SAFETY, HEALTH, AND WELLNESS: ASSESSING THE GOALS, MESSAGES, AND DILEMMAS OF DOMESTIC VIOLENCE SUPPORT GROUPS FOR WOMEN IN SUBSTANCE ABUSE TREATMENT

BY

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Abstract

Substance abuse and domestic violence are correlated issues and frequently co-occur (see, e.g., Chase, O'Farrell, Murphy, Fals-Stewart, & Murphy, 2003; Fals-Stewart & Kennedy, 2005; Stuart et al., 2006; Testa, Livingston, & Leonard, 2003). However, there is little interaction between domestic violence agencies and substance abuse treatment centers in communities across the United States (Collins & Spencer, 2002). Bland and Edmund (2008) recommended that one way for domestic violence advocates to provide support and services for those in substance abuse treatment and vice versa is to have advocates facilitate support groups regarding their area of expertise at the other agency.

In this project, I explored a domestic violence-based support group within a substance abuse treatment center. I facilitated the domestic violence support group within the substance abuse treatment center from April 2011 until October 2012; then, I observed another facilitator and the group from October 2012 until May 2013. I also conducted semistructured interviews with 20 of the group members in order to explore the helpful and unhelpful communication within the support group. The data were analyzed via an inductive and iterative process, and open and axial coding was used to identify major themes of helpful and unhelpful communication (Glaser & Strauss, 1967; Miles & Huberman, 1994).

Overall, informational support was the type of social support that was most solicited, provided, and deemed most helpful by participants. Additionally, group members reported that the most helpful (and unhelpful) communication within the support group focused on recognizing and conceptualizing domestic violence, making sense of domestic violence experiences, and discussing ways to facilitate a safer future. Moreover, group members found it helpful to listen to others' stories and to share their own stories because elaborating on their

thoughts and feelings helped them reappraise their situation in meaningful ways. These findings imply that domestic violence and substance abuse treatment centers can effectively bridge their services via support groups and that domestic violence support groups are most helpful when they: (a) are mostly peer-directed, (b) include an educational component, and (c) affirm the variety of group members' lived experiences.

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Table of Contents

Abstract iii

Acknowledgements v

Table of Contents vii

Chapter One: Introduction and Rationale 1
Rationale for Intervention 5
Rationale for Project Focus and Site of Analysis 8

Chapter Two: Conceptualizing Domestic Violence and Substance Abuse 15
Conceptualizing Domestic Violence 15
Conceptualizing Substance Abuse/Dependence 23
Summary 28

Chapter Three: Co-occurring Issues of Domestic Violence and Substance Abuse 30
Connections between Domestic Violence and Substance Abuse 30
The Importance of "Bridging" Domestic Violence and Substance Abuse Services 33
Example 1 33
Example 2 35
Challenges of "Bridging" Services 35
Summary 38

Chapter Four: Social Support and Support Groups 39
Social Support 39
Defining Social Support 40
Types of Social Support 40
Conceptualizing and Measuring Social Support 41
The Sociological Approach 41
The Psychological Approach 42
The Interactional Approach 44
Support Groups 50
Conceptualizing Support Groups 50
Distinguishing Support Groups 51
Support Groups Comprised of Individuals with Similar Experiences 54
Support Groups as Groups 57
Examining Support Groups 59
Macrolevel Assessment 60
Middle-Ground Assessment 61
Microlevel Assessment 62
Examining Outcomes in Support Groups 63
Assessing Support Group Outcomes within Institutions 66
Assessing Potential Support Group Outcomes for Domestic Violence Groups 67

Research Question 68

Chapter Five: Methodology, Methods, and Data Analysis 70
Philosophical Underpinnings 70
Research Situation 73
The Memorandum of Understanding (MOU) 75
Participants and Sites 77
Safe Haven 77
New Beginnings 78
The Domestic Violence Group at New Beginnings 80
Methodology 82
Procedures Overview 84
Stage 1 84
Stage 2 86
Stage 3 87
Methods 87
Ethnography 87
Field Notes 89
Ethnographic Data Collection and Participant Information 90
Interviews 91
Recruitment and Procedures 92
Interview Data Collection and Participant Information 93
Autoethnography and Narrative Data 94
Creative Works 95
Analysis of the Data 96

Chapter Six: Results and Interpretation 97
Introduction 97
The Intervention 99
The Facilitators' Approach 105
Communicating Beyond the Formula Story 105
Soliciting Stories 112
Providing Information 113
Helpful and Unhelpful Aspects of Facilitator's Communication 117
Helpful Facilitator Communication 117
Unhelpful Facilitator Communication 122
Helpful and Unhelpful Communication within the Domestic Violence Group 130
Recognizing Abuse 130
Helpful Aspects of the Message that Domestic Violence is "Not Right" 136
Unhelpful Aspects of the Message that Domestic Violence is "Not Right" 137
Making Sense of Domestic Violence Experiences 148
Helpful Sense-Making through Stories 148
Finding Resolve 154
Unhelpful Stories 157

Making Sense through Attribution ... 159
Preparing for the Future ... 167
Helpful Preparation ... 168
Lack of Preparation ... 171
Chapter Summary ... 172

Chapter Seven: Discussion and Implications ... 177
Summary of Findings ... 179
Theoretical Implications ... 179
A Dialogic Perspective ... 180
Attribution Theory ... 185
A Habituation Model ... 187
Practical Implications ... 188
Bridging Agencies to Address Domestic Violence and Substance Abuse ... 188
Communication within the Support Group ... 191
Limitations ... 193
Directions for Future Research ... 194
Conclusion ... 195

References ... 197

List of Appendices ... 230
Appendix A: The Power and Control Wheel ... 231
Appendix B: HSCL Approval Letter ... 232
Appendix C: Staff/Support Group Facilitator Consent Form ... 233
Appendix D: Staff/Support Group Facilitator Interview Protocol ... 236
Appendix E: Resident/Client Consent Form ... 239
Appendix F: Resident/Client Interview Protocol ... 243
Appendix G: List of Local Counseling Services ... 247
Appendix H: The Equality Wheel ... 248
Appendix I: The Power and Control Wheel for Women’s Substance Abuse ... 249

Chapter One: Introduction and Rationale

Although communication, arguably, is a very practical field, some scholars, such as Craig (2008), have asserted that researchers should explicitly address important societal issues and problems. Communication research that addresses societal issues and problems to make a difference in people's lives is known as *applied communication research* (see, e.g., Cissna, 1995; Cissna & Frey, 2009; Frey, 2006; Hickson, 1973; Kreps, Frey, & O'Hair, 1991; Frey & SunWolf, 2009; O'Hair, 2000; Seibold, 2008). According to Cissna (2000):

> Applied communication research, regardless of context, methodology, setting, or epistemology, was inquiry that sought to make a difference in the world through examining some feature of human communication (Cissna, 1982). Hence, being situated in a context is vitally important in applied communication research, and applied researchers are immersed in and with "real-life" settings and respondents. Applied communication researchers are motivated not only to understand the world, but also to change it in some respect, with luck, in a positive direction. Applied communication researchers, then, typically start with a goal to be achieved . . . . Applied communication research is, at least in part, intended for someone other than a community of scholars and includes in its conversation people who are not within the scholarly community. (pp. 169–170)

Thus, applied research

> sets out to contribute to knowledge by answering a real, pragmatic, social question or by solving a real pragmatic, social problem. Applied *communication* research involves such a question or problem of human communication or examines human communication in order to provide an answer or solution to the question or problem. (Cissna, 1982, p. iv)

With this broad definition, applied communication research includes any research that seeks to address practical, communication issues and solve social problems.

Frey and SunWolf (2009) described an applied communication scholarship continuum, such that "at the minimal definitional end of the applied communication scholarship continuum, researchers observe people confronting pragmatic communication issues to describe, interpret, explain, and in some cases, critique what occurs for the purpose of enlightening other scholars" (p. 36). Thus, at the "minimal definitional end" of the continuum, applied communication scholars observe phenomena and present practical findings to other scholars; however, they do not intervene during the project (and they may not even present their findings to the participants being studied; see Frey & SunWolf, 2009). Frey and Carragee (2007) referred to that type of applied communication research as "third-person-perspective research" because researchers do not intervene to affect change; they are "spectators whose work is best done by looking at and contemplating what occurs without trying to affect it" (Frey & SunWolf, 2009, p. 37).

Other applied communication scholars, however, go beyond observation and description to intervene to affect positive change. Such *intervention-oriented applied communication research* constitutes *engaged scholarship* (see, e.g., Applegate, 2002; Cheney, Wilhelmsson, & Zorn, 2002; Frey & SunWolf, 2009; Hartelius & Cherwitz, 2010; Simpson & Shockley-Zalaback, 2005; Van de Ven, 2007), in which researchers adopt a "first-person perspective" to intervene with and for the people, groups, and/or organizations that they are studying, and then report the results of those interventions to a wide variety of audiences, including other scholars and communication practitioners, in addition to the people studied (Frey & Carragee, 2007). The goal of intervention-oriented researchers, therefore, is to "conduct research about their

interventions with relevant audiences to manage or solve communication problems and to promote needed social change" (Frey & SunWolf, 2009, p. 39).

Not only are there differences between third-person perspective (observational) research and first-person perspective (intervention) research but there also are important differences "between intervention research that potentially maintains systems of domination and that which challenges oppression" (Frey & SunWolf, 2009, p. 41). Frey, Pearce, Pollock, Artz, and Murphy (1996) argued that, although there were notable studies at the time that challenged inequality and oppression, most of the research that previously had been published in the *Journal of Applied Communication Research* (*JACR*), the main outlet for applied communication scholarship, had "been *about* and *for* those who have many resources at their disposal (e.g., managers of for-profit organizations); relatively little applied communication research has been done *about* and *for* those who are marginalized and/or underresourced" (p. 113). Frey (1998) later explained that this observation regarding the abundance of research conducted about those with resources does not mean that researchers should *not* focus on for-profit organizations but that there should be *more* research conducted in which researchers bring "their communication resources to bear to promote social justice and make a difference" (p. 162). As described by Frey et al., a *communication and social justice approach* seeks to challenge oppression and make a positive difference through "engagement with and advocacy for those in our society who are economically, socially, politically, and/or culturally underresourced" (p. 110).

In explicating a communication and social justice approach, Frey et al. (1996) argued that a "social justice sensibility: (1) foregrounds ethical concerns; (2) commits to structural analyses of ethical problems; (3) adopts an activist orientation; and (4) seeks identification with others" (p. 111). First, researchers foreground ethical concerns by asking questions such as, "Whose

interests are being served by our research?" (Frey et al., 1996, p. 111). Second, communication and social justice researchers focus on "ways that dominant discourses, social structures, patterns of interactions, and the like produce and reproduce injustice" (Frey et al., 1996, p. 111). Third, such researchers adopt "an activist orientation . . . [to] "engage and transform social structures" (Frey et al., 1996, p. 111). Finally, Frey et al. argued that communication and social justice scholars need to identify with others, which includes Disch's (1993) "situated impartial thinking," which "involves taking divergent opinions into account in the process of making up one's own mind and, ultimately, locating one's judgment in relation to those views" (p. 686). Overall, a communication and social justice approach foregrounds discourse, ethics, collaborative sense-making, and activism to challenge and change norms and practices that maintain injustice.

The current study seeks to contribute to the growing body of intervention-oriented applied communication research by addressing the important social justice issues of domestic violence and substance abuse. *Domestic violence* (DV) is "a continuum of behaviour ranging from verbal abuse, physical, and sexual assault, to rape and even homicide" (Department of Health, 2000, p. v). According to the text revision of the Diagnostic Statistical Manual (DSM-IV; American Psychiatric Association, 2000), *substance abuse* is a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (p. 198).[1] Applied communication researchers have addressed DV (see, e.g., Fábián, 2010; Hopkins & McGregor, 1991; Rambo, 2009; Ryan & Jeffreys, 2012, Walker & Cunningham, 2007), as well as substance abuse (see, e.g., Belone et al., 2012; Hecht & Miller-Day, 2009), from a communication and social justice perspective. This study addresses

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[1]Throughout this document, *substance abuse* refers to substance abuse, dependence, and addiction; distinctions between these three terms are clarified in Chapter Two.

both DV and substance abuse by examining a DV support group within a substance abuse treatment center. In the following sections of this chapter, I describe the rationale for my intervention, as well as for focusing on the DV support group as a site for analysis.

Rationale for Intervention

As a graduate student with research interests in interpersonal communication, gender and communication, and social support, I increasingly became interested in the phenomenon of DV. In March 2010, Dr. Lawrence Frey presented a colloquium series talk to the Department of Communication Studies at the University of Kansas, arguing that researchers should combine their passion for social justice with their academic endeavors, and I was inspired by his talk. At that time, several of my colleagues and professors were volunteering at a local DV center, Safe Haven, and I decided to begin volunteering there as well. (Pseudonyms for all people and agencies are used in this project.) I began as a volunteer in the administrative office in October 2010, and then completed 40 hours of volunteer training. Once I completed the volunteer training course, I completed 16 hours of on-the-job training at the women's shelter to be a "shelter advocate."

During my training, a staff member described various roles within the organization to encourage trainees to think about how they best could serve the organization (e.g., helping at the administrative office, with court advocacy, or with numerous other programs and services). One of those roles was that of assisting facilitators of the various support groups offered by Safe Haven. Because I am interested in social support and support groups, my advisor, Dr. Adrianne Kunkel, and I thought that this would be a great opportunity to combine activism with my academic endeavors to serve the interests of those participating. She helped me to get my foot in

the door regarding these groups, and after a series of discussions, the staff at Safe Haven agreed that I could help to facilitate a support group.

In February 2011, I began training to cofacilitate a DV support group within a local substance abuse treatment center, New Beginnings. At an unknown time (Safe Haven staff did not know when), New Beginnings had contacted a staff member at Safe Haven and asked if the organization could send a Safe Haven staff member to New Beginnings once a week to help the women in substance abuse treatment learn about DV and to "process" their experiences. The DV support group at New Beginnings, at that time, was led by a single staff member and by an intern, who facilitated the group in alternating weeks. The staff member planned for me to shadow the DV support groups until I could comfortably begin to cofacilitate, and then I would cofacilitate the groups with the staff member, because the intern would soon be leaving the agency. I excitedly began researching DV, the connection between DV and substance abuse, and DV support groups, to prepare for that endeavor. Relevant literature regarding DV, the co-occurring issues of DV and substance abuse, and support groups is provided in Chapters Two, Three, and Four, respectively.

Broadly defined, *support groups* are "small groups formed for the specific purpose of providing mutual aid among members who share a common dilemma" (Cline, 1999, p. 516). After conducting some research and shadowing sessions, I realized that Safe Haven's DV "support group" at New Beginnings was more like a *class* because the facilitators did most of the talking and it had a more formal atmosphere than did most support groups (e.g., facilitators wore business casual dress, stood at the front of the room, and focused on teaching concepts). The women participants even called the group "DV class," because group meetings were more like lectures, with participants occasionally asked to give examples of the concepts presented.

Additionally, the DV group had only four rotating topics in the curriculum: (a) "DV 101," (b) coping skills, (c) equality in relationships, and (d) decision making. Because New Beginnings mandated that residents attend the DV group for at least their first 28 days (a "typical" length of time for treatment), women who stayed more than 28 days heard the same topics repeated.

Based on recommendations for DV support groups found in the scholarly literature (e.g., Bland & Edmund, 2008; Fischer & McGrane, 2001), I began thinking that the group could, or *should*, be improved. My suspicions were soon confirmed, as prior to one of my shadowing sessions, a staff member at New Beginnings told me that the women there had been complaining about the DV group because it was boring, repetitive, and unhelpful. In fact, some women were petitioning their counselors to get special permission to *not* attend the groups. The staff member then asked me to "do something about it." I also simultaneously received news that the staff member with whom I was supposed to cofacilitate the DV group was resigning from Safe Haven. Thus, because I was asked by New Beginnings to intervene and I would be the sole DV group facilitator at New Beginnings, I created a proposal based on research [e.g., Collins & Spencer, 2002; M. A. Dutton, 1992; Fazzone, Holton, & Reed, 1997; National Coalition Against Domestic Violence (NCADV), 2011] and practitioners' recommendations (e.g., Bland & Edmund, 2008; Fischer & McGrane, 2001), that I hoped would better serve the interests of the women at New Beginnings. In short, I was going to overhaul the group by making it more a support group with an educational component; the group would be led, mostly, by participants, but we would discuss information about DV, and informative handouts about the topics discussed would be provided. I presented my proposal to key staff members at Safe Haven, and after their approval, we met with the clinical staff at New Beginnings to present my proposal and, hopefully, to mend any potential hurt to Safe Haven's relationship with New Beginnings.

My proposal was approved, and I began facilitating the DV support group at New Beginnings in April 2011.

The meeting between me, Safe Haven staff, and New Beginnings staff ended satisfactorily and helped to mend a somewhat tense relationship between the agencies, but I did not know at the time that this "bridging" of agency services vis-à-vis the DV support group at New Beginnings provided an opportunity to fill a needed gap in academic literature and practice. Upon further research, which is examined in the next section, I learned that government agencies, counselors, and advocates had called for models of bridging agencies and research regarding effective curriculum for these types of groups. The following section provides a rationale for focusing on the co-occurring issues of DV and substance abuse, as well as the DV support group as a site for analysis.

Rationale for Project Focus and Site of Analysis

While preparing for my role as the DV group facilitator at New Beginnings, I learned that there still is a great deal that researchers do not know regarding the complex relationship between DV and substance abuse, although there is a statistical correlation between the two issues (see, e.g., Chase, O'Farrell, Murphy, Fals-Stewart, & Murphy, 2003; Coker, Smith, McKeown, & King, 2000; D. H. Coleman & Straus, 1983; Fals-Stewart & Kennedy, 2005; Gondolf, 1995; Hamilton & Collins, 1981; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Kantor & Straus, 1989; Leonard & Jacob, 1988; Logan, Walker, & Leukefeld, 2001; NCADV, 2011; Pernanen, 1991; Stuart et al., 2006; Testa, Livingston, & Leonard, 2003). Not only do some batterers tend to abuse drugs and alcohol, but DV also increases the probability that victims will use alcohol and illegal drugs to cope with abuse. For example, according to Stark and Flitcraft's (1996) analysis of clinical histories of women who utilized

hospital services, women who have experienced DV are 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs than women who have not experienced DV. Victims of DV may use drugs or alcohol to self-soothe and to induce a "numbing effect, thus blocking out the experience of distress and emotional pain" (M. A. Dutton, 1992, p. 64). Additionally, according to the National Violence Against Women Survey, conducted by Tjaden and Thoennes (2000), "Some of the inhibitors that may prevent persons from hurting others under ordinary circumstances are relaxed when persons are under the influence of drugs and alcohol" (p. 54). Additionally, for both male and female physical assault victims, the risk of injury *increased* if the perpetrator or victim "used drugs and/or alcohol at the time of the incident" (Tjaden & Thoennes, 2000, pp. 51–52). Given the increased probability for DV victims to use alcohol or drugs to cope with the abuse, and the increased likelihood for injury when substances are involved during violent incidents, it makes sense that the two issues could "interact and exacerbate each other" (Engelmann, 1992, p. 6), and, hence, they should be addressed simultaneously when both issues of DV and substance abuse are present (Fazzone et al., 1997).

