me why that person didn't understand anything you said to them in the meeting. It's because they dissociated... Their executive functioning is shut down. That blows my mind that people don't know that.

Through these interviews, the examples provided showed that there are minimal resources to provide for a large population in need. As Participant C noted, survivors are interacting with "systems that are kind of meant to gate keep... it feels awful for people." In efforts to determine who is given access to care, certain types of clients are preferred over others; "good" ones are described as those who take less time and effort to service and require fewer resources. The challenges created by the concept of a "good" and "bad" social services client lead to societal barriers to care. The negative interactions can act as deterrents for survivors to leave their abusive relationships, ask for help, and even within accepting help. All nine participants reflected on the ways they approached advocacy for their survivor clients in an effort to address the systemic trauma clients experienced.

Theme 3: Transparency, Accountability, and Empathy Are Central to Care

In discussing the interventions and approaches utilized to manage working with and within the social service agencies, participants discussed the importance of relationship building. Relationships were necessary to provide adequate care for survivors and to fully access services. Relationship building through transparency, empathy, and accountability applied to both survivor clients and to social service providers.

Client-centered intervention. Participants spoke of the considerable effort placed into approaching work with clients in efforts to navigate these systems. For as Participant E noted, “domestic violence is about power and control, and so it’s giving that control back to them so that they can gain that control.” A consistent approach relied on creating a relationship of trust and transparency. Participants noted this allowed them to manage the expectations of their clients during the process of accessing services. This transparency is an effort to “walk them through the whole process, even when they are deciding if they even want to do it, just so they can situate themselves and make the most informed decision they can” (Participant A). Each participant described this as an approach that allowed the survivors a sense of control and the belief in their capacity to understand the complex processes for the services they are considering. All nine participants reflected on the significant time they spend trying to prepare survivors for the potential that they won’t get what they need or possibly deserve from the systems. Participant C noted that it’s a necessary challenge:

...to somehow say to clients that the system is inherently disempowering. And here is how you can find a little bit of empowerment in there. But just know that if it doesn’t go

the way that you hope it will, that's not necessarily because you failed, it's this whole other system that is broken too.

This transparency approach was also described as requiring a genuine sense of empathy for the survivors. Participants noted that this required them to take time to understand each client, their needs, and their strengths individually. As Participant F described the importance of appreciating individual experiences to “be aware of what people may have faced simply because of their identities, but also be aware that they are an individual outside of their identity... because you don't know everything about them.”

This individual approach was noted to create a sense of trust between survivor client and clinician. Participants discussed maintaining transparency and confidentiality for their survivor clients as paramount to creating a sense of accountability. Participant E spoke to this, stating, “I'm very up front with the limitations of what I can and can't do... it's giving the choice back to what they want to share and what they don't.” Participant D also reflected on these elements, noting that confidentiality and transparency are vital “because both of those things build trust with my clients.” This trust was important, as participant stated, because it was a chance to rebuild the survivor's ability to trust others and themselves. These interventions were described as important elements that were needed to not deter a survivor from their path to recovery while accessing services. Similarly, these elements were necessary to help remove barriers to care that the participants had the ability to influence.

Systemic approach. The approaches participants utilized with their survivor clients were also applied to interventions working with and within systems. Five participants (P-A, P-B, P-C, P-D, and P-E) noted that advocacy demanded a sense of transparency of their expectations of

providers and what they were able to do in return. This created a sense of accountability within the relationship that participants sought to develop (Participant G). This relationship was created through an empathetic stance towards the systems and providers. Each participant noted the importance of having empathy and compassion for those who work in these systems and “to think about, in essence, their vicarious trauma” (Participant C). This empathetic stance towards the systems was consistent through every interview. While participants voiced frustrations, they also continually explained the ways in which they established connections and relationships with service workers. Participant A described the importance of “taking an empathetic stance with these systems... trying to understand what ecosystem they might be in, because that might help you understand what might be possible. And what isn’t possible.” Participants reflected this empathetic stance was established in an effort to help their clients and also impact the system.

Accountability was an important aspect to the relationship between the participants and systems providers as well. Participant D described an important role in advocacy is to accompany survivor clients as almost a check and balance to the treatment from providers, noting, “if they’re not heard then there is going to be someone who speaks the social work language who is going to be following up with them and holding them accountable.” Similarly, Participant G reflected, “I notice that when I’m with a client or advocating with a client... It puts more eyes on the subject and more light on the subject... I just think there’s more accountability if somebody’s with them.” These participants noted that they acted as external reminders to providers that, not only were they important for the individual client, they had a responsibility to the job.

Impacting the systems. As participants explained in Theme 2, the interactions between systems and survivors can be a dangerous cycle. The systems are experienced as re-traumatizing for survivors and survivors are experienced as traumatizing for the systems. Without information on trauma, trauma responses, the cycle of abuse, and trauma-informed approaches to working with survivors, participants noted that providers can become frustrated, burnt out, and restigmatizing of survivors. Participant A noted:

I think that can be really hard for providers to understand, especially who aren't maybe trauma trained or working in mental health, so I see that as a part of role to kind of intervene and kind of explain that, those choices without patronizing or assuming that the person can't have it a different way.