Government agencies, such as the U.S. Department of Health and Human Services (Fazzone et al., 1997), the NCADV (2011), and the Alaska Network on Domestic Violence and Sexual Assault (Bland & Edmund, 2008), as well as advocates, researchers, and counselors alike, agree on the strong link between DV and substance abuse. However, although experts acknowledge this connection, generally, there is little interaction between agencies in communities across the United States (Fazzone et al., 1997). According to Collins and Spencer (2002):

> Given the common co-occurrence of substance use and domestic violence, one might think that substance abuse treatment programs would attend to the violent behavior or

> victimization of their clients during substance abuse treatment. But in practice, domestic violence and substance abuse programs do not usually address the complementary problem. (p. 1)

Collins and Spencer noted that there are exceptions and that "things are currently changing, but most programs do not integrate domestic violence and substance abuse services" (p. 1).

Integrating services between DV and substance abuse agencies is a worthy pursuit, but there are inherent challenges to doing so. According to the U.S. Department of Health and Human Services' official report on the connection between DV and substance abuse, "The two fields have worked largely in isolation from each other, despite the considerable overlap in client populations," possibly because "both the domestic violence and substance abuse treatment fields are relatively young and new to each other" and "basic differences in philosophy and messages of the two fields have also blocked the collaborative care that is critical for treating substance abusing clients who are survivors or perpetrators of violence" (Fazzone et al., 1997, p. 7), and vice versa. Almost 10 years ago, only three locales (in Colorado, Ohio, and Illinois) reported attempting to develop model programs that integrated DV and substance abuse services; more programs recently have emerged, but a stronger effort currently is needed (see, e.g., Bland & Edmund, 2008; Fazzone et al., 1997; NCADV, 2011).

In addition to agencies, advocates, and researchers calling for more model programs that bridge substance abuse and DV agencies' services, official reports issued by the Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services (2005), the U.S. Department of Health and Human Services (Fazzone et al., 1997), and the Alaska Network on Domestic Violence and Sexual Assault (Bland & Edmund, 2008) have recommended the use of support groups, to complement individual counseling, for effective

rehabilitation for substance abuse and effective coping for DV survivors. Thus, because support groups are the leading strategy, those organizations recommended using "traveling advocates" to bridge the agencies. In other words, DV experts and/or advocates should lead support groups or offer individual support for people in substance abuse treatment programs, and substance abuse experts and/or counselors should lead support groups or offer individual support for survivors of DV to have experts of the separate fields work closely with those receiving services from the other agencies.

However, because of possible conflicting approaches and philosophies of each field, more research is needed regarding effective support group approaches and curriculum for support groups that focus on multiple issues. Accordingly, because of the need for more studies and for models of effective "bridging" of agencies in communities through support groups, the current study addresses the helpful (and sometimes unhelpful) messages of DV-focused support groups at substance abuse treatment centers and the helpful or unhelpful dynamics of those support groups.

I address these issues by using a multimethod approach that is comprised of ethnographic participant observation and informal interviewing, and in-depth, semistructured interviewing. Between January 2012 and May 2013, I interacted with, observed, and interviewed women in substance abuse treatment who attended a weekly DV support group, the DV support group facilitator, and key staff members at Safe Haven and at New Beginnings. I also facilitated the DV support group within the substance abuse treatment center from April 2011 until October 2012; thus, my insights from facilitating the group are included in this report. I also analyzed documents and handouts used in the DV support group and key documents from the substance

abuse treatment center (e.g., its website and client intake packet). Additional details about the methodology and methods are detailed in Chapter Five.

Both the DV and substance abuse treatment agencies are located within the same community in the Midwestern United States, and as mentioned, pseudonyms for all people (except me) and agencies are used in this project. The ethnographic component of this project received Institutional Review Board approval in January 2012, and an appropriate administrator at each site signed a formal letter of consent that granted me permission to conduct research at the agency. Interview questions, discussions, and field notes focused on the messages that residents/clients received from Safe Haven and New Beginnings, and, specifically, which messages were considered helpful (or unhelpful) in terms of sense-making, coping, and healing. Because of the exploratory nature of this project, I used inductive and iterative analytic techniques to analyze the data vis-à-vis open and axial coding to allow reoccurring and patterned themes to emerge from the data (Glaser & Strauss, 1967; Miles & Huberman, 1994).

With this project, I aim, first, to contribute to the growing body of intervention-oriented applied communication research, as well as to address the social justice issues of DV and substance abuse. As Cronen (2001) argued about the practicality of the field of communication, "The only reason to study such arts is to make life better for people in their joint activities. Thus, all practical arts intrinsically have a moral end" (p. 17). This project, hopefully, will benefit the women whom Safe Haven and New Beginnings serve by seeking to "improve the lives of people and have applicability for enhancing their capacities for action" (Barge, 2001, p. 6). Second, I seek to contribute to theoretical understanding of the helpful (and sometimes unhelpful) messages of DV support groups within substance abuse treatment centers, as well as to highlight potential benefits and/or detriments of those messages for support group participants. I also seek

to further understanding of the healing process for survivors of DV and, more specifically, how metanarratives of DV and labeling (e.g., labels of *survivor* and *abuser*, or *abuse* and *DV*) can be helpful or unhelpful for survivors during the coping process. Moreover, I examine how DV survivors, during the healing process, attribute meaning to messages that they receive that have potentially different philosophical underpinnings.

Upon completion of the project, I hope to offer concrete recommendations for substance abuse and DV agencies in communities that wish to join efforts regarding curriculum and positive support group dynamics for support group facilitators. Such information also may prove helpful to counselors and advocates working with DV survivors and/or persons receiving treatment for substance abuse. Although data from studying sites within one Midwestern United States community cannot be generalized to all women seeking substance abuse treatment, women who have experienced DV support groups, in general, and DV and substance abuse treatment agencies, in particular, a longitudinal study of those sites, nonetheless, will contribute to understanding how agencies can better work together to effectively help women with co-occurring issues of DV and substance abuse. Because the research sites studied serve *women*, the focus of this project also is on violence against women and women in substance abuse treatment. Although, as discussed in Chapter Two, men also may be abused by men or by women, women, generally, experience DV more than do men (Tjaden & Thoennes, 2000).

To take further steps to achieve safety and wellness for all, researchers and practitioners must continue to examine the implications of connections between substance abuse and DV, and how to move forward with the most informed methods for education, prevention, and intervention to better enable survivors to empower themselves. As previously mentioned, Frey (2000) advocated for "researchers going beyond the descriptive task of studying 'an other' and

involving themselves in the life of 'another' . . . [to] bring their communication resources to bear to make a difference in people's lives" (p. 181). The ultimate goal of this study is to learn about a phenomenon and, simultaneously, to serve the interests of those who are a part of the project.

The following chapters provide an overview of literature regarding DV, substance abuse, the connection between DV and substance abuse, social support, and support groups. Specifically, Chapter Two presents overviews of conceptualizing DV and substance abuse. Chapter Three examines connections between DV and substance abuse/addiction, and the importance of attending to those issues simultaneously for women experiencing both of them. Chapter Four describes benefits and challenges of support groups, and of providing effective support for the co-occurring issues of DV and substance abuse within support groups. Chapter Five describes the methods employed in the study to collect and to analyze data. Chapter Six presents key findings regarding the communication within the DV group that was deemed most helpful and unhelpful by the DV group members. Chapter Seven provides potential theoretical and practical implications of the findings, limitations of the study, and conclusions.

Chapter Two: Conceptualizing Domestic Violence and Substance Abuse

This chapter provides an overview of literature regarding ways in which domestic violence (DV) and substance abuse have been conceptualized. Taking a social constructionist approach, Muehlenhard and Kimes (1999) argued that how scholars define or conceptualize phenomena has tremendous power to influence norms and policies regarding those phenomena. Those who define concepts usually are in power positions, and definitions of social concepts, inherently, are political because of ways in which definitions can reify norms or create new ways of viewing phenomena (Muehlenhard & Kimes, 1999). Thus, examining ways that DV and substance abuse have been conceptualized is important because those conceptualizations can influence norms and understanding of these important issues.

Conceptualizing Domestic Violence

In the United States:

> Two to six million women experience violence from their male partners each year, 25–30 percent of women who come to emergency rooms for injuries are there for domestic violence-related problems . . . [and] over 1,000 women were murdered in the year 2004 by their husbands or boyfriends. (Johnson, 2008, p. 1)

Studies also have found ranges between 22% and 46% of those who are lesbian or gay experiencing repeated acts of DV in intimate relationships (V. E. Coleman, 1990; Gay and Lesbian Community Action Council, 1987; Lie, Schilit, Bush, Montagne, & Reyes, 1987; Loue, 2001). Additionally, the National Violence Against Women Survey, conducted by Tjaden and Thoennes (2000), found that of the 8,005 men and 8,000 women who were interviewed, an intimate partner had physically abused 7.4% of men and 22.1% of women. Research trends from DV shelters from across the nation also have found that physical DV is a possibility for all

women, no matter their age, ethnicity, class, religion, and/or education (Sokoloff & Pratt, 2005). Although these statistics are startling, counting the incidence and prevalence of DV is a hotly debated issue (see Crocker, 2010). As Barnett, Miller-Perrin, and Perrin (2005) stated, “There is simply no way we can know with certainty how much family violence exists in our society” (p. 3).

Despite the difficulties involved in counting such incidences, it is obvious from experiential observation in shelters and emergency rooms, on television news reports, and from hotline calls around the nation that DV remains a major societal issue in the United States. With the help of the feminist movement and other grassroots activists, the horrors of domestic and sex/gender violence have continued to be pushed from the private sphere to the public sphere, to increase awareness, prevention, and intervention services for those who survive the terrors of DV. There has been great progress in these endeavors, but much work remains to be done at the microlevel and macrolevel, including increased awareness of the problem, assisting survivors, effectively prosecuting and/or rehabilitating perpetrators, and creating just or fair policies.

According to D. G. Dutton (2006), a psychologist whose scholarly focus is DV within the legal system, *domestic violence* “refers to any violence occurring between intimate partners (same sex or cross sex, married or unmarried) and against children” (p. 3). Although violence against children also is a necessary component of conceptualizing DV, the primary focus of this project is on *intimate partner violence* (IPV), or violence that occurs between romantic partners.

According to D. G. Dutton (2006), *intimate partner violence* is any violence that occurs between two people who share an emotional, romantic bond. However, what constitutes “violence” against an intimate partner? Is *violence* only those acts that leave bruises or marks, or is *violence* more nuanced than physically injuring a person? Again, how concepts, such as DV,

are conceptualized and how broadly or narrowly those concepts are defined have tremendous implications for practice and policy. Levesque (2001) defined DV as “acts of omission or commission resulting in physical abuse, sexual abuse, emotional abuse, neglect, or other forms of maltreatment that hamper individuals’ healthy development” (p. 13), which Barnett et al. (2005) argued was the best definition because it is “narrow enough to avoid labeling every family potentially violent and broad enough to include the concept of nonphysical violence” (p. 17).

Although Levesque’s (2001) definition is appropriately broad and narrow, the justice and legal system, as well as advocates, feminists, and scholars, generally, are divided regarding the conceptualization of DV. The criminal justice and legal perspective, by and large, views DV as *physical* violence, whereas feminists, advocates, and scholars, generally, view DV as *any controlling tactic* used against a partner, such as verbal, economic, and spiritual abuse. Although the latter forms of abuse are forms of interpersonal control and violence, those activities alone would not constitute a felony or misdemeanor by law, as treating someone badly or emotionally abusing someone is not the same as physically harming a person.

The criminal justice and legal perspectives view DV as actions that are considered grounds for arrest, including “kicking, biting, hitting with a fist or object, beating up, or using a weapon against a victim” (D. G. Dutton, 2006, p. 3). Other assaultive behaviors sometimes are referred to as “minor assault” and include “slapping, pushing, shoving, grabbing, throwing objects at the victim,” with these behaviors being “less likely to evoke medical or criminal justice consequences” (D. G. Dutton, 2006, pp. 3–4). These definitions reflecting criminal justice policy are pertinent because they represent how the legal system defines DV and, consequently, charges defendants for these actions. Qualifying for these definitions may be the

only way for DV survivors to receive social aid or other legal services, or to obtain protection orders against abusers. Additionally, behaviors adhering to the definition may result in abusers being criminally prosecuted, whereas a lack of adherence to the definition may not result in legal action against perpetrators.

Definitions of and subsequent punishments for abuse also vary slightly from state to state. As Kansas police officer Sam Dean explained in a 2010 presentation given to Safe Haven advocates, in Kansas, *domestic battery* is "battery against a family or household member by a family or household member . . . [and is] intentionally causing physical contact with a family or household member when done in a rude, insulting, or angry manner" (K.S.A. 21-3412a, 2009). Domestic battery can result in arrests and possibly felony or misdemeanor charges, depending on the severity of the violent act. In Kansas, under statutes K.S.A.22-2401 and K.S.A.22-2307, a law-enforcement officer needs only *probable cause* to arrest a batterer for domestic battery charges (Dean, 2010), which is present if it is more likely than not that a person committed a crime. If there is probable cause to believe that domestic battery occurred, the officer *must* make an arrest at the scene, in accordance with the Kansas statutes, as well as the Violence Against Women Act, which is a federal legislation (Dean, 2010). However, as Dean (2010) explained, a mandated arrest at the scene does not guarantee that the case will go to a district attorney for felony or misdemeanor charges, because some officials opt to not charge defendants to preserve the sanctity of the family (even if the abused person may be in danger). Therefore, whether a defendant will be charged with a felony or a misdemeanor usually depends on the ability to produce evidence of *actual* physical harm, as well as on district attorneys' and judges' biases regarding DV as a family or legal issue. Obviously, charges for domestic battery vary wildly, as

domestic battery is defined and interpreted differently depending on those making the arrests and charging defendants (Dean, 2010).

Although the legal system uses these qualifications to define DV, other conceptualizations of DV entail much more than the physical abuse "needed" to qualify under contemporary United States law. For example, Denzin (1984) broadened the legal definition of DV to include "situated, emotional, and cognitive activity involving negative symbolic interaction between intimates, usually in the family or home" (pp. 483–484). Denzin, thus, acknowledged the significance of controlling behaviors that usually correspond with physical abuse.

Moreover, according to Johnson (2008), the second wave of the women's movement and "thirty years of feminist research on men's use of violence to control their partners" has led to a more nuanced understanding of how abusive partners use a "general exercise of coercive control" (p. 25) with their romantic partners. These behaviors are known as *intimate terrorism* (Johnson, 2008, p. 25), which is defined as "partner violence deployed in the service of general control" such as mental, emotional, physical, sexual, economic, and/or spiritual abuse (such as not allowing a partner to practice or participate in spiritual matters; Johnson, 2008, p. 7).

The "Power and Control Wheel," developed by researchers using testimony from abused women in Duluth, Minnesota, is a widely used representation of the forms of DV (Johnson, 2008; see Appendix A). The Power and Control Wheel illustrates the dynamic nature of DV by including controlling tactics that abusers often use to maintain power and control in a relationship, such as coercion and threats; intimidation; emotional abuse; isolation; minimizing, denying, and blaming; using children against the partner; economic abuse; and using male privilege. According to that conceptualization and as the wheel exemplifies, DV can take many

forms and be enacted through various behaviors, even though the legal system may not recognize those forms of abuse or use them as the basis of prosecution.

Although the wheel conceptualizes DV by identifying specific behaviors instead of offering abstract definitions, it minimizes dyadic factors within relationships. For example, as discussed further in Chapter Six, in the DV support group that I facilitated, women sometimes saw the wheel and began to think of themselves as "abusers" when their narratives reflected that their behaviors were retaliatory in nature. In other words, some of their behaviors constituted resistance or retaliation to violence that initially was committed against them.

Thus, Johnson's (2006) typology of *types* of DV is extremely helpful for conceptualizing DV. As Johnson explained, a failure to recognize the "different origins, different dynamics, and different consequences" and varying types of DV has "led to major errors in the empirical literature on IPV, and perhaps on violence in other types of relationships" (p. 558). In other words, if DV is viewed *only* in terms of the metanarrative of one person viciously abusing another, nuances and complexities of IPV are missed (see Loseke, 1987).

After conducting a metaanalysis on current DV research, Johnson (2006) proposed three types of DV to highlight those differences and to clarify contradictory results in the DV literature: (a) intimate terrorism, (b) violent resistance, and (c) situational couple violence. Intimate terrorism (IT) resembles the stereotypical (yet sometimes true) view of the abused person being controlled by the "brute," a narrative that often is found in public narratives of DV (Loseke, 1987). In those instances, a person enacts a system of behaviors to gain power and control over his or her partner; that system of controlling behaviors usually includes many of the behaviors found in the Power and Control Wheel. According to Johnson, mostly men commit IT. The second type of violence is violence resistance (VR), in which the person who is being

controlled by another uses violence to fight back to protect her or himself, or as retaliation for abuse. Johnson argued that mostly women commit VR. The third type of violence is situational couple violence (SCV), in which violence is mutual and symmetrical, and, generally, occurs during conflict. However, the *effects* of the violence may not be symmetrical, as Anderson (2002) found that women experienced slightly more negative effects of symmetrical verbal aggression than did men. Couples who experience SCV usually do not engage in power and control tactics during their everyday lives but they become aggressive and violent during conflict situations (Johnson, 2006).

These distinctions are extremely important when conceptualizing and conducting research about DV, because the lack of distinctions can confuse the interpretation of the results and create erroneous implications. For example, Johnson (2006) argued that there are mixed results regarding the intergenerational transmission of DV, but when those categories are analyzed separately, the results become clearer. Witnessing DV as a child is significantly associated *only* with DV as an adult, but not with SCV or VR (Johnson, 2006).

Another politically important issue is the extent to which women abuse men. Johnson (2006) argued that studies support the idea that samples from DV services (such as shelters) mostly consist of victims of IT, whereas general surveys (such as National Crime Surveys) mostly consist of victims of SCV. When considering sampling methods, it is not surprising to see how some would make the argument that women abuse men more than men abuse women, if the study consisted primarily of general population responses concerning the more common SCV. As Johnson pointed out, not taking these distinctions into account can have tremendous implications for policy; for example, if it is believed that women abuse men as much as men abuse women, funding for services for abused women could be reduced.

Johnson (2006) provided other examples of how his typology can clarify mixed results regarding correlates of DV. For instance, age is negatively associated with IT but not with SCV, income is negatively related to SCV but not IT, education is negatively related to both SCV and IT, and race is related to SCV but not to IT for African Americans. By not considering the roles that people play in DV and its intensity, researchers may draw erroneous conclusions that do not reflect the complexity of DV.

There are many other ways to conceptualize DV, such as feminist viewpoints, the nested ecological view (which includes macrosystem, exosystem, microsystem, and ontogenetic approaches), and communicative, interpersonal views (see, e.g., Barnett et al., 2005; D. G. Dutton, 2006; Feldman & Ridley, 2000; Flower, 2000; Hines & Malley-Morrison, 2005; Infante, Chandler, & Rudd, 1989; Infante, Sabourin, Rudd, & Shannon, 1990; Jacobson & Gottman, 1998; Jenkins & Davidson, 2001; Loseke, 2009; Loue, 2001; Lloyd & Emery, 2000; Renzetti & Miley, 1996; Ridley & Feldman, 2003; Sabourin, 1995; Wood, 2001). Additionally, regarding the *cause* of DV, Fals-Stewart and Kennedy (2005) argued that

> it is now widely accepted that the occurrence of violence between intimate partners is the culmination of multiple, interacting contextual, social, biologic, psychological, and personality factors that exert their influence at different times, under different circumstances, acting in a probabilistic fashion. (Crowell & Burgess, 1996, p. 6)

However, for the frame of this project, the legal view, the advocate view, and Johnson's (2006) view from his metaanalysis appear to be the conceptualizations that the women in the DV support group at New Beginnings are confronted with most often. Although those women are held within the bounds of legal conceptualizations (e.g., if pursuing legal action against an abusive partner), they often are informed about DV through advocates' conceptualizations,

which often stem from the Power and Control Wheel. Additionally, as discussed in Chapter Six, adding Johnson's typology often helped these women to make sense of their situations.

The women at New Beginnings who participate in the DV group, nonetheless, spend the majority of their time at the facility learning about substance abuse, examining the potential root causes for their addiction, and processing root causes and consequences of their addiction. Accordingly, the next section of this chapter addresses ways in which substance abuse and dependence are conceptualized by researchers and by practitioners.

Conceptualizing Substance Abuse/Dependence

In 2009, the U.S. Department of Health and Human Services completed a trend survey that consisted of more than 67,500 individuals participating in telephone interviews, with the findings revealing that "an estimated 22.5 million persons (8.9 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year" (p. 6). Among those 22.5 million persons, "3.2 million were classified for BOTH illicit drugs and alcohol . . . 3.9 million were classified for illicit drugs but NOT alcohol . . . [and] 15.4 were classified for alcohol but NOT drugs" (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2009, p. 6).

Similar to conceptualizing and counting occurrence of DV, conceptualizing and counting occurrence of substance abuse or dependence, known colloquially as "addiction," also inherently is political, because it reflects values regarding the morality of addiction and which "drugs of choice" are appropriate or inappropriate to use. For example, someone who may be perceived to be "addicted" to healthy eating and exercise would not be considered to be an "addict," because that term usually is reserved for someone whose subject of addiction is perceived by members of society to be negative. As Keane (2002) described, even the anorexic, who would be considered

to be an addict by the medical profession, nonetheless, is a "compelling figure, often evoking a response of horror tinged with admiration. On one hand her self-starvation is bizarre and inexplicable to those close to her, yet it is also an emblematic, intelligible form of bodily discipline" (p. 113). In this sense, the addicted person shows the utmost bodily discipline and control over his or her behavior, which, potentially, is viewed in stark contrast to the stereotypical addict, such as a "junkie" who is controlled by an illegal drug and will do anything for the "next fix."

Therefore, defining addiction implicitly hinges on beliefs regarding individual control and whether the subject of addiction is viewed positively or negatively. As Keane (2002) argued, "Other habitual and routine patterns of behaviour regarded as benign or positive may well be just as resilient to change; the strength of their hold generally escapes notice because attempts are not made to give them up" (p. 3). Thus, being addicted to, for instance, care-giving (codependency), maintaining one's health, and overworking may not be considered negative in social or cultural views because those activities are upheld and accepted. The result of the addiction also is a factor; for instance, if one is addicted to working, it may not be considered a problem until family or friends mention the negative toll that it is taking and suggest that the person has a problem. On the other hand, if the person receives recognition at his or her job, as well as success from working that hard, such activity may not be viewed as a problem or as an addiction.

Furthermore, according to Doweiko (2006), a licensed psychologist and practitioner who works with those seeking substance abuse treatment:

> There is much confusion in the professional community over the problems of substance abuse/addiction. Even in the case of alcoholism, the most common of the drug

> addictions, there is an element of confusion or uncertainty over what the essential features of alcoholism might be. (p. 13)

As Doweiko further explained, “Much of what is ‘known’ about addiction is based on mistaken assumptions, clinical theory, or, at best, incomplete data” (p. 12). Most of the research on substance abuse and addiction has been conducted with participants at treatment centers, Veterans Administration hospitals, or in public, state facilities. Thus, as Doweiko stated, “A serious question that must be asked is whether individuals in treatment are representative of *all* drug/alcohol addicted persons” (p. 13).

Doweiko (2006) and Keane (2002) argued that much of what is known about addiction is based on “moral” models. Some scholars and practitioners conceptualize substance abuse and addiction using medical and psychological models (Doweiko, 2006), whereas others use moral models (Doweiko, 2006; Keane, 2002), and still others use a disease model (Doweiko, 2006). Regardless, Carr (2011), who conducted a 3-year ethnographic study of a substance abuse treatment center, asserted that much of the knowledge and practice about substance abuse inherently is political and scripted.

Although definitions of addiction and substance abuse or dependence may vary based on cultural values and norms, an often-used source of definition for substance abuse or dependency is the Diagnostic Statistical Manual (DSM-IV), which classifies substance abuse or dependency in clear-cut terms, and which is used for the actual diagnosis of substance abuse or dependence (Doweiko, 2006; Keane, 2002). However, even receiving a diagnosis for substance abuse or dependence, generally, is a subjective enterprise; whereas one clinician may believe that someone fits the criteria for a diagnosis, another clinician might disagree because the criteria are subject to opinion.

According to the American Psychiatric Association's (1994) Diagnostic Statistical Manual (DSM-IV), "a person can be abusing a substance or dependent on a substance but not both at the same time" (p. 181).[2] Colloquial knowledge regarding substance abuse or dependence may vary, but for someone to clinically be diagnosed with substance abuse or dependence, he or she must fit the criteria described below, according to the DSM-IV (1994):

> Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:
>
> 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).
> 2. Recurrent substance use in situations in which it is physically hazardous (such as driving an automobile or operating a machine when impaired by substance use).
> 3. Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct).
> 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights). (pp. 181–183)

Whether a woman seeks treatment voluntarily or is mandated to receive treatment, she receives an assessment by a New Beginnings staff member before receiving treatment to determine the

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[2]After the prospectus of this dissertation was approved by the committee, the American Psychiatric Association released the DSM-V in May, 2013.

best treatment plan for her situation. Accordingly, someone who is diagnosed as having a substance abuse problem would more than likely be expected to stay 28 days at New Beginnings, which is a "typical" length of stay. However, someone diagnosed with substance dependence may enter at a different level, have more intense treatment, and stay for a longer period of time. According to the DSM-IV (1994):

> Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:
>
> 1. Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or (b) Markedly diminished effect with continued use of the same amount of the substance.
> 2. Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance, or (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
> 3. The substance is often taken in larger amounts or over a longer period than intended.
> 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
> 5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
> 6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
> 7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the

> substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption). (pp. 181–183)

Substance dependency, generally, is considered to be more serious than is substance abuse because of the effects that tolerance, withdrawal, and general addiction have on the body. A person entering New Beginnings with a diagnosis of substance dependency might be admitted for detoxification and expected to have a longer stay—even months, if needed.

However, even these criteria are not comprehensive. As the University of Maryland Medical Center (2011) pointed out:

> A physical dependence on a substance (needing the drug to function) is not always part of the definition of addiction. Some drugs (for example, certain blood pressure medications) do not cause addiction but they can cause physical dependence. Other drugs cause addiction without leading to physical dependence. Cocaine is an example. (para. 2)

Obviously, defining substance abuse is a political act that reflects cultural norms, beliefs, and attitudes regarding the morality and result of addictive behaviors. However, receiving the diagnosis of substance abuse or dependence, or being labeled as an addict for using *illegal drugs or alcohol*, inherently, is viewed as being negative by societal members, and it may likely result in some form of treatment (Keane, 2002).

Summary

This chapter examined how DV and substance abuse are conceptualized, and, as mentioned in Chapter One, how the issues of DV and substance abuse can exacerbate each other when they both occur. Consequently, these issues are important to examine together (NCADV,

2011). Moreover, receiving services for one issue may provide an opportunity to receive services for the other. For example, a person may be court-mandated to attend substance treatment after his or her third ticket for driving under the influence, although that person may not be diagnosed with a substance abuse problem. If that person is involved in a relationship permeated by DV, he or she, hopefully, can receive services and information regarding this issue within the mandated treatment program. The next chapter, Chapter Three, examines the relationship between DV and substance abuse, and why these issues should be examined together when they both are present.

Chapter Three: Co-occurring Issues of Domestic Violence and Substance Abuse

Although substance abuse does not necessarily cause domestic violence (DV), or vice versa, studies have found connections between the two issues. As mentioned in Chapter One, some batterers tend to abuse illegal drugs and alcohol, and DV increases the probability that victims will use alcohol and illegal drugs to cope with abuse. This chapter examines the correlation between DV and substance abuse, as well as the importance of addressing both issues simultaneously with people who experience DV and substance abuse.

Connections between Domestic Violence and Substance Abuse

According to Fazzone et al. (1997), researchers and advocates agree that DV and substance abuse are correlated but that “its precise nature remains unclear” (p. 14), leading researchers to continue to explore their relationship. As noted already, Johnson (2006) argued that most correlational research regarding DV confounds different *types* of DV, a problem that might explain unclear results regarding the correlation between DV and substance use. The studies reviewed below, indeed, show a correlation between the two issues, but there may have been subtle differences in the results if intimate partner terrorism (IPT), violent resistance (VR), and situational couple violence (SCV) had been examined as separate types of DV. Regardless, many studies have found statistically significant correlations between DV and substance abuse, and they frequently occur together (see, e.g., Chase et al., 2003; D. H. Coleman & Straus, 1983; Gondolf, 1995; Hamilton & Collins, 1981; Holtzworth-Munroe et al., 2000; Kantor & Straus, 1989; Leonard & Jacob, 1988; Logan et al., 2001; NCADV, 2011; Pernanen, 1991; Stuart et al., 2006; Testa et al., 2003).

Many studies focus, in particular, on the connection between substance abuse and DV for batterers. Researchers have found, for instance, that one fourth to one half of men who commit

acts of DV also have substance abuse problems (D. H. Coleman & Straus, 1983; Gondolf, 1995; Hamilton & Collins, 1981; Kantor & Straus, 1989; Leonard & Jacob, 1988; Pernanen, 1976). Additionally, Bennett and Lawson (1994) reported that the substance abuse treatment providers in their survey estimated that about half of the men entering substance abuse treatment engaged in IPV with their partners. Furthermore, the NCADV (2011) reported that

> the U.S. Department of Justice found that 61% of domestic violence offenders also have substance abuse problems. Batterers living with women who have alcohol abuse problems often try to justify their violence as a way to control their victims when they are drunk. Men who batter frequently use alcohol abuse as an excuse for their violence. They attempt to rid themselves of responsibility for their violence by blaming it on the effects of alcohol. (p. 1)

The NCADV also reported that a 1994 study conducted by the U.S. Department of Justice on murder in families "found that more than half of defendants accused of murdering their spouses had been drinking alcohol at the time of the incident" (p. 1). Obviously, the dangerous connection between *batterers* and substance abuse cannot be ignored when the consequences for victims, literally, can be life or death.

Of equal importance, researchers have found a connection between substance abuse and *victims* of DV. For example, Collins and Spencer (2002) found that 36% of victims in DV programs also had substance abuse problems. Moreover, The National Center on Addiction and Substance Abuse found that 69% of women in treatment for substance abuse reported that they had been sexually abused as children (as cited in NCADV, 2011). Additionally, as mentioned in Chapter One, Stark and Flitcraft (1996) found that women who have experienced DV are 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs than women who have

not experienced DV. Survivors of abuse also may use and abuse substances to cope with the abuse, or they may be coerced into using by an abuser with substance abuse issues. Thus, both DV abusers and survivors may have a significant likelihood of also having substance abuse or dependency issues.

Not only are DV and substance abuse correlated, but these issues can co-occur and exacerbate each other. For example, according to the National Violence Against Women Survey, for both male and female physical assault victims, the risk of injury *increased* if the perpetrator or victim "used drugs and/or alcohol at the time of the incident" (Tjaden & Thoennes, 2000, pp. 51–52). If there is an episode of violence and the abuser *or* victim is intoxicated or high, that person's lack of inhibition may increase the severity of violence, resulting in mutual violence, or limiting a victim's ability to safely escape or defend her or himself against the violence.

These connections between DV and substance abuse have important consequences regarding social norms as well. Societal misconceptions regarding both issues may perpetuate the potentially false idea that substance abuse treatment will "cure," or at least minimize, abusive behavior, which it usually does not (Fazzone et al., 1997). Even if substance abuse treatment *might* mitigate excessive violence that may occur with the loss of inhibition from intoxication, the batterer may behave in other controlling or abusive behaviors in lieu of physical violence, such as engaging in emotional abuse (for reviews of batterer intervention strategies and outcomes, see Gondolf, 2002; Mederos, 1999).

Fazzone et al. (1997) also explained that societal misunderstandings and stigmas regarding the connection between DV and substance abuse may result in blaming victims if those survivors also are substance abusers. Fazzone et al. argued that it is more socially accepted for

men, rather than women, to have a substance abuse problem, and that people may blame survivors for the abuse if they also attach negative stigmas regarding substance abuse to them (Fazzone et al., 1997). Thus, some might think that survivors are abused *because* of their substance abuse—to keep them "in line." For example, imagine what misinformed police officers might think if they pull up to a house on a DV call and the victim is intoxicated or high. They might not take the issue as seriously. They might partially blame the victim, or they might not believe him or her.

The Importance of "Bridging" Domestic Violence and Substance Abuse Services

Because DV and substance are significantly correlated, can exacerbate each other, and can be stigmatized by society, agencies should address these issues simultaneously to better promote safety and wellness in their communities (see, e.g., Bland & Edmund, 2008; Engelmann, 1992; Fazzone et al., 1997). For example, a substance abuse treatment center may help a woman to become clean and sober, but what may happen to her when she returns home to her abuser? Alternatively, a DV center may help a woman feel safe and empowered, but how will she move forward with a substance abuse issue? If DV and substance abuse co-occur, each issue potentially impedes recovery from the other. Promoting holistic safety and wellness, thus, can occur most effectively when local DV and substance abuse agencies bridge their services.

For example, consider the following hypothetical situations that are based, loosely, on experiences women shared with me at Safe Haven and New Beginnings:

Example 1: *A woman has been emotionally and financially abused, isolated, and controlled for years by her partner, who is an alcoholic and uses methamphetamine. He frequently pressures her into engaging in these activities as well. After some time, she begins to drink more frequently and use methamphetamine by herself because it numbs her pain and*

makes her feel better. She thinks that she might be in an abusive relationship, but she feels that no one will believe her and that it is not technically DV because he does not hit her. However, the DV eventually escalates to physical violence. During an argument when they were both high, he put his hands around her neck, slammed her against a wall, and punched her. The following day, she called a DV agency's 24-hour hotline and entered a shelter.

At the shelter, she is told that DV is more than just physical violence, and she begins to recognize the abuse for what it was—power and control tactics. She uses her time at the shelter to find a job and to obtain housing, beginning to take control of her life. She anxiously awaits the day when she can move into her new apartment. Group living is not always fun and the time at the shelter often has been stressful. Some nights, she wishes that drinking alcohol was allowed at the shelter.

After living on her own, she begins to feel lonely and misses her abuser; after all, she loves him and he is not "always" abusive. She feels scared, intimidated, and depressed. After some time, she calls the only dealer she knows—the one who her abuser contacts as well—and meets up with the dealer because she believes that it will help her to cope with her new situation.

From here, one might guess where the hypothetical story goes: The dealer could tell the abuser about the survivor the next time that he passes through, meaning that her safety now is compromised. If DV agencies ignore such substance abuse issues with survivors, they essentially are saying, "We will provide information and resources to leave your abuser if you want, and, by the way, good luck dealing with your new situation with that substance abuse problem that we pretended we did not notice!" Additionally, many DV shelters have policies in place to immediately "exit" a woman if she has drug paraphernalia with her. Thus, if a woman is

kicked out of a DV shelter because of a substance abuse issue, where will she more than likely go—perhaps straight back to her abuser?

Example 2: *Same woman, different situation. After drinking for a few hours, the man demands that the woman visit their dealer because they are out of methamphetamine. She knows that she is over the blood-alcohol limit to drive, but she does not want to start an argument, so she gets in her car, drives to the dealer's house, makes the exchange, and begins to drive home. Then: swirling police car lights, walking the line, a pat-down, a car search, handcuffs, judge, "Third Offense," and landing in a drug treatment center. It was all a blur to her, and now she feels angry and scared.*

At the center, the woman makes great progress. She receives counseling regarding abuse that she endured as a child, and she works on building her self-esteem up a bit. She successfully navigates the 12 steps of the program and becomes clean and sober. She anxiously awaits her check-out day.

On that day, her husband picks her up . . .

One can probably tell how this hypothetical story most likely plays out as well: If substance abuse treatment centers ignore the DV that is occurring, they are essentially saying, "We will help you get clean and sober, but good luck staying that way when you return to your abuser!" If DV and substance abuse co-occur, they, undoubtedly, can exacerbate each other and possibly impede recovery from both DV and substance abuse.

Challenges of "Bridging" Services

Although it is a worthy and important pursuit for DV and substance abuse agencies to bridge their services to better promote safety and wellness for those seeking their services, there are inherent challenges to doing so. First and foremost, those agencies tend to have basic

differences in their philosophies and messages. According to the Alaska Network on Domestic Violence and Sexual Assault (Bland & Edmund, 2008), those basic differences in philosophy may present conflicting messages from representatives of those agencies. If advocates and counselors are not aware of these conflicting messages, those hearing them may be confused. Here are some examples of those messages from the Alaska Network's (Bland & Edmund, 2008) handbook regarding multitrauma support groups:

> ***Substance abuse counselor:*** You have a disease. You need treatment.
>
> ***Women's advocate:*** You are a victim of a crime. You need justice.
>
> ***Substance abuse counselor:*** Your priority must be sobriety.
>
> ***Women's advocate:*** Our priority is your safety.
>
> ***Substance abuse counselor:*** You must accept your powerlessness.
>
> ***Women's advocate:*** You need to be empowered.
>
> ***Substance abuse counselor:*** You need to look for your part in your problems.
>
> ***Women's advocate:*** You are not responsible for what happened. The perpetrator must be held accountable.
>
> ***Substance abuse counselor:*** You need to change yourself and be of service to others.
>
> ***Women's advocate:*** We need to change society. (Handout section, Sorting Out Messsages, para. 2)

These conflicting messages can be reconciled and handled in ways to show that they all can be true, but it can be problematic or confusing for women receiving such conflicting messages when those presenting such messages are not aware of their basic differences. For example, DV advocates at Safe Haven often help women to engage in "safety planning," which allows them to stay as safe as possible within dangerous situations. In contrast, New Beginnings

helps women to form "relapse prevention plans," which involves forming plans to help them avoid relapse. Both types of planning—safety planning and relapse prevention planning—often include avoiding people who may exacerbate the situation. By being aware of these differences and similarities in the plans, advocates can help women to form prevention plans for both DV and drug relapse.

Moreover, as mentioned earlier, both DV and substance abuse are stigmatized issues (Bland & Edmund, 2008). According to Bland and Edmund (2008), Western society tends to view addiction as a moral failure rather than as a health problem. Furthermore, feelings of guilt and isolation of those dealing with substance abuse might be compounded when DV occurs as well (Bland & Edmond, 2008).

Agencies also may have difficulties bridging their services because of a lack of funding and training (Fazzone et al., 1997). Successfully bridging DV and substance abuse agencies requires time, people, and resources. Because many agencies are operating with nonprofit budgets, finding resources to bridge the agencies may be difficult. Additionally, as Fals-Stewart and Kennedy (2005) argued:

> Substance abuse treatment providers and programs have not raised [intimate partner violence] as a primary concern because they believe their plate is full. They are being asked not only to address substance use, but also psychiatric comorbidity, legal issues, medical problems, educational and vocational deficiencies, and so forth. Adding an issue as complex and controversial as IPV appears overwhelming. (p. 15)

If most clients stay for 28 days at a substance abuse treatment center, there, indeed, are many issues that potentially need to be addressed. However, places such as New Beginnings that take a holistic approach to treating substance abuse may be more likely to consider issues of DV.