All nine participants noted that they approached this issue with the same intervention: reframing the situation for the provider and providing education on the realities of domestic violence. The majority of participants (P-A, P-B, P-D, P-E, P-F, P-H, and P-I) provided trainings in organizations to help assist them to better understand the impact of trauma and how to manage such survivors. All nine clinician also discussed that it was important to understand that social service systems are made of human beings. Participant F reflected on this, stating, “everybody’s human and everybody’s individual, but trauma – everybody has some form of trauma... Even the people in these service agencies that we’re going to that are driving us crazy, they have some trauma too.” Participants utilized this reminder to expand their capacity to work within these systems. Each participant described learning to approach the systems from this human point of view. Participant B reflected on this, saying, “social services are well intended... often because of their limitations, restrictions, rules, laws, whatever [they] fall short... so there’s a lot of work

we have to do with each other... it's really important that we learn how to communicate.”

Participant G summarized the sentiments of many participants:

...our conversation is prompting me to think about how things could get better, how social services could better serve—and I really mean including the law enforcement... to school teachers to DCF to anybody – more education around trauma, around how to be sensitive, and culture. Not just, “Here’s how you treat Black people,” and, “Here’s what Latinos like,” but something that would get people to question and respect the boundaries of the other. Question the assumptions that they habitually make, know how to talk to people in a way that helps them feel empowered and respected as an individual who has literally survived this far without you... they bring history and strengths and— strengthsbased, trauma-informed, we need this.

These interventions and approaches were described as creating trust and safety within systems that tended to feel re-traumatizing. Participants noted that the challenges faced by survivors had extensive impacts that created barriers to leaving abusive relationships, accessing help, and recovering.

Theme 4: Compounding Impact of Marginalized Identities Can Increase Barriers to Care

A final theme in this study was the recognition that many clients have marginalized identities that compound their experiences of trauma and increase their barriers to receiving care.

Participants continually noted that each survivor they worked with had a unique situation and response to trauma, which therefore required an individualized approach to care and treatment.

While the importance of acknowledging and identifying the unique characteristics of each survivor was consistent, participants also noted that survivors who held marginalized identities faced additional barriers and could experience significant stigma in their efforts to receive care. Marginalized identities were defined as “vulnerable populations” (Participant A), or, as Participant I described, “anybody with a lack of privilege is in a marginalized population, somehow. So then, the rates of drug addiction, the rates of violence, the rates of everything go up.”

Populations impacted. Participants (P-A, P-F, P-G) noted that domestic violence was a crime that could occur to any individual. As Participant A noted, “there’s this sense that this is the sort of crime that could kind of happen to anybody and I think that supplies this low level terror for everyone.” This was discussed by all participants as possible, regardless of gender identity, race, sexual orientation, ethnicity, immigration status, and other demographic categories. Participants noted that survivors holding marginalized identities, however, tended to experience additional barriers and trauma within their lives. Participant G attempted to describe the impact that could occur from holding an IPV survivor identity compounded with other marginalized identities: “it’s almost like—I’m getting this image of lead vests, right? If you’ve got one layer of trauma and you’ve got another identity that is also traumatized, it’s hard to move if you’re carrying all these lead vests.” Marginalized identities themselves were described as being associated with complex experiences of trauma and oppression. Participant D spoke to this:

People who have marginalized identities, in particular, always have a lifelong experience of trauma. Whether it’s micro-aggressions, like they call them papercuts, or really like

big specific moments that they remember. I think those will continue to happen throughout their lives, whether it's to them or to their community as a whole and how that can really feel like a huge impact.

The huge impact acknowledged in the aforementioned quotation speaks to the pervasive nature of societal oppression experienced by marginalized populations. All nine participants identified individuals who experience racism, sexism, transphobia, homophobia, and discrimination based on their ethnicity, documentation status, and religious background as a few populations that can be impacted in these extensive ways. Participant B attempted to capture this in their statement:

...there are some demographics, let's call it, that are astoundingly impacted by society, by politics, by the laws of this country. And how people are treated. It's one thing if you're abused by a family member, that's a terrible experience. It's another thing if you're abused by your community, school, by the whole culture treating you as less than. And a lot of people experience that in their lives, women do certainly, any members of a minority, certainly immigrants, LGBT...

Experiences of societal oppression and discrimination were described as creating a sense of fear and distrust that is associated with the threats to life, livelihood, and personal expression that come with being treated as a marginalized person. Participant G noted that "you can be so vulnerable if you reach out for help, ask for services... so you almost feel like you have to be more on your own, or you have to be very, very careful who you trust." This can lead to increased barriers to leaving abusive relationships and accessing services and care. As one participant reflected, compounded marginalized identities were "just added layers of trauma..."

it's more excuses for systems to look down on people.” Therefore, systems were found to exacerbate the experiences of trauma, hinder recovery, and create additional traumatic experiences for survivors.

Barriers to service. As Participant D noted, domestic violence is generally discussed “under a very specific heterosexual narrative. And I would say white heterosexual narrative.” As noted earlier in this chapter, white, heterosexual survivors are not the only individuals experiencing IPV. This trauma can occur across a broad range of identities. All nine participants noted, however, that recovery from abuse can be a uniquely and individually complex process for survivors with marginalized identities. The experience of continual societal and community trauma and oppression also adds to the experience and recovery. Participant D reflected on the traumatization and re-traumatization that can occur even after a survivor has managed to escape the abuse:

...a lot of my work with transgender clients, aren't even specific to their partner, but it's that ongoing oppression and trauma experienced in the world and how that will never leave them. So they say with trauma you can only start healing from it once it stops, but what do you do when it hasn't stopped... Or you don't have power and control over your own body and your agency to make decisions about your hormones or surgery or any of these other things? And that's a loss of power, right? That's being controlled by this system that is denying you access to the things you need in order to survive.

Similarly, protections that have been created for survivors can be experienced as equally, if not more so, dangerous for survivors who hold identities that leave them vulnerable to other experiences of trauma. Participant A described the potential challenges to access legal and social

services intended to protect survivors. “I think that people without status and, similarly, people who don’t have a strong command of English, are not going to report as much and are probably not going to present to DV shelters as much, so that’s really scary.” Participant A also identified those without a strong command of English or non-native speakers as those who might also be unfairly discriminated against in the processes of accessing services:

With the example of getting an interpreter in the court... client perspectives seem to be that someone will walk out of an office around the corner, but it’s like, no they have to page someone and they have to show up and you could be waiting for hours. Or they’ll have to reschedule your hearing because there is no one available that day... But I also know that they cannot be denied one. So if the client walks in and the courthouse staff is like “oh are you sure, can you have your son interpret? We just need to keep moving.

And if you really need an interpreter, we will have to reschedule and were scheduling out weeks ahead of time.” And it’s like manipulative.

Participant F also noted that identity can increase stigma to accessing services, reflecting “a lot of people dismiss domestic violence among gay males and they’re not willing to take it seriously or try and get a restraining order. They’re like, ‘Why do you need this? You’re a guy.’”

Participant A also discussed this issue, noting “men who are survivors of DV... same-sex relationship or a heterosexual relationship, I think there’s a lot of stigma... I love our DV shelter systems around here but... they paint things around the shelter pink... I don’t know what that would be like as a man staying in the shelter, even if they are technically welcome there.”

Another example of how this can impact transgender survivors was provided by Participant (D):

I would say my trans clients don't want to come to office, they only want to do phone appointment... if they do not have access to financial resources and medical resources that allows them to transition in a way that the world has an expectation that trans people will transition... And in general are just less likely to use the police, even if they need certain benefits they are less likely to apply for those benefits, because again of having to interact with people... it's so expensive to do things that help people "pass".

As Participant A noted, these issues can lead to increases in survivors who "decide not to pursue these avenues, access services, or choose to leave because of these barriers." This can also increase feelings of isolation, when survivors are already living in fear of treatment from law enforcement and the greater society.

Summary

In conclusion, this study found that trauma has extensive and reverberating impacts on an individual, their relationships, and their communities at large. Growth out of trauma is possible, as survivors regain their sense of self and begin to reestablish their trust in their capabilities. In the process of providing services, social service systems replicate the instability, unpredictability, and feelings of manipulation experienced in domestic violence relationships. These elements create a loss of power and control that re-traumatizes survivors as they either continue to manage in or attempt to recover from an abusive relationship. Participants noted that survivors holding marginalized identities in addition to their survivor-hood tended to experience compounded impacts of trauma and additional barriers to accessing services.

Participants found that our current approach to domestic violence struggles to view survivors through a multi-dimensional lens and to serve the needs of those impacted. Service

systems were described as malfunctioning approaches to creating solutions that were made of predominantly individuals trying their best with extremely limited resources and support. Participants discussed the limitations of the American societal understanding of domestic violence. It was felt that large numbers of individuals, including some in the social service systems and outside providers, were unaware of the complexities within abuse, the range of people impacted, and the ways these survivors experienced services and care.

In the following fifth chapter, these findings will be discussed in comparison to the current relevant literature. Implications for our current understanding of domestic violence and approaches to services will be considered. The limitations of this study and suggestions for future research will also be discussed. The final chapter of this study will summarize and reflect on the information collected and the thesis process.

CHAPTER V

Discussion

This chapter reflects on the findings of this research and compares the findings with the current literature on trauma and domestic violence (DV), also known as intimate partner violence (IPV). This chapter reviews the overall findings about what trauma is, who is traumatized, and the barriers to accessing care for survivors of domestic violence. The limitations and strengths of this study are also presented, as well as implications for social work practice, policy, and future research.