Fazzone et al. (1997) also argued that even if adequate resources are available and agencies are willing to address co-occurring issues of DV and substance abuse, there may be a considerable lack of training from those fields in each other's areas. This lack of training in the other area may lead to consequences ranging from not even noticing the other issue because of poor screening, to not knowing how the issues relate, to not knowing enough about the issue to properly provide support and information (Fazzone et al., 1997).

Summary

Although both DV and substance abuse are fraught with controversy regarding their definitions, causes, and effects, should communities *not* attempt to help people with these issues when such help is requested? Obviously, more research is needed regarding these issues, such that advocates, counselors, law-enforcement, and communities can move forward in the most informed ways. Although bridging services between DV and substance abuse agencies presents communicative challenges, informed members from both agencies, nonetheless, can work together to better promote safety and wellness with their clients, which, ultimately, promotes safety and wellness within a community. Because these issues have a strong correlation, can exacerbate each other, and can impede recovery from either, bridging these services is a worthy pursuit. The following chapter, Chapter Four, addresses the importance of multi-issue support groups that address both DV and substance abuse. Accordingly, Chapter Four focuses on relevant literature about social support and support groups, in general, as well as social support within support groups. Dilemmas and attributes of successful support groups also are discussed.

Chapter Four: Social Support and Support Groups

Chapter Three argued that it is a worthy pursuit to bridge domestic violence (DV) and substance abuse services, even though that bridging process presents certain challenges. Additionally, as mentioned in Chapter One, agencies, advocates, and researchers have called for more model programs that bridge substance abuse and DV agencies' services, and the official report by the Domestic Violence and Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services (2005) and the Alaska Network on Domestic Violence and Sexual Assault (Bland & Edmund, 2008) recommended that DV advocates should provide support and services for people in substance abuse treatment programs, and that substance abuse counselors should provide support and services for survivors of DV. Specifically, those reports recommended support groups as an effective rehabilitation option for substance abuse and effective coping for survivors of DV.

The following sections, first, address how social support, given its significance in support groups, is conceptualized in the literature (e.g., Cline, 1999; Hobfoll, 2009; Sarason & Sarason, 2009; Vangelisti, 2009). I then provide an overview of characteristics of support groups, how researchers examine support groups, and the possible benefits and dilemmas of support groups. The chapter concludes with the research question posed for the current study.

Social Support

Sarason and Sarason (2009) argued that although social support is a necessary and worthwhile research pursuit, researchers still do not have consensus regarding its conceptualization, how to effectively and reliably assess it, and how to interpret findings about it. Burleson, Albrecht, Goldsmith, and Sarason (1994) also mentioned disagreements within the study of social support but maintained that studying social support has pragmatic, theoretical,

and moral imperatives. Thus, although the study of social support is important because of its potentially powerful positive (and negative) effects, communication scholars have argued that the construct needs further clarification and refinement (see, e.g., Hobfoll, 2009; Rook & Underwood, 2000; Sarason & Sarason, 2009; Vangelisti, 2009). The subsequent sections describe prominent ways in which social support has been conceptualized, followed by important theoretical and methodological issues involved in the study of social support.

Defining social support. There are varying definitions for social support, but Burleson et al. (1994) and Cutrona's (1996) definitions are often utilized in social support literature and research. Burleson et al. conceptualized *social support* simply as verbal and nonverbal behaviors enacted to help someone in need of those behaviors. Cutrona broadened the concept of social support by arguing that it is

> conceptualized most generally as responsiveness to another's needs and, more specifically, as acts that communicate caring; that validate the other's worth, feelings, or actions; or that facilitate adaptive coping with problems through the provision or information, assistance, or tangible resources. (p. 10)

Even more broadly, Cutrona viewed social support as an ongoing process (see also Goldsmith, 2004), arguing that social support does not just occur in times of stress or need but also in everyday, mundane moments of life. In Cutrona's view, social support is a part of building intimacy, trust, and love because it is the fact of "being there" and engaging in everyday support that buffers people from *potential* stress, as well as helps them in times of need.

Types of social support. Perhaps the mostly widely used typology of social support was provided by Cutrona and Suhr (1992), who categorized support into five types: informational, tangible, emotional, network, and esteem. *Emotional* support is "communicating love, concern,

or empathy"; *esteem* support is "communicating respect and confidence in abilities"; *informational* support is "providing information about the stress itself or advice on how to deal with it"; *tangible* support is "providing or offering to provide goods or services needed in the stressful situation"; and *social network* support is "communicating commonality with or belonging to a group of persons with similar problems or interests" (Cutrona, Hessling, & Suhr, 2005, p. 384).

Conceptualizing and measuring social support. Burleson and MacGeorge (2002) described how the study of social support began over a century ago when English and French scholars noted a correlation between marriage and health, with the support that marriage provides appearing to be health promoting. Much later, in the 1970s, social support was conceptualized from the support *receiver's* view, with social support viewed as feeling cared for and loved (Burleson & MacGeorge, 2002; see also G. Caplan, 1974), or feeling that one "belonged" (Burleson & MacGeorge, 2002; see also Moss, 1973). Since then, social support, generally, has been approached and conceptualized from three perspectives: (a) sociological, (b) psychological, and (c) communication perspectives (Burleson & MacGeorge, 2002). The following sections describe these three views, as well as how researchers approach studying social support within these views.

The sociological approach. In general, the sociological approach focuses on the number and benefits of social ties, and it assumes that having many social ties within a network correlates with positive health outcomes because there is a solid network of support providers (Burleson & MacGeorge, 2002). In a foundational study within this tradition, Berkman and Syme (1979) examined how people's social integration (i.e., the extent of their group memberships and how often they interact within those in their groups) influenced their health

and mortality. Berkman and Syme found that those who had more social ties and who were more socially integrated had lower mortality rates and were less likely to have various health-related issues or illnesses. Since Berkman and Syme's study, numerous other scholars have found a correlation between social integration and positive health outcomes (see reviews by Berkman, Glass, Brissette, & Seeman, 2000; Cohen, Gottlieb, & Underwood, 2000).

Conversely, Burleson and MacGeorge (2002) argued that the structure of people's network is related only weakly to health outcomes because not all social ties are health promoting. For example, Rook (1990) found that even though relational networks provide support, they also may produce stress. Thus, social integration may both promote and hinder positive health outcomes (see also La Gaipa, 1990; Rook & Underwood, 2000). Accordingly, "counting" social network members and relating that number to health outcomes may not appropriately assess the correlation between health and social support (Burleson & MacGeorge, 2002). Additionally, Burleson and MacGeorge argued that health outcomes are best predicted by how and whether individuals *perceive* the availability of support and the quality of the support provided rather than the number of people in their networks. The psychological approach, which is discussed in the next section, focuses on perceptions about the availability of support, as well as psychological processes and individual states and traits that affect support processes.

The psychological approach. Whereas the sociological approach to studying social support focuses on social integration, the psychological view focuses on individual states and traits that affect the social support process, as well as psychological processes involved in receiving and perceiving social support (Burleson & MacGeorge, 2002). In this tradition, special attention is paid to the link between received support (actual supportive behavior) and perceived

support (i.e., how receivers perceive supportive behavior; Burleson & MacGeorge, 2002; see also Rook & Underwood, 2000). Scholars within this tradition, generally, have studied how the *amount* of support provided (for a review, see Wills & Shinar, 2000) and how perception of the *availability* of support influence health and well-being (Cohen & Wills, 1985; Kessler, 1992). For example, if people perceive that support is available from their network if needed, even the *mere perception* of support availability can have powerful effects on their coping (see Rook & Underwood, 2000). Moreover, to explain the link between support and well-being, the psychological view focuses on cognitive processes, such as *appraisal*, a process "in which [a] person evaluates the significance of events for personal well-being" (Lazarus & Lazarus, 1994, p. 232).

Overall, Lazarus's (1991; see also Lazarus & Lazarus, 1994) appraisal theory explains that how people interpret, or *appraise*, stressful events has greater effects on their experience of stress than do actual stressful events. Thus, how people perceive a stressful event (e.g., whether it is controllable or whether it is viewed positively or negatively) can have powerful effects on their well-being (Lazarus, 1991; Lazarus & Lazarus, 1994). Accordingly, Lazarus (1991) argued that social support is especially needed when individuals examine their coping options and appraise stressful situations such that they believe they do not have control over those situations. In those situations, problem-focused coping (i.e., coping strategies that focus on "solving" a problem) may not be an option, and emotion-focused coping (i.e., coping strategies that focus on making people feel better, or gaining more perspective, about their situation) may be a better option (Lazarus, 1991; Lazarus & Lazarus, 1994). Social support from others may help people to *reappraise* those situations in different ways, and that reappraisal may help them to feel less stressed and more positive after reframing those situations (see Burleson & Goldsmith, 1998).

Burleson and MacGeorge (2002) explained that the psychological view, which focuses on psychological processes, such as appraisal and perceptions of support availability, is “both important and exciting” (p. 383), but that it has limitations because it does not consider how interaction with others influences those cognitive processes (see also Burleson et al., 1994). In contrast, the communication approach, as described in the following section, foregrounds interaction within the study of social support and considers the role of relationships and context in support processes.

The interactional approach. The interactional approach places interaction/communication between people at the forefront of studying social support. This view focuses on enacted support (i.e., actual supportive behaviors provided and how and why they are provided), how social support relates to individual and relational well-being, the role of providers’ intentions in providing social support, and “interaction and relationship outcomes” (Burleson & MacGeorge, 2002, p. 386; see also Goldsmith, 2004) associated with social support. Overall, the interactional view considers the overarching communicative context involved in giving and receiving social support, and it grounds the examination of social support in interactional processes between people and within their unique relationships. From an interactional perspective, social support is viewed as communicative exchanges that frequently occur and that are ongoing in relationships (Burleson et al., 1994; see also Goldsmith, 2004). From that view, assessing social support (including messages and interaction) leads researchers to question *why* and *how* support providers attempt to offer support, and *why* and *how* recipients may or may not be helped by those attempts (Burleson et al., 1994). Communication between people, therefore, is central to measuring social support, and support is measured within the context of relationships.

According to Burleson et al. (1994), foregrounding communication in the study of social support

> means studying the *messages* through which people both seek and express support; studying the *interactions* in which supportive messages are produced and interpreted; and studying the *relationships* that are created by and contextualize the supportive interactions in which people engage. (p. xviii)

Accordingly, communication scholars have examined an extensive array of topics that focus on messages, interactions, and relational contexts of social support. For example, communication scholars have focused on receivers' perceptions of helpful and unhelpful forms of social support (e.g., Barbee, Derlega, Sherburne, & Grimshaw, 1998; Dakof & Taylor, 1990; Davis, Brickman, & Baker, 1991; Lehman & Hemphill, 1990; Sullivan, 1996); aspects that distinguish perceived helpfulness of messages, such as humor and providers' skills (e.g., Bippus, 2000, 2001; Burleson 1994; S. M. Jones 2004, 2005); contextual factors influencing perceptions of received support (e.g., Cutrona, Cohen, & Igram, 1990; Dunkel-Schetter, Blasband, Feinstein, & Herbert, 1992; S. M. Jones & Burleson, 1997; Kunkel & Burleson, 1999); relational outcomes from social support (e.g., Acitelli, 1996; Burleson, 1990; Cobb, Davila, & Bradbury, 2001); and effects or outcomes of emotional support (e.g., Berkman, Leo-Summers, & Horwitz, 1992; Samter, 1992; Samter & Burleson, 1990; Sprecher, Metts, Burleson, Hatfield, & Thompson, 1995).

Although communication scholars' topics of interest regarding social support vary widely, Burleson and MacGeorge (2002) argued that four major method paradigms are used in the communication/interaction approach: (a) naturalistic paradigm, (b) interaction analysis, (c) message perception, and (d) experimental paradigms. First, the *naturalistic paradigm* is the "most frequently used approach in studies of support message effectiveness" and entails using

interviews or questionnaires to have "participants provide retrospective self-reports regarding 'helpful' and 'unhelpful' messages they have received from others" (Burleson & MacGeorge, 2002, p. 389; see also Clark & Stephens, 1996; Dakof & Taylor, 1990). This method is useful for understanding a range of behaviors that are considered to be helpful or unhelpful (Vangelisti, 2009). Additionally, Burleson and MacGeorge asserted that the main strength of this method paradigm is that it "examines instances of naturally occurring supportive communication in the context of real (and substantial) stressors and frequently preserves aspects of participants' natural language categories for these acts" (p. 389). However, Burleson and MacGeorge also argued that the major limitation of this approach is that it may only actually measure perceptions of support providers' *intentions* because others' intentions are easier for people to remember than are actual messages. Moreover, when using single-item measures, this method paradigm may not fully assess contextual and relational effects on support receivers' perceptions (Burleson & MacGeorge, 2002; see also Vangelisti, 2009).

Second, in the *interaction analysis paradigm*, researchers focus on conversations between people in a laboratory; these conversations are recorded and coded for types and frequencies of support (Burleson & MacGeorge, 2002; see Hill, 1996; Winstead, Derlega, Lewis, Sanchez-Huscles, & Clark, 1992). The strengths of this method paradigm are that it does not rely on participants' recall of events and it utilizes precise and realistic data, although researchers should be aware that the laboratory setting and chosen topics of conversation might influence the support process (Burleson & MacGeorge, 2002). Burleson and MacGeorge (2002) asserted that the major limitation to this approach is the same for the naturalistic paradigm: the coding used in this paradigm "obscures other dimensions on which messages vary and their effects on important outcomes" (p. 390).

Third, the *message perception paradigm* involves providing participants with various supportive messages and having them evaluate those messages and/or the providers using certain evaluative criteria (Burleson & MacGeorge, 2002; see also S. E. Caplan & Samter, 1999; Goldsmith & MacGeorge, 2000; Kunkel & Burleson, 1999; Samter, Burleson, & Murphy, 1987). The major strength of this paradigm is "its capacity to allow the researcher to isolate, control, and observe the effects of specific message features" (Burleson & MacGeorge, 2002, p. 391). Conversely, its major limitations are that the actual experience of receiving supportive messages in a time of distress may differ from evaluating them using a hypothetical situation, and that it is difficult to relate message *evaluations* to message outcomes (Burleson & MacGeorge, 2002).

Finally, the *experimental paradigm*, typically, involves researchers inducing some mild stress in participants and then exposing them to support messages, which then are assessed by participants (Burleson & MacGeorge, 2002). According to Burleson and MacGeorge (2002), this paradigm "combines the strengths of the interaction analysis and message evaluation paradigms, permitting the systematic manipulation of specific features of supportive messages and the evaluation of message effects on multiple outcomes" (p. 392). However, the major limitation of this approach is that the "experimental situation may limit the generalizability of the results" (Burleson & MacGeorge, 2002, p. 392).

Overall, because each method paradigm for studying social support has strengths and limitations, Burleson and MacGeorge (2002) recommended using multiple methods. Vangelisti (2009) and Sarason and Sarason (2009) also argued that researchers need to continue using a wide array of methods to clarify relationships between social support and positive and/or negative outcomes.

Furthermore, Goldsmith (2004) argued that studies where social support processes actually are observed between parties best enables researchers to examine how social support is collaboratively and rhetorically constructed. Moreover, Hobfoll (2009) argued that the entire approach to measuring social support has glimpsed only a “snippet” of an entire “movie” of social support. Hobfoll argued that, too often, researchers take “the easiest route” (p. 94) by using questionnaires, that they inaccurately measure what actually is happening in social support episodes, and that they are not doing justice to the rich complexities of providing and/or receiving social support. For Hobfoll, measuring specific behaviors of support during *one* specific interaction is like measuring a millionaire’s withdrawal of $20 from automated teller machines. Hobfoll’s reasoning is that people have “caravans” of social support providers that come and go during their lives, and that the context of their entire lives shapes how they perceive their support resources. Thus, like Goldsmith, Hobfoll argued for employing more nuanced methods to study social support.

Given that I am a communication scholar and that the current study focused on supportive interactions in the DV group at New Beginnings, as well as on group members’ perceptions about the support given and received, this study takes an interactional approach. However, as described in Chapter Six (which presents the results of this study), group members’ sense-making and appraisal processes vis-à-vis support processes also were integral regarding what was considered to be helpful and unhelpful about the group. Accordingly, the current study also draws from the psychological approach’s focus on appraisal, even as it foregrounds communication’s role in appraisal.

Moreover, in accordance with calls by Burleson and MacGeorge (2002) and Vangelisti (2009) to use multiple methods, and calls by Goldsmith (2004) and Hobfoll (2009) for more

nuanced ways of examining social support than currently are being employed, the current study included pairing participant observation of actual supportive communication within a naturally occurring group with informal and semistructured interviewing to examine actual communicative exchanges and support receivers' perceptions of support. As described in the subsequent chapter (Chapter Five: Methodology, Methods, and Data Analysis), the current study draws from the naturalistic paradigm (by conducting interviews regarding group members' perceptions of helpful and unhelpful communication within the support group) and from the interactional analysis paradigm (by observing actual supportive messages exchanged in the group). However, unlike the typical approach within the interactional analysis paradigm (Burleson & MacGeorge, 2002), the DV group at New Beginnings is *not* in a laboratory setting and is a naturally occurring group. Addition, as explained further in the next chapter, the group interactions were analyzed via participant observation because I did not believe that it was ethical to audio record the group and, thereby, possibly, influence group members' willingness to share and potentially affect their coping or treatment.

Additionally, Goldsmith, McDermott, and Alexander (2000) asserted that often-used, single-item measures of global perceptions of the "goodness" or "badness" of social support behaviors may miss nuances and complexities of how receivers evaluate support messages. For example, although there are similarities in interpretations between evaluations of helpful, supportive, sensitive, and effective messages (e.g., Goldsmith et al., 2000; Kunkel & Burleson, 1999; Samter et al., 1987), it is also possible that a support receiver might evaluate a message as helpful (e.g., it helped to solve a problem), but also as insensitive (e.g., the way the helpful advice was given was slightly demeaning). Thus, scholars should examine perceptions of received support in nuanced ways that illuminate complexities of how support is perceived

(Goldsmith et al., 2000). To examine these nuances, the current study used interviews to ask group members *how* and *why* messages were perceived as helpful, sensitive, and/or effective.

Support Groups

One way for people to access a "caravan" (Hobfoll, 2009) of social support when dealing with stressful life events is to participate in support groups. According to Cline (1999), *support groups* are "small groups formed for the specific purpose of providing mutual aid among members who share a common dilemma" (p. 516). Support groups began to gain popularity in the "self-help 1980s," with Wuthnow's (1994) national survey finding that up to 40% of United States Americans had been a member of a "supportive group" at some point. Cline argued that "industrialization and the growth of technology radically changed the geographic landscape and yielded parallel losses in familial and community social support" (p. 517), with the result being that people started turning to support groups as an alternative for interpersonal or dyadic social support (see also Wuthnow, 1994).

Traditionally, according to Alexander, Peterson, and Hollingshead (2003), support groups "have been loosely structured groups with less than 15 members that meet face-to-face" (p. 309), but with technological advances, thousands of support groups have been created online. Hence, communication scholars have examined both online and face-to-face support groups.

In the following sections, first, I describe characteristics of support groups. I then describe how scholars, typically, have examined support groups—from the macrolevel to the microlevel. I then explain how researchers have assessed support group outcomes. Finally, this chapter concludes with a summary of the literature and the posing of a research question.