Discussion of Key Findings

What is trauma? Many of the narratives from participants in this study focused on defining domestic violence in the context of trauma and trauma theory. While trauma and stressor-related disorders defined in the *DSM-5* (APA, 2013) include threats to self and safety of the survivor, participants in this study stated that most discussions of domestic violence omit details of emotional and verbal abuse. Participants reported that the detrimental effects from emotional and verbal abuse were equivalent, even potentially more impactful, for survivors, yet the conversation around domestic violence is centered on experiences of physical abuse. This was described as a limitation in the domestic violence narrative, one that leaches into the social service systems. These omissions are detrimental because they reinforce the concept that there are “legitimate” types of trauma and abuse and only certain types of survivors are deserving of care. Every clinician noted that current social service systems perpetuate a hierarchy of trauma.

In police reports, hospital records, and restraining orders, public systems require the existence of physical evidence to justify a survivor needing services.

Another salient finding from this research was the compounding impact that trauma has for survivors. This was described as layered experiences of trauma that stay with a survivor, even as they accumulate more. For example, the experience of childhood abuse was identified for many survivors in addition to experiences of IPV. This finding is in accordance with other research that has found a correlation between experiences of child abuse and intimate partner victimization (Craft & Serovich, 2005; Zolotor et al., 2007). Survivors with marginalized identities were also noted to have past and on-going experiences of oppression and discrimination. In other words, this study supports the understanding that trauma is additive over a lifetime.

Who is traumatized? There are extensive limitations to the current domestic violence narrative identified by participants. Participants noted that the current socially understood narrative is a survivor who is a straight white woman escaping an abusive white husband. And while that is representative of a section of the population of survivors, that narrative excludes a significant portion of people. Even the term domestic violence was discussed as historically representative of that small portion of the people impacted. Originally deemed the battered women's movement, participants noted that this movement gained traction from white women organizing their efforts to support each other by allowing survivors to sleep on each other's couches to escape abuse. The account of white women organizing speaks to who had access to legitimizing systems, to renting property, to starting organizations, and more readily to gaining access to funding. White privilege and the protected white female identity allowed white women

to gain more notoriety around this issue and begin to craft services focused on serving more white women. A few clinicians noted that the term domestic violence is so intertwined with the heterosexual white narrative that it is difficult at times to expand the definition for the outside society. Not only does this definition exclude communities of color, it also excludes the experiences of survivors with intersecting queer identities.

The findings from this research support the literature on the prevalence of domestic violence and the view that domestic violence can occur to any individual across demographic factors. Research has found that IPV occurs in equivalent rates and utilizes similar tactics of coercion and control in both homosexual and heterosexual relationships (Elliot, 1996; Murray et al., 2006).

The findings in this study are further supported by the current body of research that identifies the challenges faced by survivors holding marginalized identities and the realities of compounding trauma. For example, Howard, Feder, et al. (2013) suggest that significantly high rates of IPV can occur in communities with limited access to resources. Participants in this study discussed the barriers experienced by survivors trying to access resources and believed those barriers were exacerbated for individuals who hold marginalized identities. The literature also supports the study's findings that systemic and institutional resources are crafted in a manner that creates barriers for non-normative survivors.

What is the impact of trauma? The findings from the current study and the existing literature uniformly support the concept that DV or IPV is centered on power and control within a relationship. Participants in the study described the tactics of abuse in accordance to the patterns reflected in the Power and Control Wheel framework (Yllo, 2005). This framework

depicts the interactions between violence, coercion, exploitation of vulnerabilities, intimidation, minimization, isolation, and threats. These findings support the power and control framework, while expanding it with the addition of the pervasive unpredictability that these tactics create. This unpredictability was described as a key factor that kept survivors in the cycle of abuse.

While the literature reviewed for this study focused on the general impact of domestic violence, participants focused largely on the effects it had on the internal world of the survivor. The research found connections between DV and mental health disorders, medical and psychological hospitalization, and death (Oram et al., 2013; Vos et al., 2006). The findings from this study focused on the impact IPV can have on a survivor's self-concept. The factors central to one's self-concept were defined as a person's understanding of self, their capability, and identity. Participants identified negative effects of domestic violence on self-concept as destruction of sense of identity, erosion of trust of the self, and alteration of decision-making abilities of individuals impacted by domestic violence. Survivors can experience hypervigilance and a constant questioning of safety.

Participants described a consistent capacity of survivors to read the body language and context of their abusive partner to try to predict and prevent explosive episodes. This is also where the self-doubt and isolation become the most dangerous for the survivor and effective for the abuser. Participants noted that survivors can begin to believe they are to blame for their suffering, after repetitive manipulation and isolation from supports who might provide alternative perspectives. This, in turn, reinforces their hypervigilance and attempts to justify or even limit all of their behaviors and actions. Therefore, the cycle of abuse is more than just the repetition of

actions but the incremental breakdown of a survivor's autonomy and, potentially, the destruction of avenues for escape.

Is there post-traumatic growth? One of the primary questions in this research explored the existence of post-traumatic growth for DV survivors. The participants described the healing process for survivors as personal for each survivor, though grief, ambivalence, creativity, empowerment, and resiliency were common elements found in the recovery process. The limited research on the growth potential of DV suggests a need to focus on the strength created out of traumatic experiences (Moos & Schaefer, 1986). However, despite this study's focus on posttraumatic growth, participants understandably struggled to highlight solely positive aspects to traumatic experiences.

Participants instead presented the ambivalence faced by survivors in the aftermath of their traumas. The findings suggest that survivors can highlight the growth they have experienced, but the growth may be more complex than previous research suggests. Participants cited a new understanding of the self, growth of self-confidence, and the development of new interests, hobbies, and capabilities as positive changes experienced by survivors. This supports the research, which found that after trauma individuals develop new self-understanding and positive adaption (Ickovics & Park, 1998; Woodward & Joseph, 2003). Participants also noted how these changes were integrated with the reminder of the trauma experienced, as well as the feelings of self-doubt, stupidity, and helplessness that accompanied the abuse. Many participants said their clients could look back and appreciate how far they had come, yet many also mourned the time they had lost in their relationships. Many survivors were cited as establishing a new sense of empowerment as they successfully left the abuse, managed to navigate the systems, and create a

new life for themselves. This empowerment, however, was to the backdrop of deep feelings of powerlessness and isolation they had experienced within their abusive relationship.

These findings suggest that the potential for post-traumatic growth is a nuanced concept. While positive development is possible in the aftermath of trauma, participants noted that the ways in which their survivor clients recovered and thrived were not singularly positive. The intricacies of ambivalence, grief, and resiliency in survivors created experiences that held pain and growth, positives and devastation. These findings suggest that this phenomenon is multifaceted, which suggests the current theory of post-traumatic growth should be altered to capture the complexity.

What are the barriers to care? Participants also found that compounding trauma was magnified by the presence of marginalized and targeted identities held by a survivor. This supports Stile-Shields and Carroll's (2015) findings of a significant high rate of complex trauma for DV survivors in same-sex relationships. Stile-Shields and Carroll (2015) found that survivors within the queer community can experience increased barriers to services. Research has found that systems are geared for cis-gender, heterosexual, and female-identified survivors, and LGBTQ survivors can experience a lack of services focused on their particular needs (Ard & Makadon, 2011; Condrey, 2012). These findings support the accounts from participants in the current study, who noted that for individuals who hold sexual or gender identities that do not conform to the heterosexual, cisgender narrative, a piece of the abuse can be the abuser's threat to expose or use that identity against the survivor. This identity can also lead to discrimination or misunderstanding by service system providers for survivors who are trying to access care.

Findings from this study added to the past research, describing nonnative survivors and those without documentation as another group of survivors whose marginalized identities were vulnerable to additional traumatization. Participants noted that those without documented status could experience abuse that manipulated or threatened their safety and presence in America. Survivors could be threatened with deportation, and their partners could take their children or call the cops on the survivor's family. Multiple participants also noted that legal services, the court systems, and the majority of social services served as sources of fear for individuals who were unsure what legal rights they were allowed and what protections existed for them. Participants reflected that a lack of information, acts of discrimination, and the unknown future due to the current political climate left survivors without security or a sense of which services and people might get them deported, arrested, or attacked.

All of these compounding influences and gaps in services suggest that the way domestic violence is conceptualized and approached needs to be altered. Participants identified the need for a shift in the American cultural conversation around violence, gender, race and the way our services are crafted to provide access to a larger group of people. The findings from this study suggest that barriers to accessing services can impede recovery from abuse, inhibit survivors from the resources necessary to leave abuse, and even escalate current abuse. Participants described multiple aspects of accessing services that could be impacted by holding marginalized identities. Examples provided were law enforcement and other providers being unsure how to determine abuse between queer couples; service systems, like medical providers, shelters, and case workers mis-gendering and misnaming transgender clients; and shelters and other services being unsafe spaces for clients who hold an LGBTQ identity.

Limited research examines the ways that social service systems can replicate forms of abuse similar to that experienced within domestic violence (Keeling & Wormer, 2012). Thus, the research questions for this study were designed to begin to explore the ways in which systems may replicate these tactics of abuse. All participants of this study identified ways in which systems replicated abuse and re-traumatized survivors. Participants identified specific examples from legal services to the department of children and families to housing systems to depict this phenomenon.

Courts ask survivors to retell their stories with vivid detailed memory. Housing agencies require extensive forms that require the capacity to focus and write comprehensively. Department of Children and Families (DCF) and Department of Transitional Assistance (DTA) can ask survivors to follow plans that include attending classes, mental health treatment, maintaining employment, and establishing stable housing. Participants depicted this process as trapping survivors in reliving their abuse, through feelings of being monitored, manipulated, and incapable. This also reinforces the idea that survivors must justify their experience to deserve help. This also reinforces the prioritization of physical abuse over financial, emotional, and verbal abuse, as the latter types of abuse are much more difficult to prove and do not lend themselves to physical documentation. These findings validate past research by acknowledging that trauma impacts all aspects of a survivor's life, and there is a potential for positive growth. The findings also endorse that our current social service systems re-traumatize survivors. This study expands the current DV literature by providing specific examples of systemic interactions that replicate tactics of abuse in IPV relationships. The complexity discussed in this research

suggests the need for a more nuanced and intricate approach to understanding trauma and how service systems approach survivors.