Conceptualizing support groups. Overall, as mentioned above, support groups are *groups* of individuals who seek support from others who are facing a *similar issue* or dilemma

(Cline, 1999). The following sections examine the characteristics of support groups. First, I describe how they differ from other intervention groups (i.e., therapy groups and self-help groups). Second, I explore the underlying philosophy of support groups. Third, because support groups are *groups*, I provide an overview of relevant group communication perspectives.

Distinguishing support groups. As mentioned previously, support groups vary greatly in terms of culture, organization, structure, and numerous other ways (Cline, 1999). Additionally, support groups differ from counseling and individual therapy interactions, because support groups "primarily affect participants' personal empowerment rather than bring about specific therapeutic change" (Barak, Boniel-Nissim, & Suler, 2008, p. 1879). Whereas individual counseling and therapy, generally, aim to produce "tangible emotional, cognitive, behavioral, or physiological changes in individuals," support groups, generally, promote feelings that "have to do with bettering a sense of self-control, with well-being, self-confidence, mood state, self-image, loneliness, optimism, and even with a sense of control" (Barak et al., 2008, p. 1879; see also Broom, 2005).

Barak et al. (2008) point out that it is a myth that "a good support group might replace therapy" (p. 1869). Nonetheless, as Barak et al. explained:

> Participation in a support group—perhaps even more so in an online support group—might in many cases provide added value to standard therapy, counseling, or professional care of any kind, as this means of emotional support has the great potential to contribute to participants' sense of personal empowerment. (p. 1869)

Support groups can be empowering providers of social support because, usually, they are self-directed in terms of goals and focus of discussions, and because participants (usually) voluntarily become part of the "community" (Barak et al., 2008).

Besides differing from individual therapeutic interventions, support groups, themselves, vary greatly in terms of the goals of the group and what types of support, generally, are provided and appreciated the most. For example, Dennis, Kunkel, and Keyton (2008), studying a breast cancer support group, found that even though emotional displays were not discouraged, *informational* support was the type used most often during group sessions. Conversely, in Braithwaite, Waldron, and Finn's (1999) study of online support groups for people with disabilities, emotional support was the most frequent type provided (40%), followed by informational support (31.3%).

Support groups vary greatly in dynamics and culture, and they differ from other intervention groups; most notably, therapy groups and self-help groups, which, according to Barak et al. (2008), are the two main types of support groups (including face-to-face and online). As Barak et al. explained:

> A support group differs substantially from a therapy group. Several core differences should be noted: first, unlike a therapy group, no pre-planned, targeted professional manipulation—a treatment protocol—is conducted or delivered in a support group. Second, the purpose of support groups is basically to offer relief and improved feelings rather than therapeutic change in the emotions, cognitions, or behaviors of participants. Third, support groups may operate without a leader or manager or have a nonprofessional administrator, whereas therapy groups always have trained professionals who lead them. Fourth, a support group is usually an open forum, which participants can join or leave at any time, whereas a therapy group is seldom open. Fifth, and related to the previous characteristic, support groups last without specific time limits, and indeed they may last continuously, whereas therapy groups are usually time-limited. (pp. 1868–1869)

Hence, in a support group, there are no formal prescribed solutions or behavioral outcomes, the desired goals are determined by the group, participants help each other as they are helped, there are no time constraints, and participation in the group is (usually) voluntary (Barak et al., 2008).

Helgeson and Gottlieb (2000) noted that support groups' characteristics are a hybrid of therapy groups and self-help groups. Self-help groups, typically, are peer-led, have open membership, and do not have a fixed duration (Helgeson & Gottlieb, 2000). Thus, Helgeson and Gottlieb argued that self-help groups are different because support groups "have a closed membership, involve expert leader(s), usually have a fixed duration, and do not engage in advocacy activities" (p. 222). This conceptualization of a support group differs slightly from that of Barak et al. (2008) in regards to open or closed membership, and duration. In contrast, Braithwaite et al. (1999) argued that support groups and self-help groups are similar in terms of "principles of empowerment, inclusion, nonhierarchical decision-making, shared responsibility, and a holistic approach to people's cultural, economic, and social needs" (p. 125).

As discussed further in Chapter Five, the DV support group at New Beginnings can be considered a support group in Helgeson and Gottlieb's (2000) view because it was a *mixture* of a therapy group and a self-help group, and included elements of both (see also Barak et al., 2008; Braithwaite et al., 1999). The DV group at New Beginnings incorporated the following elements from a *therapy group*: participants were required by New Beginnings to attend the DV group (at least for the first 28 days if they are staying longer); it was not "an open forum, which participants can join or leave at any time" (Barak et al., 2008, p. 1868); and it, usually, was time-limited (about four sessions). Alternatively, the DV group resembled a *support group* because it had "no pre-planned, targeted professional manipulation," and it aimed to offer "relief and improved feelings" (Barak et al., 2008, pp. 1868–1869). Accordingly, because the DV group's

aspects that resemble a therapy group revolve around the context constraints of the group (i.e., it occurred within a substance abuse treatment center) rather than the group's culture and goals, the remaining literature review, generally, focuses on support groups. Furthermore, as described further in Chapter Six, I modeled the group after support group and self-help group dynamics (e.g., Braithwaite et al., 1999). I wanted members to feel as if they owned the group (rather than having fixed topics that were determined by me), and I wanted them to feel like it, indeed, was a support group—even within the structural confines of a therapy group.

Support groups comprised of individuals with similar experiences. Another important distinguishing characteristic of support groups is that they are groups of individuals seeking support for similar issues or problems. It *can* be extremely helpful for some in distressing situations to exchange informational, emotional, esteem, and network support with others who better understand what they are going through (see, e.g., Barak et al., 2008; Dennis et al., 2008; Yalom, 1985). According to Yalom (1985), the philosophical foundation of support groups is that the most effective way to cope with problematic issues is to disclose information to, listen to, and learn from people who face similar issues. Support groups provide members with opportunities to talk with multiple others who have experienced similar issues, and it can be very powerful for group members to seek and give support with others who have "been there" and "done that" with respect to similar issues (see, e.g., Barak et al., 2008; Dennis et al., 2008).

Receiving and giving support in a group with members facing similar issues may be beneficial because support providers' "credibility" can affect how support is perceived by receivers. According to Taylor (2007), "Different kinds of support . . . may be valued from different members of a social support network" (p. 151) because of those members' levels of closeness with the support receiver and the providers' expertise on the subject. For example,

support may be dismissed or considered to be unhelpful and/or inappropriate by the receiver when the provider is considered to have less credibility on the subject; conversely, support from someone perceived to be an "expert" on the subject may be considered more helpful and/or appropriate by receivers (see, e.g., Benson, Gross, Messer, Kellum, & Passmore, 1991; Dakof & Taylor, 1990). Accordingly, receiving support from those with credibility on the subject may be beneficial for other members.

Support groups have the potential to promote an atmosphere that encourages members to disclose and share information because participants interact with others who may better understand their situation than those in their outside social networks (e.g., friends and family). This potential to have experiences affirmed by others can be extremely powerful. Dennis et al.'s (2008) exploration of a face-to-face breast cancer support group, for instance, found many positive benefits that those groups provide. Upon interviewing a veteran of the group who had emerged as the facilitator, Dennis et al. reported that the facilitator/veteran "convinced us that this [group] improved the quality of members' lives, provided an outlet for talking with similar others, revolved around members' emotional and informational needs, and helped members develop coping strategies" (p. 417; see also Kunkel, Dennis, & Keyton, 2010). Similarly, in Cummings, Sproull, and Kiesler's (2002) study of an online support group for those with hearing disabilities, some participants felt alienated and that they lacked social support before becoming a member of the online support group. The study "demonstrated that those participants with relatively low levels of real-world support particularly felt they obtained emotional and informational benefits" (Cummings et al., 2002, p. 86) from communicating with those facing similar issues.

Cummings et al. (2002) and Kunkel et al.'s (2010) findings illuminate the special circumstances of support groups: members' ability to affirm and learn from other members' experiences. Dennis et al. (2008) reported that the facilitator/veteran of the group

> described the group's strongest support attribute as "that we've all been there. At the same time, no two of us have had the identical experience." She identified the bonding solidarity among its members: "I thought there was something terribly wrong with me, but when I talked about that, I found that that was quite a normal occurrence for a lot of people." Continuing, she remembered, "I learned something; I was supported in some way that made it easier to bear." (p. 417)

Sharing similar experiences can help normalize and legitimate experiences (both important components of effective social support), while also helping to alleviate a sense of isolation (M. A. Dutton, 1992). According to M. A. Dutton (1992), for survivors of DV, "Support from well-intentioned professionals or family members sometimes cannot compare with the support that comes from knowing and hearing about other battered women and their stores" (p. 120; see also A. Jones & Schechter, 1992). Sharing with others who have experienced similar things may increase feelings of understanding because of others' expertise regarding the issue. Overall, "sharing experiences with other people facing a similar stressor is expected to lead to validation, normalization of the experience, a reduction in social and emotional isolation, and a sense of belonging" (Helgeson & Gottlieb, 2000, p. 225).

Although it could *not* be assumed that the women attending the mandatory DV group at New Beginnings were all survivors of DV, the vast majority of them were survivors. As discussed in Chapter Six, some of the women even had distrust for support providers who had

not experienced the issues that they were discussing, and many others greatly appreciated affirming each other's experiences and learning from them.

Support groups as groups. Overall, like other groups (e.g., work groups, teams, and clubs), there are many differences in support groups, from leadership style, to organization, to rituals, to ways of handling "problematic" situations (Cline, 1999). Support groups, however, are groups; consequently, examining support groups from a group communication lens is beneficial. However, as Cline (1999) asserted, "Despite the fact that social support *groups* are the phenomenon at issue, little attention has been paid to the 'group' and its communication, the ostensible helping process" (p. 532). Cline suggested that further research should focus on aspects of the *group* in support groups, such as "cohesiveness, communication climate, members' role definitions and shifts from helpee to helper, and leadership emergence, maintenance, and contention" (p. 532).

A prominent conceptualization of group communication and dynamics is the symbolic–interpretive (S–I) perspective (see Frey & SunWolf, 2004, 2005). As articulated by Frey and SunWolf (2004):

> When applied to groups, a symbolic–interpretive perspective is concerned with understanding (a) ways in which group members use symbols (words, objects, or actions that stand for or represent something else) to communicate and the effects of symbol usage on individuals, and collective processes and outcomes, and (b) how groups and group dynamics themselves are products of such symbolic activity. (pp. 277–278)

In addition to these foci, the S–I perspective also asserts that because groups are a socially constructed concept, "a group is not a container with a fixed location, static boundaries/borders, or an existence apart from the environments within which it is embedded but, instead, is

characterized by permeable boundaries, shifting borders, and interdependence with its contexts" (Frey & SunWolf, 2004, p. 283). This view is based on the *bona fide group perspective*, which is an alternative to the "container model" (e.g., which views groups as being static or fixed; see Putnam & Stohl, 1990, 1996).

Bona fide groups have at least two important characteristics: their boundaries are stable, yet permeable; and they have "interdependence with their relevant contexts" (Frey, 2003, p. 4; see Putnam & Stohl, 1990, 1996). Bona fide groups have stable yet permeable boundaries because group members hold other various roles outside a particular group that, potentially, influence their behavior in that group, group membership often changes (i.e., with some people joining and others leaving at various points in time), and people vary in terms of how much commitment and loyalty they feel to a particular group (Frey, 2003). Additionally, the bona fide group perspective acknowledges that groups are embedded in environments with which they have a reciprocal relationship, because "those contexts influence what occurs within a group and what occurs within a group influences those contexts" (Frey, 2003, p. 5; see Putnam & Stohl, 1990, 1996). Support groups share these group communication attributes because they create situations where participants use and interpret symbols to create shared meaning, have permeable yet stable boundaries, and are interdependent with their contexts.

This perspective is important for the current study because the DV group at New Beginnings is located within and influenced by a larger group—the New Beginnings substance abuse treatment center as a whole. As described in detail in Chapter Six, the communication processes of the substance abuse treatment center influenced the communication processes within the DV group. The DV group, indeed, did have a different set of practices, rules, and topics of conversation than did other groups within New Beginnings [e.g., "process groups,"

creative writing groups, art groups, and members of Narcotics Anonymous (NA) and Alcoholics Anonymous (AA)], but the DV group's borders were shifting and the group was interdependent with its environment. For example, as mentioned in Chapter Three, DV advocates, typically, encourage survivors to place all blame with the abuser and patriarchy in society, whereas substance abuse counselors, typically, encourage those in treatment to find their place in their problems (Bland & Edmund, 2008). Accordingly, as described in Chapter Six, some women in the DV group tended to "find their place" in their experiences of DV, which led to (partially) blaming themselves for the abuse.

Examining support groups. Similar to the study of social support, scholars who examine support groups have focused on a wide array of issues and a wide array of supportive groups. However, "communication scholars . . . have focused primarily on online support groups, an interaction context with different communication and membership characteristics than face-to-face groups" (Dennis et al., 2008, p. 416). There are numerous differences between online support groups and face-to-face support groups. First, because there are thousands of support groups online (Alexander et al., 2003), people can choose which online support group format or "community" of members is most supportive for them (see also Barak et al., 2008; Cline, 1999). Additionally, online support groups allow access to those who are dealing with stigmatized situations, have little access to effective support providers in their offline network, or do not have a support group of the desired nature nearby (e.g., Barak et al., 2008; Cummings et al., 2002; see also Weinberg, Schmale, Uken, & Wessel, 1995). Moreover, the anonymity of the internet is more comfortable for some people, and this feature minimizes fears regarding physical appearance, and it downplays any social "markers," which, hopefully, diminishes biases from, or stereotypical interactions with, others (Barak et al., 2008; Weinberg et al., 1995; Wright, 2002).

Online support groups also differ from face-to-face groups because of the *disinhibition effect*, or the propensity to find more ease in discussing sensitive topics online rather than face-to-face (see Furger, 1996). Some people may feel more comfortable disclosing very personal or emotional information online than in face-to-face support groups (Barak et al., 2008; Furger, 1996; Weinberg et al., 1995; Wright, 2002).

In contrast, members of face-to-face groups can view nonverbal cues from others participating in the group, which, potentially, is helpful when discussing emotional issues, and face-to-face groups do not have lapsed response times, which characterizes online groups (Wright, 2002). Moreover, Wright (2000) explained that face-to-face groups allow physical contact between members and immediate feedback; conversely, online support groups lack nonverbal cues, sometimes are hostile (see, e.g., Preece & Ghozati, 2001), and include greater deception, as well as more opportunities to provide misinformation from misinformed members (see, e.g., Fox, 2000; Rice, 2001).

As mentioned previously, communication scholars, primarily, have studied online communities (Dennis et al., 2008). However, as examined below, generally, Cline (1999) noted that communication scholars have examined support groups at three levels: the macrolevel, the "middle-ground" (p. 521) level, and the microlevel.

Macrolevel assessment. First, at the macrolevel, "analysts have explored the relationship between group communication processes and group ideology" (Cline, 1999, p. 521; for a review, see Cline). Recently, scholars have explored how various ideologies function within support groups. Barton (1999), for example, examined how the "repeated use of slogans and sayings in the discourse of a support group for parents of children with disabilities" served informational and interactional functions (p. 461). Barton observed face-to-face support group meetings and

found that the repetition of slogans and sayings provided information for members, as well as established solidarity between group members. Additionally, Christian (2005) examined how the cultural stepmother myth influenced stepmothers' personal narratives within an online support group, and found that stepmothers contested the cultural myth by creating a binary between "the biological mother as 'wicked' and the stepmother as 'good'" (p. 27).

Another example of macrolevel analysis is Hollihan and Riley's (1987) analysis of the rhetorical strategies of "Toughlove" support groups for parents of delinquent children. Through their narrative analysis of face-to-face support group meetings, Hollihan and Riley argued that the rhetoric of Toughlove groups, potentially, can be harmful for families because it encourages parents to do things such as kicking their children out of the house if rules are not followed, and that such rules may lead to more negative consequences for the children and/or family. Hollihan and Riley, thus, illuminated the potential negative effects of support groups.

Middle-ground assessment. Second, communication scholars have examined support groups from the "middle-ground" (Cline, 1999, p. 521) level. According to Cline (1999), "Substantial attention to middle-ground concepts has emphasized the role of group communication climate and leadership" (p. 521; for a review, see Cline, 1999). For example, Peterson (2009) examined how group norms and rules shaped how an online support group for gay men with HIV and/or AIDS influenced their social support processes. Overall, Peterson found that the group's insistence on talking only about issues in *positive* ways formed a unique community that focused on and met their needs. Additionally, Stommel and Koole (2010), examining the paradoxical group climate of an online eating disorder support group, found that group members, simultaneously, welcome new members and confront them to achieve conformity; they argued that the findings imply that nonacceptance of new members who are not

quite ready to fully accept groups' norms and categorizations may result in newcomers "falling back into social isolation" (p. 375).

Microlevel assessment. Third, Cline (1999) argued that "very little research has focused on microlevel communication processes, that is, actual dialogue, specific messages, and their effects" (p. 521). Since the time of Cline's assertion, the growing popularity of online support groups has increased the prevalence of microlevel studies of communication processes within support groups. As mentioned earlier, communication scholars now, predominantly, focus on online support groups; in large measure, because online support groups that are open to the public provide researchers with access to rich, interactional data (Dennis et al., 2008). Accordingly, although Cline might still argue that little research examines microlevel processes in face-to-face support groups, there have been numerous recent microlevel analyses of online support groups. For example, Eichhorn (2008) analyzed a "longitudinal, systematic random sample of 490 postings" (p. 67) on eating disorder discussion boards to examine what types of support were used by members and how social support was solicited. Eichhorn found that informational support was the most frequent type of social support used in discussions, and that members shared experiences most frequently to solicit social support. Additionally, Cawyer and Smith-Dupre' (1995) examined the communication of group members in a face-to-face support group for people living with HIV and/or AIDS. Cawyer observed the group, which met weekly, over a 3-month period. Cawyer and Smith-Dupre' found that the major themes of discussion for the group were "coping with loss, fighting for individual rights, surviving amidst adversity, and finding peace in a sometimes unjust and cruel world" (p. 248); the major types of supportive episodes were "(a) *communicating to heal,* (b) *communicating to prepare*¸ (c) *communicating to vent emotions,* and (d) *communicating to change society*" (Cawyer & Smith-Dupre', p. 248).

Examining outcomes in support groups. Whereas numerous scholars have focused on various support group aspects (from the macrolevel to the microlevel), others have focused on support group outcomes, with researchers measuring outcomes in various ways. For example, according to Dennis et al. (2008), "In medical and psychological studies of [breast cancer] support groups, survivors are randomly assigned to treatment and control conditions with the typical treatment condition consisting of a formal 8- to 12-week curriculum" (p. 416). According to Cline (1999), communication scholars, typically, measure support group outcomes via pre- and post-group data, group members' self-reports (e.g., questionnaires or interviews), and experimental designs that include intervention and control groups.