Strengths and Limitations of Study

Strengths. This study had significant strengths by providing in depth exploration of the research questions. This study provided the opportunity for participants to discuss the systemic issues within the mental health and domestic violence fields. As a result, the study benefits the field of social work through its assessment of the strengths of our current social service systems, as well as areas for growth. As a field that focuses on individuals in relation to their environment and a discipline that constantly assesses the ways in which oppression is experienced and enacted, social work must focus on how policies and agencies are serving individuals and families in real time. The major strength of this study is that the research provided an opportunity for a focused exploration of the policies and agencies related to domestic violence and to the individuals being served.

This research also allowed me to orient myself to the perceptions of experienced clinicians. It allowed me to gain a new understanding of the ways in which our social service systems have changed over time and how they may need to continue to evolve. It also served as a reminder of the strength, adaptability, and creativity of survivors in the face of abusive treatment and painful experiences. It allowed me to discover a deeper understanding of resilience and illuminate a path of change as the field continues to grow.

Limitations. While qualitative research design was a conscious choice to represent the data collected, there were limitations to this study. Time constraints and snowball sampling limited the number and clinical background of participants contacted to participate. The research

could have benefited from a larger and more diverse sample size. This researcher was unable to recruit the desired 12-15 participants intended for interviewing due to time demands and geographic limitations. Further, participants were predominantly social workers, and this study would have profited from the inclusion of different mental health perspectives. In efforts to increase the sample size, the inclusion criteria were expanded from licensed clinicians to any practitioners working with domestic violence survivors in some capacity. Methods of interviewing were also expanded to include interviews by phone and by video conferencing. It is the belief of this writer that collecting a larger, more diverse sample size would have been possible if time constraints could have also been altered.

Similar to findings from most qualitative studies, these findings can only be generalized to the small sample size of these nine participants. These participants were recruited through this researchers' professional network of domestic violence organizations in the Boston area and the listserv of one private practice mental health provider located in the Western Massachusetts area. Although this recruitment was intended to reach a diverse sample, very few participants represented disciplines other than social work. This sample also was found to be fairly homogenous regarding ethnicity and gender. Finally, this study focused the research question through a systemic lens, instead of framing it through an individual lens, which may have influenced the number of clinicians interested in participating. The focus on domestic violence agencies may have limited the types of responses received and the disciplines of the participants included.

Regarding reliability and trustworthiness of the data, there are certain biases that must be considered in the design and implementation of this research. This researcher designed the

research questions, so there is a level of bias that can be assumed. There is a reasonable assumption that this researcher influenced responses through engaging in these conversations. Interviews were conducted in the agency or office of the participant, which also could have impacted the responses of the individual as interviews were a time-consuming process for both participants and the interviewer.

Implications for Social Work

Implications for practice. The systemic deficits cited and reflected on by the participants in this study suggest that change needs to occur on a multidimensional level. On an individual practice level, there is a need to increase the number of clinicians with different perspectives, who could help expand the way treatment is approached. Some participants noted that they became clinicians to provide the support they wish they had received when they were first struggling with their own survivor identities. Other clinicians noted that the one-dimensional approach of popular psychology did not apply to their communities or to the communities that systems are attempting to serve. Through these findings, the message was clear. Participants were calling for more clinicians to represent these marginalized populations and calling for clinicians who demand and utilize different approaches. In other words, we need more queer clinicians of color and more immigrant and non-English speaking clinicians to expand the ways we approach treatment prevention solutions.

We also need the continued development of non-normative, non-white centered theories—theories that speak to the complexity of intersectional identities and traumatic experiences and abuse; theories that can hold the power and strength of survivors without lessening survivors due to their "vulnerabilities." We need this understanding instead of asking

survivors of color, queer survivors, and immigrant survivors to see themselves in a DV narrative that highlights the experiences of white, straight women. Participants voiced a need for new narratives to be established to influence current policies and practice. As the participants explained, our systems are broken. They are filled with the best intentions, without the resources and very rarely with the inclusion of the voices of all varieties of survivors. The words of the participants are clear: we are re-traumatizing survivors and working in traumatized systems as well.

Recommendations for policy. The participants identified multiple ways that survivors and providers would benefit from policy changes. Participants discussed needing policy adjustments within the court system, police response, and housing system. Participants identified mandatory trainings as a vital change that could increase understanding for providers. This could help to adjust the ways police, medical providers, and other providers approach survivors of domestic violence, especially for those who also hold marginalized identities. The inclusion of survivor voices in the systems would help to adjust systemic processes to address needs. Participants described specific changes, like creating a new procedure for court that does not require survivors to physically face their abuser. Further, housing systems that require physical proof of domestic violence should be reconfigured to legitimize experiences of non-physical violence in relationships.

Future research. Future qualitative and quantitative research needs to explore the DV topic with a larger and more diverse sample of provider-participants. Even with the inclusion of intersectionality as a focus for this study, discussion of the nuances of intersectional identities was limited in this study and did not fully delve into the ways experiences of domestic violence

occur at the intersections of systems of oppression (Condrey, 2012). Therefore, research would benefit from focusing more specifically on the nuances within intersectionality and experiences of domestic violence. Further research focusing specifically on providers who work within social service systems would help the field to understand the potential for re-traumatization of survivors from the system. Such research may also serve to open the lines of communication between providers and systems, as well as continue to create methods to navigate system processes for providers and survivors. Future research would also benefit from interviewing survivors themselves. A significant finding of this study was the necessity of considering survivor voices in treatment and policy. Therefore, it would behoove the field to include and highlight the experiences and needs that survivors voice. Despite the challenges of accessing and recruiting this population for research, the information from these survivors would be invaluable as the field continues to consider its inclusivity and the ways in which survivors are served.

Conclusion

In conclusion, this research examined perspectives on how domestic violence impacts survivors and the ways in which social service systems affect resiliency and recovery. The research suggests that IPV impacts every aspect of a survivor's life, specifically self-concept and relationships. This study found that there is an emphasis on physical violence in abusive relationships that excludes the detrimental impact of emotional and verbal abuse. Emotional and verbal abuse was found to negatively affect survivors' self-esteem and creates feelings of isolation, manipulation, a lack of control, and unpredictability. Similarly, survivor interactions with social service systems were described as involving aspects of the abusive experience. Participants noted survivors often felt manipulated, disempowered, and worthless while

attempting to access services and resources. Systemic processes often omitted survivor voices and created a sense of unpredictability for the future. Participants also found that the systems reinforced the hierarchy of physical violence over emotional and verbal abuse. Physical proof needed to access resources is more easily attained in the context of a physically abusive relationship rather than an emotionally or verbally abusive one. These findings are vital for the field of social work in the consideration of how best to serve IPV survivors, navigate our current systems, and begin to consider how to alter systemic processes in the future.

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Appendix A: HSR Approval Form



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 27, 2017

Emily Jacobs

Dear Emily,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee



Appendix B: HSR Amendment Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063 T
(413) 585-7950 F (413) 585-7994

March 15, 2017

Emily Jacobs

Dear Emily,

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Andrew Jilani, Research Advisor



Appendix C: HSR Amendment Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063 T
(413) 585-7950 F (413) 585-7994

April 11, 2017

Emily Jacobs

Dear Emily,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Susanne Bennett, Research Advisor



Consent Form 2016-2017

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

.....
Title of Study: How Our Service Systems Impact Resiliency and Recovery of Domestic Violence Survivors: Clinical Perspectives **Investigator(s):**
Emily Jacobs, ejacobs@smith.edu

.....
Introduction

- You are being asked to be in a research study to gain an understanding of how social service systems impact survivors of domestic violence/intimate partner violence from a clinical perspective.
- You were selected as a possible participant because you are a clinician who has been working within the anti-violence field or with survivors of domestic violence/intimate partner violence for at least 2 years.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of this study is to examine how clinicians perceive the influence of social service systems on the resiliency and recovery of domestic violence survivors. This study hopes to reflect upon the potential for growth and the development of resiliency that can occur in the aftermath of surviving violence and abuse. The focus on the potential for growth in the face of trauma also requires an acknowledgement of the traumatic nature of seeking social services. There is a growing body of research questioning the ways in which the social work profession and social service systems can replicate forms of coercion, similar to that experienced within domestic violence relationships. Therefore, it is important to continue to assess the ways in which the growth of survivors can be both positively and negatively impacted by systems created to serve this population.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things: Each participant will be asked to schedule a one time, 60-minute interview. Interviews will be semi-structured, conducted in English, and include prompts around timeline working in the anti-violence field, how trauma impacts the

clients of each participant, and reflect on interactions with social service agencies between clinician and their clients. To make these interviews more accessible, I will meet participants in any public or agency based location where they feel comfortable, specifically at the offices or agencies where each participant works. Recording devices will be utilized, so that the researcher can transcribe and analyze the common themes. This will also allow for quotes to be utilized in the research.

Risks/Discomforts of Being in this Study [*choose one of the following*]

- There are no reasonable foreseeable (or expected) risks.

Benefits of Being in the Study

- The benefits of participation are: The narrative approach to this thesis will allow clinicians to reflect on their experiences within the field and give weight to their voiced opinions.
- The benefits to social work/society are: This research benefits the field of social work with its assessment of the strengths of our current social service systems, as well as areas for growth. As a field that focuses on individuals in relation to their environment and is constantly assessing the ways in which oppression is experienced and enacted, it is vital that social work research focuses on how policies and agencies are serving individuals and families in real time.