In line with the study of social support, literature shows that support groups can influence members in both positive and negative ways (see, e.g., Albrecht & Adelman, 1987; Albrecht, Burleson, & Goldsmith, 1994; Coyne, Ellard, & Smith, 1990; Helgeson & Gottlieb, 2000; Sullivan, 1996). According to Cline (1999), "Empirical research has investigated a wide array of outcomes variables. These range from changes in affect and cognition to changes in behavior" (p. 527). Regarding changes in affect, studies have found that support groups potentially can increase members' self-esteem (Hinrichsen, Revenson, & Shinn, 1985; Kurtz, 1990), hope and optimism (Vachon, Lyall, Rogers, Freedman-Letofsky, & Freeman, 1980; Wilson & Soule, 1981), and feelings of validation and overall life satisfaction (Fiske, Davis, & Horrocks, 1995; Lieberman & Gourash, 1979); they also can decrease distress (Constantino, Kim, & Crane, 2005; Galanter, 1988). Support groups also may lead to increased healthy behavior and decreased unhealthy behaviors (e.g., McWhirter, 2011), among many other potential benefits (for reviews, see Cline, 1999; Helgeson & Cohen, 1996; Helgeson & Gottlieb, 2000; Roberts, 1990). Moreover, Roberts's (1990) review of the literature described how support groups can facilitate

the following benefits: making contacts and establishing relationships, examining and defining problems, exploring emotions and assessing past coping strategies, generating alternate solutions, implementing plans of action, and following up with members.

There are noted benefits for attending support groups for stressful life events or issues, but there are important circumstances that influence whether such groups might be beneficial for members. Dennis et al. (2008) recommended that support groups should promote the following to be most beneficial: positive reappraisal, emotional expression, positive and negative evaluations, honesty and nonjudgment, identifying and valuing various levels of uncertainty, information sharing, involvement in conversation, and sense-making. Furthermore, Helgeson and Gottlieb (2000) argued that support groups, perhaps, are most effective when they include some educational component or informational support (see also Helgeson, Cohen, Schulz, & Yasko, 1999). However, emotional and appraisal support also is important, especially when coping with issues that are not controllable (see, e.g., Lazarus, 1991; Lazarus & Lazarus, 1994).

Moreover, group members' level of participation might influence benefits received. For example, Cummings et al. (2002) found in their study of an online support group that more active participation in the group was associated with more perceived benefits from the group and a stronger sense of community with the group. Members' active participation might be an important factor in terms of perceived benefits received; however, Patricia J. Bland, from the National Center on Domestic Violence, argued in a June 2012 webinar that members in face-to-face support groups still can gain tremendous benefits simply from listening if they do not feel comfortable speaking in front of the group. Thus, in a way, full attentive listening could be considered a form of participation.

Whereas there are noted benefits from participating in support groups, there also is evidence that support groups are not as effective as other means for support (see, e.g., Frey, Adelman, Flint, & Query, 2000; J. A. Kelly, Murphy, Bahr, & Kalichman, 1993; Stephens, Roffman, & Simpson, 1994), are not generally beneficial for members (see, e.g., Coates & Winston, 1983; Hughes, 1988), and can negatively influence group members (e.g., Hollihan & Riley, 1987). For example, Fleming, Klein, and Corter's (1992) study found that women in a postpartum support group experienced decreased self-confidence. Additionally, Helgeson and Gottlieb (2000) argued that there are numerous risks associated with participating in support groups; for instance, support groups may foster an environment of social comparison, which, although it might not necessarily be harmful, could lead some members to evaluate their coping in terms of others' coping, which could lead to negative self-perceptions. Moreover, social comparison could lead a person in a support group who may have a lot, or a few issues, compared to the other members to feel like a deviant (Helgeson & Gottlieb, 2000). Helgeson and Gottlieb further argued that participants' identification with the group might interfere with existing relationships through social comparison; for example, participants' close identification with the group might influence them to be more closed about their situation with intimate partners, family, and/or friends. Another risk associated with support groups is that they may not be long enough in duration to actually help with problem- or emotion-focused coping (Helgeson & Gottlieb, 2000). Members also might feel expected to help one another and to provide emotional support for other members, which might make some feel uncomfortable (Helgeson & Gottlieb, 2000). Despite the potential pitfalls associated with support group participation, there is still a vast amount of research that highlights the benefits of participating (for reviews, see Cline, 1999; Helgeson & Cohen, 1996; Helgeson & Gottlieb, 2000; Roberts, 1990).

Assessing support group outcomes within institutions. As mentioned previously in this chapter, the DV group at New Beginnings is a support group within the larger institution of New Beginnings. Some scholars have examined support groups within institutions, or those that are operated by organizations. For example, Frey et al. (2000) examined the supportive communication of people "living in a residential facility for people with AIDS" (p. 53; see also Adelman & Frey, 1997). Adelman and Frey engaged in participant observation and conducted 43 interviews with residents at the facility and 11 interviews with staff members (Frey et al., 2000). Using ethnographic and interview data that they collected, Adelman and Frey constructed a questionnaire; Flint and Query helped to analyze the data and to report the findings (Frey et al., 2000). Frey et al. found a "relative lack of significant statistical relationships between support groups and perceived health outcomes, with only exercising being statistically significant" (p. 67). Frey et al. asserted that although the findings had insufficient power from low sample sizes, if accurate, the results "might suggest that formal, once-a-week support groups may not be as important to residents' physical and emotional health as are other periodic communication activities (e.g., social events and rituals)" (p. 68). Hence, people who are living together in residential institutions or communities may benefit from the day-to-day supportive communication that occurs, and, in this sample, those everyday supportive communicative behaviors were more influential than was attending weekly support groups.

Constantino et al. (2005), from the field of nursing, also examined a support group within an institution—a support group for residents within a DV center. Constantino et al. assessed health outcomes before and after the intervention, and they used a randomized control design, in which some women engaged in the "social support intervention" group, whereas others were in the "no treatment group" (p. 582), with those simply spending their group time chatting with

each other. Overall, women in the social support intervention group showed greater improvement in psychological distress symptoms and in perceptions of social support, and decreased utilization of health-care services when compared to the control group (Constantino et al., 2005). Although the sample sizes were small (n = 24), the control group controlled for everyday supportive communication in the shelter; thus, these findings imply that social support interventions within DV shelters, potentially, may have been "effective in improving health outcomes" for the women who attended the groups (Constantino et al., 2005, p. 575).

Assessing potential support group outcomes for domestic violence groups. Many studies have documented benefits of various types of support groups, and some have examined DV support groups, specifically (e.g., Constantino et al., 2005). Because DV, generally, is a stigmatized issue (Bland & Edmund, 2008) and survivors, usually, are isolated from support networks as a result of their abuse (M. A. Dutton, 1992; Johnson, 2008), support groups for DV survivors have the potential to be beneficial for participants in numerous ways. For example, within the field of social work, Tutty, Bidgood, and Rothery's (1993) analysis of 12 DV support groups revealed that participants reported "significant improvements . . . in self-esteem, belonging support, locus of control, less traditional attitudes toward marriage and the family, perceived stress, and marital functioning" (p. 325). Furthermore, Larance and Porter (2004) cofacilitated a DV support group and reported that participants received positive benefits of gaining trusting relationships and supportive networks.

Additionally, van Wormer (2001) argued that, for survivors of trauma (including sexual assault and DV):

> Group therapy is invaluable in helping survivors sort things out, letting go of their self-blaming thoughts and regaining their self-confidence. As group members, each of whom

> may unconsciously blame herself for her own suffering, come to share each other's stories of brutalization, a revelation may take place. In conjunction with an emerging sense of "we" instead of "I," the revelation may become something like, "We did not deserve these things to happen to us." (p. 160)

Similar to other support groups, DV support groups, potentially, can help members to make sense of their experiences as they, simultaneously, receive affirmation from others about those experiences.

Research Question

As the review above indicates, support groups are a way for people to access a "caravan" (Hobfoll, 2009) of social support. Support groups can be effective means of providing and receiving support because groups consist of people who have experience regarding similar issues (see Barak et al., 2008; Kunkel et al., 2008). At the time that this dissertation project was written, there appeared to be no research assessing a DV support group within a substance abuse treatment center; thus, the current study is exploratory in nature and sought to examine what participants found helpful and unhelpful about the communication that characterized that group.

This broad approach aligns with Coyne et al.'s (1990) argument that researchers sometimes impose their frameworks on research participants and, instead, that they should elicit their help in shaping the study. Thus, as described in Chapter Six, ethnographic participant observation, informal interviews, and semistructured interviews with DV group members illuminated ways in which the group communication was helpful and unhelpful. Additionally, as mentioned previously, in accordance with calls for using multiple methods and nuanced ways of examining social support (e.g., Burleson & MacGeorge, 2002; Goldsmith, 2004; Hobfoll, 2009; Vangelisti, 2009), the current study used participant observation to examine the supportive

communication within a naturally occurring group, and it employed informal and semistructured interviewing to examine support receivers' perceptions of helpful and unhelpful communication within the group.

Moreover, Cline (1999) asserted that, "standard experimental designs that rely on random assignment to interventions likely alter the nature of the membership, compromise the natural group processes, and jeopardize their potential helpfulness" (p. 532). As mentioned previously in this chapter, Cline also asserted that support group studies have paid little attention "to the 'group' and its communication, the ostensible helping process" (p. 532). Accordingly, the current study aimed to address Cline's call for researchers to investigate communication processes within support groups and to examine the "group" aspects, as well as ideologies (e.g., locus of control), dialectics, and symbolic interactionism. Overall, this exploratory study sought to examine *how* and *why* a DV support group within an addiction treatment center, New Beginnings, was helpful and unhelpful for members. Therefore, the following research question was posed:

RQ: What do participants perceive as helpful and unhelpful communication within the New Beginnings domestic violence support group?

Chapter Five: Methodology, Methods, and Data Analysis

This research project is a multimethod investigation that aims to contribute to the growing body of literature on intervention-oriented research, as well as to contribute to theoretical and practical understandings of social support within support groups for women with the co-occurring issues of domestic violence (DV) and substance abuse. Specifically, the study addresses the helpful (and unhelpful) messages exchanged in a support group within a context that incorporates potentially competing philosophies—those of DV advocates and substance abuse counselors (see Bland & Edmund, 2008; Fazzone et al., 1997). In this chapter, I first address methodological underpinnings of this research project. I then provide an overview of participants and sites in the study. The chapter concludes with a description of methods and analytic techniques to answer the research question posed in the study. Pseudonyms for all people and agencies are used in this project to protect confidentiality.

Philosophical Underpinnings

As described in Chapter One, this study constitutes intervention-oriented applied communication research (see, e.g., Applegate, 2002; Cheney et al., 2002; Frey & SunWolf, 2009; Hartelius & Cherwitz, 2010; Simpson & Shockley-Zalaback, 2005; Van de Ven, 2007) conducted with a social justice sensibility (Frey et al., 1996). Within applied communication research, intervention-oriented research is at the opposite end of the definitional continuum from purely observational research, because researchers intervene with the people and groups with whom they work and help to make sense of situations (see Frey & SunWolf, 2009). The goal for intervention-oriented researchers is to “conduct research about their interventions with relevant audiences to manage or solve communication problems and to promote needed social change” (Frey & SunWolf, 2009, p. 39). Furthermore, intervention-oriented research constitutes *engaged*

scholarship, which is defined by Van de Ven and Johnson (2006) as “a collaborative form of inquiry in which academics and practitioners leverage their different perspectives and competencies to coproduce knowledge about a complex problem or phenomenon that exists under conditions of uncertainty found in the world” (p. 803). Additionally, a communication and social justice approach seeks to make a positive difference through “engagement with and advocacy for those in our society who are economically, socially, politically, and/or culturally underresourced” (Frey et al., 1996, p. 110).

Regarding applied communication research, broadly, researchers examine important social issues to promote positive change (see, e.g., Cissna, 1995; Cissna & Frey, 2009; Frey, 2006; Hickson, 1973; Kreps et al., 1991; Frey & SunWolf, 2009; O’Hair, 2000; Seibold, 2008). To achieve that goal, applied communication researchers employ a wide variety of methods (see, e.g., Frey & Cissna, 2009; Kreps et al., 1991). Given that this study examines social support processes and communication within support groups, the research methods employed are shaped by methodological suggestions from the literature about social support, support groups, and group communication.

As mentioned in Chapter Four, Burleson et al. (1994), Burleson and MacGeorge (2002), and Goldsmith (2004) emphasized that the interactional approach is the best method for studying social support, because that approach considers the ongoing nature of social support and how it is rhetorically constructed within the context in which it occurs. An interactional approach views social support as communicative behavior that is ongoing in relationships (Burleson et al., 1994; see also Cutrona, 1996; Goldsmith, 2004). Through an interactional lens, researchers studying social support question why and how people provide support, as well as why and how supportive behavior does or does not help receivers (Burleson et al., 1994). Given that the context of the social support process is foregrounded in the interactional approach, naturalistic studies in which

researchers observe actual social support processes as they occur are ideal (Goldsmith, 2004). Support group literature also calls for interactional approaches (see Cline, 1999), for although asking people for their global assessments of support group participation can be beneficial for knowing their overarching perceptions, focusing on actual exchanges made during group interaction is very informative regarding how social support processes occur within support groups (Cline, 1999).

Furthermore, in the group communication literature, Frey (1995) asserted that there need to be more naturalistic studies that examine groups *within* their relevant contexts. In his review of group communication scholarship, Frey (1988) found that:

> 64% studied zero-history groups, 72% used students, 60% took place in a laboratory (50% of "field" research studied groups created for classroom purposes), and 72% observed a group only once (the average number of observations for groups studied more than once was only 2.75). (as cited in Frey, 1995, p. 14)

To study "natural" groups and to eschew studying groups without a history (zero-history), groups from convenience samples, or groups *created* by researchers, group communication scholars have turned to conducting naturalistic studies, using ethnographic methods, specifically, to gain more nuanced knowledge of how naturally occurring groups function and communicate (see, e.g., Dollar & Merrigan, 2002). Furthermore, as discussed in Chapter Four, bona fide groups (e.g., which also are "naturally" occurring groups) are not containers; they are interdependent with their contexts and external environments, and their boundaries are permeable, yet stable (see Frey, 1994; Putnam & Stohl, 1990, 1996). Thus, the bona fide group perspective also lends itself to researchers employing ethnographic methods to observe group practices in their contexts and to move "back and forth continually between"

examining internal processes and external group dynamics (Stohl & Putnam, 1994, p. 287). Although examining social support in naturalistic studies with interactional frames can be challenging for researchers because of its complexity, it may better than other perspectives for addressing why and how social support is enacted, received, and perceived within support groups.

Accordingly, as I describe in detail later in this chapter, I used ethnographic participant observation to observe a DV support group with an addiction treatment center, New Beginnings, to examine support processes in it from an interactional perspective, while simultaneously using a bona fide group frame. I also used autoethnography in the reporting of the results because I facilitated the DV group from October 2010 until May 2013; consequently, my experiences leading the group are a part of the analysis. Moreover, I engaged in informal and formal interviewing to assess members' global perceptions of the support group, which include perceived benefits and helpful (and unhelpful) messages. Finally, I solicited creative works from support group members to examine how they used creative means to facilitate coping and sense-making. In the following section, I provide an overview of the research situation; subsequent sections describe the research sites, participants, and methods employed.

Research Situation

As described in Chapter One, I was a volunteer advocate at Safe Haven, a DV center, from October 2010 until May 2013. To become a shelter advocate at Safe Haven, I completed 60 hours of training at Safe Haven's administrative office, followed by 16 hours of on-the-job training at the shelter. As an advocate within the shelter, I volunteered 4 to 6 hours a week, which involved answering the crisis line phone, conducting intakes, participating in peer-counseling with the women at the shelter (e.g., offering help finding resources and acquiring

skills, providing information about DV, listening to their stories, and offering social support), and generally helping with maintenance at the shelter (e.g., stocking the food pantry, cleaning rooms, or doing yard work).

In January 2011, my academic advisor, Dr. Adrianne Kunkel, had several discussions with staff at Safe Haven to help me gain a role within the organization as one of its support group facilitators. After discussing my qualifications, the staff at Safe Haven decided in February 2011 that I would begin training to cofacilitate a weekly DV-based support group within the addiction treatment center, New Beginnings. At that time, a Safe Haven staff member and an intern for the organization facilitated the group in alternating weeks (with one facilitating one week, and the other the next week), and the group was organized like a class. Both facilitators "taught" the group members about various DV topics, rotating the same four topics, as the women listened and, occasionally, provided examples. I shadowed those two cofacilitators six times; after that shadowing period, I was supposed to replace one of them as a cofacilitator. However, the person with whom I was supposed to cofacilitate resigned from Safe Haven; consequently, I unexpectedly began facilitating the group by myself in April 2011.

As described in Chapter One, during my shadowing period, one of the New Beginnings staff members asked me to make the group less repetitive and more "helpful" for the women, because the previous groups were deemed by group members to be boring, unhelpful, and too "class" like. Accordingly, I created a proposal for the new group format that was based on practitioner handbooks for leading DV support groups (e.g., Bland & Edmund, 2008; Fischer & McGrane, 2001). Safe Haven and New Beginnings staff members approved my proposal, and I began facilitating the DV support group based on the information that I had gathered and learned.

I served as Safe Haven's sole representative at New Beginnings from April 2011 until October 2012. During that time, I facilitated a weekly DV support group within New Beginnings—as Safe Haven's representative. I also met with women at New Beginnings one-on-one and in small groups to discuss their experiences, to serve as a peer counselor, and to help them make "safety plans" and find resources within the community. In October 2012, I trained a Safe Haven staff member, Sam, to replace me as the main Safe Haven representative at New Beginnings. After Sam shadowed me as the facilitator for a month (i.e., for four support group sessions), she began facilitating the DV support group at New Beginnings, and I attended the groups as an "extra advocate," because we both agreed that the group should have two advocates available. Further, I wanted to observe the group being facilitated by another person. During that time, I continued to meet with women at New Beginnings in one-on-one meetings when requested, and I was colloquially considered to be Sam's "helper" because my role was limited during the DV group. I began conducting interviews with group members in February 2013 to examine their global perceptions of the support group, and I continued to observe the group until May 2013 and to serve as the "peer helper."

The Memorandum of Understanding (MOU). Although this part of the story is not a part of the current reported project, it helps to establish my role as a participant–observer who also wants my research to be service-oriented. My initial, single goal for the project was to assess the DV support group at New Beginnings, but as I researched the link between DV and substance abuse to prepare for my role as a facilitator of the DV support group at New Beginnings, I came to believe that the community would benefit tremendously from New Beginnings and Safe Haven forming a stronger alliance and "bridging" their services (see Bland & Edmund, 2008; Fazzone et al., 1997; NCADV, 2011).

I, thus, first, approached the lead organizer at Safe Haven, Tess, to see if she would be interested in working with New Beginnings on a coordinated community response (CCR) that provided holistic care for the women whom the two organizations were serving. She was immediately on board and excited about the opportunity to collaborate with New Beginnings to better aid women with the co-occurring issues of substance abuse and DV. Tess also recommended that we add Mending Together, a rape crisis center, to the conversation. After weeks of coordinating, the directors and key staff from each agency—New Beginnings, Safe Haven, and Mending Together—and I met to establish how they could better bridge their services, share resources, simplify the referral process, and provide cross-trainings for each agency (among many other things).

After developing an initial plan from my recommendations and their suggestions, the representatives at that meeting asked me to write a Memorandum of Understanding (MOU). That document was created and eventually signed by all three directors. The MOU is a legally binding document that outlines each agency's individual and joint responsibilities. The MOU identifies numerous responsibilities (e.g., meeting monthly to discuss progress and to brainstorm next steps), but the relevant item for this project is the part that states, "All parties agree to provide on-site therapeutic services (perhaps shared) with the other agencies, such as support groups, and to provide recommendations regarding support group curriculum." Thus, the current project, ultimately, aimed to fulfill this part of the MOU.