Confidentiality

- Your participation will be kept confidential.
- The interviews will be recorded using audiotapes, to which only this research and thesis advisor will have access. This researcher will discuss participants with thesis supervisor only. Each tape will be named Participant A, B, etc. with identified date of the interview, so that no confidential information is included or kept with the audio. The audio transcripts will be kept on a flash drive, stored in a lock box. The physical transcripts will also be stored on a confidential flash drive that is locked away in the same lock box.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. **Signed informed consents will be kept in a secure location different from other research materials.** In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. **I will not include any information in any report we may publish that would make it possible to identify you.**

Payments/gift

- You will receive the following payment/gift: a \$5 Starbucks gift card

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* (up to the date noted below) without effecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by 05/01/2017. After that date, your information will be part of the thesis, dissertation or final report. If this is an anonymous

survey, simply exit at any point by clicking on 'escape' at the top of the screen if you wish to do so. Answers to questions prior to exiting will remain in the survey up to that point, but I will have no way to know who you are, and the survey will be discarded as I will not use incomplete surveys in my study.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Emily Jacobs at ejacobs@smith.edu or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

Form updated 6-13-16

Appendix E: Professional Transcriber Confidentiality Form

2016-2017

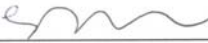
Volunteer or Professional Transcriber's Assurance of Research Confidentiality Form

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, - *insert name of researcher* - shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, - *insert name of researcher* - for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

	Signature
_____	4/18/17
_____	Date
Emily Jacobs	_____
_____	<i>Insert name of researcher</i>
4/18/17	_____
_____	Date

To whom it may concern,

I am a current Masters of Social Work student at Smith College. I am looking to recruit licensed clinicians working with survivors of domestic violence to interview for my Master's thesis. This interview is intended to collect a narrative reflective of experiences working in the anti-violence, Intimate Partner Violence, and Domestic Violence field. Through this thesis, I have been researching the ways in which survivors not only survive, but recover and grow positively, as a result of the aftermath of trauma. I am hoping to gain a broad range of narratives to paint a picture of the many paths to recovery and the services that survivors interact with on the way.

Interviews will be allotted for about an hour and can be conducted in a location of your convenience. Interviews will be audio recorded and conducted in English. Each participant will receive a \$5 Starbucks gift card at the end of the interview. Please contact me by phone, xxxxxx-xxxx, or email, ejacobs@smith.edu to discuss this thesis project, scheduling options, or any questions or concerns.

Thank you for your time,

Emily Jacobs

As you may know, this interview is for my Master's thesis focusing on clinicians working with survivors of domestic violence. This interview is intended to collect a narrative reflective of your experience working in the anti-violence, IPV/DV field. Through this thesis, I have been researching the ways in which survivors not only survive, but recover and grow positively, as a result of the aftermath of trauma. As someone who has limited experience working within a DV social service agency, I also saw the potential for services to be replicative of abuse, re-traumatizing in some ways. This research is intended to assess the ways in which social service systems impact your clients who identify as survivors. When answering the interview questions, I ask that we maintain confidentiality for clients and refrain from using names or overtly identifiable information. These interviews will be coded for themes, specific referenced clients, agencies, and clinicians will not be named in the analytical data, analysis, or reflection in the thesis.

This interview is allotted for 60 minutes and will look at your experience in the field, your understanding of the impacts of trauma for your clients, and how social service systems impact your work and your clients.

Prompt 1: What brought you to the field of domestic violence/intimate partner violence work?

- What positions have you held within the field?
- What is meaningful about the work that you do?
- How have you seen the field change in the years you've been working with this population?

Prompt 2: How have you seen trauma impact survivors?

- What aspects of a survivor's life are impacted by trauma? Please explain what that looks like for the survivor's you serve.
- In what ways have you seen the detriments created by experiences of trauma?
- In what ways have you seen growth or positive change created in the aftermath of trauma?

Prompt 3: In your experience, how have you seen trauma impacting survivors of different identities

- How has trauma impacted clients of different gender identities and gender presentations (female, transgender, male, etc.)
- How has trauma impacted clients across backgrounds and cultural groups (race, ethnicity, immigrant status, etc.)
- How has trauma impacted individuals across sexual preferences (lesbian, gay, straight, bisexual, pansexual, etc.)

Prompt 4: How have you worked with social service systems in service of your survivor clients?

-What have your interactions been like advocating for clients to receive services or benefits from government and public agencies and programs? From private agencies and programs?

-How has your understandings of social service systems changed over time?

-How have you changed the ways in which you interact with these

Prompt 5: How have you seen interactions between survivors and social service agencies impact your survivor clients?

-How have these interactions differed for clients across different identities (genders, backgrounds, cultural groups, sexual preferences, etc.)

-How have the impacts from these interactions differed for different clients across gender identities, backgrounds, cultural groups, sexual preference, etc.?

-How have the interactions impacted survivors' path to recovery from abuse?

-How have the interactions positively impacted survivors' paths to recovery from abuse?

- How have the interactions negatively impacted survivors' paths to recovery from abuse?