After I finished gathering data for this project (e.g., conducted participant observation and interviews), I presented the key findings informally to the lead team in May 2013. Following this project's conclusion, I will provide my complete written findings to the MOU group and key staff at New Beginnings, Safe Haven, and Mending Together, to enable those

organizations to better continue to serve as a model for bridging services and, more specifically, to provide recommendations for future support groups that the agencies offer. Ultimately, the goal of this research is to "go public" with the findings to help agencies in other communities to bridge services as well. While Mending Together was part of the MOU, they were not specifically examined as part of this dissertation project.

Participants and Sites

Participants in this study included residents/clients of New Beginnings who attended the DV support group, as well as key staff and volunteers at Safe Haven and New Beginnings who are staff members, interns, volunteers, or counselors, and facilitators of DV, substance abuse, or trauma support groups. As mentioned in Chapter One, the ethnographic component of this project received Institutional Review Board approval in January 2012 (see Appendix B for HSCL approval letter). Additionally, an appropriate administrator at each site signed a formal letter of consent and/or approval that granted me permission to conduct research at the agency; however, these letters are not included in this research report to preserve the confidentiality of the organizations involved.

The following sections describe the "key players" and scenes involved in this project, including the sites of research and details related to their missions and services. Both Safe Haven and New Beginnings are located within the same community in the Midwestern United States.

Safe Haven. Safe Haven was founded in the 1970s and was one of the first battered women's shelters in that particular state. Safe Haven provides services for approximately 270 women every year. The organization provides a wide variety of free and confidential services, including a safe-house; a 24-hour crisis line; advocacy programs, such as court advocates;

weekly support groups in the shelter and in the community; and community education programs. Safe Haven uses an empowerment model based on Attorney Barbara Hart's (1996) articulation:

> Empowerment advocacy believes that battering is not something that happens to a woman because of her characteristics, her family background, her psychological "profile," her family of origin, dysfunction, or her unconscious search for a certain type of man. Battering can happen to anyone who has the misfortune to become involved with a person who wants power and control enough to be violent. (as cited by Buel, 1999, p. 721)

To Safe Haven, an empowerment model means that advocates support survivors as they advocate for themselves. Thus, there is no set "program" for women seeking services; advocates and staff are there simply to provide information, inform women about services and resources, and support women survivors as they make decisions that *they* believe are best for themselves. Safe Haven advocates are trained to not give advice because the woman is the expert of her life. However, as noted by Trethewey and Ashcraft (2004), sometimes, an ironic part of organizational functioning for service providers is that concertive control vis-à-vis rules and processes may disempower people, and services intended to offer opportunities for empowerment can lead to dependence on those services or they may not fully meet clients' needs (see also D'Enbeau & Kunkel, 2013; Vaughn & Stamp, 2003).

New Beginnings. New Beginnings is a part of a larger community organization that was founded in the 1970s as a grassroots effort to help those in the community who struggled with alcoholism. New Beginnings offers a range of alcohol and drug treatment, including in-patient and out-patient services for women and their children. In-patient services include nonmedical detoxification (to help manage withdrawal), intensive short-term residential stays (28 days), or

extended residential services to help the women transition back into their communities (Housing Intensive Out-Patient, HIOP). If a woman is considered HIOP, she resides at New Beginnings, but she only is required to attend certain groups, and she may leave the facility during certain times of the day. In essence, women in HIOP reside at New Beginnings, but it is considered a transitional stay as they work to find a job and reintegrate into the community. Intensive in-patient services include individual counseling, group counseling, cognitive behavioral therapy, and 12 step programs.

New Beginnings takes a holistic approach to substance abuse treatment by tailoring services to women's needs and providing counseling beyond simply focusing on substance abuse to minimize the threat of relapse that might be exacerbated by other factors. New Beginnings (a place that focuses almost exclusively on substance abuse) differs from Safe Haven (a DV shelter) in terms of meeting program requirements, such that for women to continue to move through and, ultimately, graduate from the program, they must meet specific goals (i.e., complete a "treatment plan") and attend required group sessions and individual counseling meetings.

Although some women may enter treatment at New Beginnings voluntarily, others may be encouraged by the court system or family services to complete the program for a variety of reasons (e.g., regaining custody of their children or having court charges reduced). Others are court-mandated to stay at New Beginnings for a designated period of time; this is known as being on "body release."

This aspect of New Beginnings differs from Safe Haven because women must voluntarily seek services from Safe Haven, whereas some women enter treatment at New Beginnings involuntarily. Regardless of whether women in the area receive services from New Beginnings or from Safe Haven, there is a high probability that these women will have had experience with

both substance abuse and DV, as these issues frequently co-occur (see, e.g., Chase et al., 2003; Coker et al., 2000; D. H. Coleman & Straus, 1983; Fals-Stewart & Kennedy, 2005; Gondolf, 1995; Hamilton & Collins, 1981; Holtzworth-Munroe et al., 2000; Kantor & Straus, 1989; Leonard & Jacob, 1988; Logan et al., 2001; NCADV, 2011; Pernanen, 1991; Stuart et al., 2006; Testa et al., 2003).

The domestic violence group at New Beginnings. The DV support group at New Beginnings can be viewed as a *mixture* of a support group and a therapy group, because it incorporates elements of both (Barak et al., 2008). The group at New Beginnings, which was led by me from April 2011 until October 2012, fits the description of a *therapy group* in that participants are required to attend (at least the first four sessions, if they are staying more than 28 days); it is not "an open forum, which participants can join or leave at any time" (Barak et al., 2008, p. 1868); it usually is time-limited and enforced (about four sessions); and it has a group facilitator instead of being self-led.

Before conducting research about support groups and therapy groups, I had no experience leading support groups, and I had no experience working with people with substance abuse issues. However, I considered myself to be a *quasi*-professional because I did have experience leading classroom discussions, I had taken a doctoral-level seminar on social support, and I was fully trained to be an advocate against DV. Hence, in Safe Haven's view, I was capable of being a "peer facilitator." Comparatively, Sam, the person I trained to take my place as lead facilitator in October 2012, had experience in leading substance abuse "process" groups during a previous internship at a substance abuse treatment center. She also had completed Safe Haven's DV training.

Alternatively, the group at New Beginnings resembles a support group because it has "no pre-planned, targeted professional manipulation" and it offers "relief and improved feelings" (Barak et al., 2008, pp. 1868–1869), even though it also includes an educational component by providing informational support about DV and informative handouts. After reading about "true" support groups, I wanted the group at New Beginnings to have the feel of a support group as much as possible within the constraints of that institutional context. Consequently, I tried to utilize characteristics of support groups in terms of focusing on "principles of empowerment, inclusion, nonhierarchical decision-making, shared responsibility, and a holistic approach to people's cultural, economic, and social needs" (Braithwaite et al., 1999, p. 125). A support group format was part of the proposal that I presented to Safe Haven and New Beginnings staff members and that they approved.

This mix of characteristics of support group and therapy group can create further constraints on the group, however. According to Bland and Edmund (2008), some challenges presented in therapy groups involve a possible lack of enthusiasm for being there or an unwillingness to grow or learn, because some women enter treatment involuntarily, and there may be a lack of empowerment opportunities for members because of those groups tending to be mandatory (Barak et al., 2008). Moreover, an extremely important complexity of the DV group at New Beginnings is that, because attendance is mandatory for most women there, it could not be assumed that the women attending the group, in fact, are survivors of DV (although most were) or that they might identify themselves as abusers.

In the following sections, I describe the methods used in this study and the techniques used to analyze the data collected. First, I describe a methodological frame for the study. I then

describe the methods used and provide relevant participant information for each method employed.

Methodology

Ellingson (2009a) developed *crystallization* as a methodological frame because of her dissatisfaction with having to choose between genres, methods of analysis, and ways of reporting findings in her work. Ellingson grounded her framework in feminist ideology and the view that dialogue and embracing multiple, sometimes competing, voices is emancipating and does justice to the complexity of a phenomenon. Ellingson also grounded her articulation of crystallization in Richardson's (1994, 2000) concept of "qualitative *crystallization* as a postmodern reimagining of traditional, (post)positivist methodological triangulation (i.e., validating findings through mixed methods research design) as a messy, multigenre, paradigm-spanning approach to resisting the art/science dichotomy" (p. xii). Overall, Ellingson summarized crystallization as follows:

> Crystallization combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers' vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them. (p. 4)

Accordingly, this frame includes the epistemological view that there are multiple ways of understanding, interpreting, and knowing the world; consequently, using "all there is to use" (Burke, 1973, p. 23) is beneficial for building complex understandings that reflect the complex nature of the examined phenomenon. As Ellingson explained, "Crystallization problematizes the

truths it presents" (p. 22) because this frame recognizes how knowledge is partial, local, and historically situated (see also Haraway, 1988; Harding, 1997, 1998; Harstock, 1983).

Ellingson's (2009a) articulation of crystallization, thus, was a framework employed for this study. Ellingson posed five key concepts for this frame. First, similar to qualitative research (see Geertz, 1973), crystallization provides "deep, thickly described, complexly rendered interpretations of meanings about a phenomenon or group" (Ellingson, 2009a, p. 10). Second, crystallization involves including, from the qualitative continuum, at least one approach from the "middle-ground (constructivist or postpositivist)" and one interpretive, creative, or artistic approach (Ellingson, 2009a, p. 10). Third, the crystallization approach uses multiple genres of writing when reporting findings (e.g., the traditional research report, narrative, art, poetry, and film). Fourth, within this frame, there is a "significant degree of reflexive consideration of the researcher's self and roles in the process of research design, data collection, and representation" (Ellingson, 2009a, p. 10). Fifth, this frame acknowledges and embraces the idea that knowledge is "situated, partial, constructed, multiple, embodied, and enmeshed in power relations" (Ellingson, 2009a, p. 10).

Although Ellingson (2009a) argued that researchers should use the crystallization framework as they see fit and adapt it according to their goals, she explained that there are two ways to enact this framework. First, *integrated crystallization* refers to presenting multigenre texts in one coherent format (e.g., a book or documentary). Second, *dendritic crystallization* presents ongoing interpretations in more than one format (Ellingson, 2009a). This dissertation project uses integrated crystallization, with narrative, artwork (including two pieces from a DV group member and photographs circulated in popular press), and traditional research reporting segmented throughout the results section.

Ellingson's (2009a) approach definitely resonated with me. I began my volunteer service with "correct" organizational conceptualizations of DV based on my training at Safe Haven and from reading academic literature about that phenomenon. However, the women's real, lived experiences quickly challenged my original conceptualizations. I quickly learned how complex DV is conceptually, and how advocate metanarratives and scholarly definitions can offer women the opportunity to empower themselves through relating to the stories or create confusion, tension, or resentment when they do not. As I continued to read scholarship about DV, substance abuse, the co-occurring issues of DV and substance abuse, and those who experience them, I would sometimes think, "It's more complicated than that." Moreover, this study was informed by multiple methodologies, fields, and perspectives that all seemed to weave together to illuminate the complexity of the DV support group at New Beginnings.

Procedures Overview

There were three stages to this research project. The following sections provide an overview of procedures and methods used in those three stages. Following the description of the research stages, I provide more detailed information about each method used and relevant participant information.

Stage 1. During Stage 1 of the research project (January 2012–October 2012), I facilitated the DV group at New Beginnings. I engaged in participant observation and recorded field notes about group dynamics, topics of conversation, supportive messages, and dilemmas. I also noted my reactions to facilitating the group, and I documented feedback that the women gave me regarding helpful (and unhelpful) aspects of the group.

As the results described in Chapter Six demonstrate, the women generally provided negative feedback regarding the topics that practitioner handbooks suggested should be

addressed in such groups. In response, I encouraged the women to select the topic that the group would discuss the following week (e.g., cycles of violence, healthy versus unhealthy relationships, safety planning) and, sometimes, they chose to "leave it open" to address whatever the women wanted to discuss that day. I informed them that I was conducting a study, and that part of the study was building a curriculum, and I asked them—with sincerity—for their aid in building the ideal and most helpful curriculum. Generally, they were excited for the opportunity to shape their group and to determine topics that would be discussed, as well as the idea that they would be helping other women in the future.

Moreover, from an advocate perspective, I truly believed that for the group to be "their group" and to be most beneficial for them, they should choose the "curriculum" and what was discussed in the group; this attribute would make it more of a true support group. This approach also aligned with Helgeson and Gottlieb's (2000) argument that "more effort needs to be invested in soliciting the input of the intended beneficiaries of support groups regarding outcomes that matter to them" (pp. 240–241). By choosing what would be discussed in the DV group, my hope was that the women would receive the outcomes that best met their needs. Moreover, in a doctoral seminar on social support, Dr. Kunkel told us that if we ever do not know what type of support to provide to someone in need, sometimes it is best to simply ask that person. As discussed in Chapter Six, that sound advice worked well with the group for numerous reasons.

Furthermore, having the women choose much of what was discussed was in accordance with Miller et al.'s (1984) assertion that researchers should "view the relationship between researchers and the community members as a partnership in which each party makes a

contribution to the other" (p. 53). Hence, group members and I worked together to coconstruct a group that would best meet their needs.

Additionally, from a research perspective, this approach aligned with Coyne et al.'s (1990) argument that researchers should not impose their frameworks on research participants but, instead, researchers should elicit help from participants in shaping the study. Accordingly, I refrained, largely, from using preexisting typologies and, instead, explored what was generally helpful (or unhelpful) for group members, what they hoped to get out of the group, what they thought they should get out of the group, and outcomes that they perceived to be most beneficial.

Stage 2. In Stage 2 of the study (October 2012–May 2013), I trained the Safe Haven staff member, Sam, to take my place as lead facilitator of the DV group at New Beginnings. Sam and I met and exchanged e-mails before she started shadowing me, so that we could begin discussions about the DV group at New Beginnings, the approach that I used, and suggestions I had regarding facilitating the group. Key staff from Safe Haven, my advisor, and I decided that it would be best for me to train someone to take my place as lead facilitator for two major reasons. First, from an advocate perspective, we knew that I would be "exiting" the scene once I completed my doctoral degree; thus, we wanted to allow plenty of time for me to train someone, have him or her shadow me, and then have me observe him or her to provide feedback. Second, from a researcher perspective, I let Safe Haven know that it would be beneficial for the project if I could *observe* a facilitator in the group, because my previous field notes were based only on my experiences facilitating the group. Additionally, I knew that I would interview group members about their perceptions of the DV group during Stage 3 of the study, and that it would be more comfortable for interviewees if they could answer interview questions about the DV group if someone else was facilitating.

Sam had an M.A. degree in psychology and had experience facilitating substance abuse process groups during a previous internship at a substance abuse treatment center. She also completed Safe Haven's DV training. After numerous discussions and shadowing me four times as I facilitated the group, we both thought that she was ready to start facilitating the group on her own. I continued to attend the group to observe, but, ultimately, we decided that the group should always have two members from Safe Haven present during the group, for numerous practical reasons (e.g., helping to sign attendance forms and answer questions after the group, as well as having someone there for "back up" in troublesome situations, such as conflict between group members or when members became upset).

Stage 3. Stage 3 of the study (February 2012–May 2013) involved me conducting semistructured, and sometimes interactional, interviews with members from the DV group at New Beginnings. I also interviewed a staff member from New Beginnings and my replacement facilitator, Sam. During Stage 3, I also invited women to submit their poetry, creative writing pieces, artwork, or any other creative work for presentation of the project.

Methods

The previous section provided an overview of the research stages for this project. The multimethod approach of this project is comprised of ethnographic participant observation and informal interviewing, and in-depth, semistructured interviews. Autoethnography based on my experiences leading the New Beginnings group also is used in the presentation of results (Chapter Six). The following section provides descriptions of the methods used and relevant participant information for each method.

Ethnography. Ethnography was used in the first two stages of this research project. Relevant details about data collection and participant information is provided at the end of this

section. As described in Chapter Four, Helgeson and Gottlieb (2000) asserted that more studies should examine the actual communicative nature of support groups by recording, transcribing, and analyzing group sessions so that researchers can learn more about basic communicative processes of support groups. I originally planned to audio record group sessions to analyze the conversation and support processes; however, I knew that informing the women that the group would be recorded might hinder their participation in group discussions or make them feel uncomfortable. The women frequently commented about how they loved that they could "say anything" in the group and felt comfortable doing so. Because discussing their DV experiences, potentially, could be powerful for them while in treatment, I decided that, ethically, I could not impose an environment that might hinder their open, honest communication. Thus, ethnographic participant observation was used, instead. Obviously, my field notes are only fractionally detailed compared to original recordings; however, a social justice sensibility grounds ethical concerns (Frey et al., 1996) and I did not want to potentially interfere with anyone's coping and/or recovery.

For the ethnographic component of the research, I immersed myself in the cultural settings (Denzin & Lincoln, 2008) of Safe Haven and New Beginnings, which was possible because I was a volunteer advocate at Safe Haven. I was the facilitator of the group at New Beginnings, and I facilitated meetings with the MOU group. According to Gold (1958), there are four ways to enact participating and observing. First, a *complete participant* participates in a group's activities as an insider but observes the setting covertly (Gold, 1958). Second, a *participant as observer* is a part of a group and observes the group in order to understand or improve processes (Gold, 1958). The role of participant–observer privileges participation over observation. Third, an *observer as participant* has minimal involvement in the setting being

studied; in this role, observation is privileged over participation (Gold, 1958). Finally, a *complete observer* is not involved in the setting at all and simply observes unobtrusively (Gold, 1958; see also Waddington, 2004).

For this dissertation study, my role was that of the participant–observer because I fully engaged in the groups' activities (volunteering at both Safe Haven and New Beginnings), and even facilitated the group at New Beginnings. I then observed the group as Sam facilitated, so my role became that of an observer–participant. According to Emerson, Fretz, and Shaw (1995), someone engaging in participant observation may fall within several "roles" within the scene (e.g., the authoritative academic, the "buddy-researcher," or the naïve student), but whatever researchers' extent of participation or the role that they assume, the scene, nonetheless, always will be affected by someone observing it.

Some of the strengths of participant observation are that it occurs in a naturalistic setting and that it allows researchers to spend copious amounts of time in the field observing, talking to, and participating with group members to construct interpretations of that scene (Ellingson, 2009b). Doing so can lead to a nuanced, in-depth way of interpreting human communicative behaviors. Moreover, participant–observers can continuously check and recheck their assumptions as they further engage in the field, and they can collaborate with others to produce multivocal analyses (see, e.g., Angrosino, 2008; Ellingson, 2009b; Emerson et al., 1995; Hammersley, 1990; Lindlof & Taylor, 2011; Spradley, 1980; Waddington, 2004; Wolcott, 2005; Zahle, 2012).

Field notes. As part as my participant observation, I took field notes about the interactions and dynamics of the support group, as well as recorded my emotions and thoughts regarding my experiences of facilitating the DV support group, working with the women at New

Beginnings, and hearing their stories (in accordance with Wolcott, 2005). Because I was facilitating groups at New Beginnings, I could not take field notes during the group sessions but after each group session, I immediately took scratch notes of the events and/or recorded my thoughts with a voice recorder in my car in the parking lot, and I then expanded on those notes when I arrived at my house. Some notes were transcribed via computer soon after they were taken, for maximum validity (Lindlof & Taylor, 2011), whereas others were handwritten in research journals (see Ellingson, 2009b). Richardson (2000) recommended using separate field note journals for recording personal feelings about observations, and journals were used to organize varieties of fields notes (e.g., notes about observations, methods, theory, or personal thoughts).

Ethnographic data collection and participant information. Safe Haven collects demographic data from the women at New Beginnings, but that information is limited (i.e., name, birthday, ethnicity, and sex). I was allowed to report this information for the study. Women were asked to fill out demographic forms, but they were informed that providing that information was completely voluntary and confidential. Accordingly, the numbers in the next paragraph underrepresent the actual number of women who participated in the DV group at New Beginnings.

From January 2011–October 2012, the time period when I facilitated the DV group at New Beginnings, 153 women attended the DV group. Additionally, 110 women attended the DV group when Sam facilitated (total $N = 263$). Approximately 16–18 women attended the DV group on any given day. The women’s average age was 31 years (age range = 18–60+ years). The women’s ethnic composition was 81% Caucasian, 9% Multiracial (with 2.7% identifying as

having Hispanic ethnicity), 6% African-American, 2% Native American, and 2% Unknown/Other.

During the time that I facilitated the DV group at New Beginnings and after IRB approval of the project, I completed approximately 118 hours of participant observation with the DV group and relevant meetings (e.g., staff meetings about the DV group and individual meetings with residents). I also completed 89 pages of single-spaced, typed pages of field notes, and filled two 5” × 7” 100-page notebooks with handwritten field notes during the time that I facilitated the support group. I also wrote memos in margins of 37 handouts that were used in the DV group. During the time that Sam facilitated the DV group, I completed approximately 45 hours of participant observation, and I recorded 80 pages of handwritten field notes in one 5” × 7” notebook and wrote memos in the margins of 29 handouts.

Interviews. Interviews were used in Stage 3 of the project to check my observations of the group and to “generate rich and descriptive data” (Yu, 2010, p. 25). Interviews were used to “encourage interviewees to reflect on their experiences or beliefs, or to provide segments of talk that researchers can analyze to learn about their inner worlds” (Sprague, 2005, p. 119; see also Charmaz 1991). To gain insights from participants’ experiences with the DV group, I used a semistructured interview protocol to have a “guided” conversation with the women (Lindlof & Taylor, 2011). Hence, I had a framework for the interview, but I also probed for more information at times (Dilley, 2000). I also followed Dilley’s (2000) suggestions for interviewing: I listened carefully; compared what interviewees said to my observations, as well as to what they said in other parts of the interview; and I deviated from the protocol if necessary to respect interviewees’ time, as well as to probe for more information when clarification was needed (see Appendix C for the staff/support group facilitator consent form; Appendix D for the

staff/support group facilitator interview protocol; Appendix E for the resident/client consent form; and Appendix F for the resident/client interview protocol).

Participants' circumstances also may have affected the power dynamics of the interviews conducted (Sprague, 2005), but I took Heasley's (2011) advice and focused my energy on treating them in respectful, friendly ways—no matter what they said—such that they would feel that I was not judgmental and that I was open to hearing their views, which was especially important for women at New Beginnings, who might have discussed both their substance abuse issues and, possibly, criminal behavior.

Recruitment and procedures. I recruited interview participants by face-to-face invitation in numerous ways. First, for residents and clients at New Beginnings, I announced the call for interviews before numerous DV group sessions. Second, I announced the opportunity to participate in interviews before two "house meetings" at New Beginnings. Third, I spoke with numerous past residents about participating in the study when I saw them by chance in public. Moreover, once word about my study started spreading at New Beginnings, several residents approached me to discuss their participation. All interviews were either scheduled on the spot, or I gave the women my business card so that they could call at a later time to schedule an interview. For staff members, the organizer at New Beginnings announced the study to staff during a staff meeting and e-mailed staff members my contact information. I also invited numerous staff members to participate in the study via face-to-face conversations, and I left a stack of my business cards at the front desk for them.

However, after numerous attempts, only one staff member agreed to be interviewed. Thus, I do not provide the staff member's demographic information in this dissertation project because it could be potentially identifying. Although Sam gave me her explicit permission to

include her interview information, I am not including her demographic information for confidentiality purposes.

During initial recruitment for residents, clients, and staff, I explained the research purpose, general procedures, and consent process. I also stressed that participation was voluntary and that choosing to participate (or not), in no way, would affect their access to services and/or employment, or their volunteer status at Safe Haven or New Beginnings.

The interviews took place at a public location or in private meeting rooms at New Beginnings, with participants and me determining the date, time, and location of the interview. Before the interviews took place, I reminded participants of the procedures and consent process. Following the interviews, participants were provided with a list of local counseling services in case any issues came up during the interview that were upsetting or stressful (see Appendix G).

Interview data collection and participant information. Interviews were conducted between February 2013 and May 2013. In total, 20 women participated in the semistructured interviews, and interviews totaled 30 hours and 6 minutes. The interview audio files were transcribed by a professional transcription service, Verbal Ink, which had experience transcribing academic interviews. The audio files were uploaded to Verbal Ink's secure server via encrypted files. Once the transcriptionist completing transcribing an interview, all files at Verbal Ink related to that interview were permanently deleted. Upon receiving the completed transcripts, I checked them for accuracy. The average interview length was 1 hour and 30 minutes, and interviews ranged from 33 minutes to 2 hours and 35 minutes. Single-spaced transcriptions resulted in 743 pages.

Of the 20 interviewees, the average age was 31.63 years (*SD* = 8.85; age range = 21–48). The women's ethnic composition was 16 (80%) Caucasian, 1 (5%) African American, 1 (5%)

Multiracial, and 1 (5%) Hispanic; one participant identified as “spotted” and another as “human.” Thirteen (65%) of the women identified as heterosexual, three (15%) identified as bisexual, and two women identified as gay (10%). Two women (10%) did not provide their sexuality. Twelve (60%) of the women entered treatment at New Beginnings voluntarily, whereas 5 (25%) entered treatment due to suggestions from the court system or family services, and 3 (15%) entered New Beginnings on “body release” from prison.

At the time of the interviews, six (30%) of the women were in intensive short-term residential stay (28 stays); six (30%) currently were in extended residential stay (HIOP), six (30%) were transitioning into HIOP, one (5%) graduated from intensive short-term care and was receiving outpatient services, and one (5%) was a past resident of New Beginnings. The average length of time receiving services from New Beginnings was 35.7 days (range = 13–102 days). The women had varying education levels, from a 10th-grade education to college degrees, and they held various occupations (e.g., professional medical aid, nurse, cosmetologist, stay-at-home mom, unemployed, painter, welder, teacher, and exotic dancer). Every participant had experienced some type of DV; their experiences ranged from experiencing situational couple violence and some controlling behaviors to rape and severe intimate partner terrorism.

Autoethnography and narrative data. Autoethnography and narrative data are used in Chapter Six to present findings and to share experiences. According to Bochner and Ellis (2006), autoethnography breaks down the dichotomy of and merges objectivity–subjectivity, other–self, and self–social. The overall aim of autoethnography, through stories and dialogue of personal experience, is to engage readers in a dialogue with the text that allows readers to relate their experiences and to “fill in the blanks” for themselves (Goodall, 2004; see also Bochner & Ellis, 1992). This process leads readers to view how *communication* is used to make sense and

to engage in dialogues that synthesize the past, present, and future (drawing from the past in the present to move forward in the future). For Ellis and Bochner (2006), autoethnography is an epistemological, methodological practice that seeks to aid others to learn about themselves through witnessing and relating to others' stories and dialogues about trying (and sometimes distressing) events.

I use elements of autoethnography in this project, given that I participated as a facilitator. In that sense, I hope that others can learn from my experiences of leading the group. I also can identify the "ups and downs" of leading these groups as I experienced them. Furthermore, as S. H. Jones (2008) stated, autoethnography "is a discussion that moves discourse to storytelling performance, from autonomous texts to situated practices, from received storylines to emergent dramas with numerous possible 'endings,' and from omniscient narrators to a proliferation of unreliable reflexive voices" (p. 774).

Creative works. During Stage 3 of the project, I invited women to submit their poetry, prose, artwork, or other creative works to be included in the presentation of the study. Interviewees were given a small notebook to record creative works or their thoughts about attending the DV group and/or their recovery process, in general. They also were given a sealable envelope in which they could return the materials or submit other creative works. I also told the women that I could make copies of anything submitted and return the originals to them if they wished. They also were told that they could submit documents in the sealed envelope directly to me or that they could leave them at the front desk at New Beginnings, where I could collect them. One person submitted original artwork for the project, and another submitted the beginnings of an autobiography that she started writing in treatment.

Analysis of the Data

Because of the exploratory nature of this project, I used inductive and iterative analytic techniques to analyze the data by open and axial coding, to identify reoccurring and patterned themes within the data (Glaser & Strauss, 1967; Miles & Huberman, 1994). The inductive, constant comparison coding method was used to analyze perceptions regarding helpful and unhelpful support messages and group dynamics, as well as anticipated, desired, and actual perceived outcomes from the support group.

To begin, I developed substantive codes (codes derived primarily from participants' words; see Charmaz, 2006). I used colored markers on the printed transcripts to highlight types of support given and received, as well as common themes that emerged through constant comparison. I also wrote memos throughout the process to document notes, thoughts, and reactions during the coding process. I then compared and contrasted the substantive, preliminary codes that emerged and generated a codebook for more general codes from the substantive coding, using axial coding and further constant comparison methods (Charmaz, 2006). As suggested by Lindlof and Taylor (2011), the codebook contained notes regarding my coding decisions, themes, code names for each theme, and examples from each theme.

The open coding process required multiple passes through the data, as the coding scheme was shaped through comparative sense-making, and the coding process was ongoing. Axial coding was used to delineate relationships among the helpful and unhelpful messages and dynamics of the group, as well as to document perceived outcomes. I identified initial themes by using a the constant comparison process, and those themes were further collapsed into categories through the axial coding process (Charmaz, 2006).

Chapter Six: Results and Interpretation

This chapter focuses on aspects of the domestic violence (DV) support group that participants perceived as helpful and unhelpful. First, I describe my intervention with the DV group. Next, I describe communicative approaches Sam (a staff member at Safe Haven and the most recent facilitator of the DV group at New Beginnings) and I used in facilitating the DV group. Then, I provide the major themes participants identified as helpful and unhelpful communication within the DV group.

Introduction

As discussed in Chapter Three, there is a correlation between DV and substance abuse (see, e.g., Chase et al., 2003; Coker et al., 2000; D. H. Coleman & Straus, 1983; Fals-Stewart & Kennedy, 2005; Gondolf, 1995; Hamilton & Collins, 1981; Holtzworth-Munroe et al., 2000; Kantor & Straus, 1989; Leonard & Jacob, 1988; Logan et al., 2001; NCADV, 2011; Pernanen, 1991; Stuart et al., 2006; Testa et al., 2003). The issues of DV and substance abuse can "interact and exacerbate each other" (Engelmann, 1992, p. 6) and should be addressed simultaneously when both issues are present (Fazzone et al., 1997).

The staff at New Beginnings approach substance abuse treatment holistically; thus, they recognize the importance of helping women to cope with various issues that might contribute to or exacerbate their substance abuse, including DV. Although substance abuse counselors and staff at New Beginnings have basic knowledge about DV, New Beginnings sought *DV experts* to provide DV support for the women in treatment. Accordingly, representatives from Safe Haven, a DV agency, facilitate a weekly DV group at New Beginnings so that DV experts and substance abuse counselors can address issues of DV and substance abuse simultaneously. This approach aligns with recommendations that DV advocates provide support and services for people in

substance abuse treatment (Bland & Edmund, 2008; Domestic Violence and Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services, 2005).

Many of the women at New Beginnings who attended the mandatory DV group identified that they had experienced DV in the past or were currently experiencing DV in their relationship, whereas some did not have experience with DV. Additionally, some women did not *initially* identify their experiences as DV, but eventually did after attending the DV group. Although not every woman at New Beginnings felt that the DV group was pertinent to her treatment plan, many of the DV group attendees I interviewed expressed how they thought the DV group was a necessary part of their recovery. For example, Birdy never sought services for her experiences with DV or sexual assault because "*life got in the way*." When I asked her if she thought that the DV group at New Beginnings was necessary, she replied:

> *I do. Because I think it goes hand in hand with addiction. It's too intertwined to not be addressed. It's too common to not be addressed. And I think it needs a safe place to be addressed. And I think that people are more open too. And I think outside of here, it's not going to happen. Inside here is a good place—because when we're out there, we're not going to go to some DV group. You know what I'm saying? And life gets in the way. And in here, life is here.*

Moreover, as Kathy explained:

> *There's such a huge correlation between domestic violence and addiction. I like it the fact that it's interrelated [here] and it needs to be interrelated. And if you're going to be in substance abuse treatment you need to have domestic violence as part of that therapy, and vice versa. I think that as part of what Safe Haven offers is part of a comprehensive*

treatment. I mean if women are willing to go through the addiction process and further treatment for that part of it, I think it needs to be holistic.

Overall, the DV group at New Beginnings provides a forum for women to discuss their experiences of DV, to learn from each other and from the facilitator about different aspects of DV, and ultimately, to make sense of how DV has, does, or could affect their lives. For some, examining their experiences with DV was a positive process that helped them to make sense of those experiences and to heal. For others, examining their experiences with DV was a confusing, scary, or heartbreaking process. Women referred to the DV group as "heavy" countless times; group members often cried, felt confused, or became angry. However, group members also often laughed together and provided each other with support, affirmation, and hope.

I began this intervention-oriented project when Safe Haven asked me to facilitate the DV group at New Beginnings, and New Beginnings asked me to improve the group from how it had operated previously, to make it more helpful for the women who attended. After I facilitated the DV group for 8 months, the research component of this project began in order to examine what DV group members deemed as helpful and unhelpful communication within the DV group. This chapter provides the major findings, and relevant interpretations, to the research question:

RQ: What do participants perceive as helpful and unhelpful communication within the New Beginnings domestic violence support group?

The Intervention

As mentioned in Chapter Five, during my shadowing period in preparation to become the DV group facilitator at New Beginnings, a New Beginnings staff member told me that I needed

to "do something about"[3] the DV group because the women did not believe that the group was helpful. Consequently, I created a proposal for the "new" DV group, and members of Safe Haven and New Beginnings approved my proposal during a joint meeting.

There were several factors that I needed to consider when developing my proposal. First, the women at New Beginnings were required to attend the weekly DV group during their first 28 days of treatment. Some women graduated and left the facility after 28 days, so most women only attended four sessions. If a woman graduated and stayed at New Beginnings in Housing Intensive Out-Patient (HIOP), she could choose whether to attend the DV group. Thus, some women chose to attend the DV group for much longer periods of time. Finally, some women checked themselves out of New Beginnings or were "kicked out" for various reasons *before* 28 days, so some women might have attended only one group session. Second, because new women came to the treatment center and DV group every week, the group's membership constantly changed. Third, because *every* woman at New Beginnings was required to attend the DV group, their experiences with DV varied greatly. In addition, it could not be assumed that some women were not "abusers" themselves. Overall, I needed a plan that would be relevant enough to be beneficial for members who did not attend the group more than once, varied enough to keep it "fresh" for those who attended more sessions, and open enough to include various kinds of lived experiences (or lack thereof) with DV.

My proposal was that the group would be more like a "support group" than a class because I wanted the women to be able to discuss their issues and to make sense of their experiences with each other. Both agencies wanted me to continue to incorporate an educational

[3] Throughout this chapter, I do not italicize women's words when the language reported came from my field notes, and thus, from my memory. Words are only italicized when they are verbatim quotes from interviews (for arguments regarding using verbatim quotes, see Corden & Sainsbury, 2006; Manning & Kunkel, 2014; Sprague, 2005).

component within the group, and New Beginnings suggested that I prepare a handout for each group meeting so the women had information to take with them. This suggestion also aligns with Helgeson and Gottlieb's (2000) assertion that support groups, perhaps, are most effective when they include informational support (see also Helgeson et al., 1999).

My plan for the weekly, 50-minute[4] group was to begin by briefly introducing myself and asking, "Is there anyone I haven't met before?" That way, I could get an idea of who was new to the group. Then, I would briefly explain the reason I was there (i.e., a couple of statements about the relationship between DV and substance abuse and why it is important to discuss DV). I would then quickly describe Safe Haven's services and pass out informational fliers about Safe Haven. Then, to "break the ice" and start on a positive note, anyone who wanted to share something she accomplished that week or something she was proud of could share that with the group (see, e.g., Bland & Edmund, 2008). After "proud moments," I would ask if there were any questions about Safe Haven or the group from the previous week. Then, if relevant, I would ask if anyone wanted to provide a review of the last session for any new members. Next, we would begin discussing the topic of the day.

On the first day that I facilitated the group, I introduced myself and told the women that we were going to "change things up" and that we would spend the last 10 minutes discussing what they wanted from the group. They started looking around at each other, and someone asked, "Really?" I replied, "Yeah, really. I want this to be *your group*." During our discussion of how we should change the DV group, numerous women suggested topics that they wanted to discuss. Bland and Edmund (2008) asserted that facilitators should "Be flexible. Think kitchen-table—have a topic in mind but be willing to change. Let women own the group" (p. 19). Thus,

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[4] New Beginnings eventually scheduled the group for a longer amount of time (1.5 hours) in October 2012 because the women requested more time for the group. Three participants I interviewed (who attended the once a week, 1.5 hour group) reported that they wished the group was even longer or met more than once a week.

on the first day, I asked the women, "Do you all just want to pick what topic we will discuss the next week?" There were resounding replies of "Yes!" As the women were leaving, I said what my general closing became: "Thanks for a great group, ladies! Have a fantastic week!" I overheard numerous positive comments as the women were leaving, and a woman came up to me and said, "I'm glad you're leading the group now. You have such a positive presence. We all hated, dreaded this group, but it's going to be cool now!" I firmly believe that having the power to choose their curriculum was a large part of their excitement.

Thus, a new plan was established: from that moment on, at the end of each DV group, I asked, "What do you all want to talk about next week?" Hence, the women chose their topics (or curriculum), and it varied depending on *their needs*. If the women were not sure what they wanted to discuss, I provided as many examples as I could and we brainstormed from there. Alternatively, if there was not a clear consensus, I would say, "Or, do you want me to just roll in next week and keep it open?" There were many weeks in which the women chose to keep the topic "open." In those cases, the women wrote down any questions or ideas that they had throughout the week (e.g., how DV affects children, tips for raising self-esteem after DV, and red flags for abusive relationships) and we started the next group by addressing those topics. Then, we simply followed wherever the discussion led.

I also carried copies of *every* handout I had gathered from various sources (including ones that I had made) with me to the group in a large bag so that I could accommodate their topic ideas. I learned to carry those handouts because sometimes the planned topic of the day changed. For example, during one session, the women chose to talk about the effects of DV on children for the next week because they all had children who witnessed DV and wanted to learn more about ways to address that issue. When I started passing out the handouts the following

week, one of the women said, “Hey Jenny, do we have to talk about this today? We’ve all had a really bad week regarding kid stuff.” I replied, “Absolutely not,” and we moved onto another topic.

Overall, we discussed many issues related to DV. Some of the broader topics included: the “Wheels” (Power and Control, Equality, Substance Abuse; see Appendices A, H, and I, respectively); healthy relationships; coping, grieving, and healing; empowerment; gender issues; state DV laws; survivors’ stories; self-esteem; how to regain trust; the “mindset” of abusers; effects of DV; DV cycles (generational and within DV relationships); and safety planning. We also sometimes watched videos that I borrowed from Safe Haven’s collection, did relaxation exercises, or engaged in “free-writing sessions” in which I gave the women sheets of blank paper and they wrote nonstop for 5 minutes. As Pennebaker (1997) described, writing can facilitate sense-making and coping. Although I sometimes led the women in activities and discussion, the women also spent a lot of time telling their stories, asking questions, and sense-making about their experiences.

I firmly believe that—for this forum and for me—it was best that the women chose topics that they wanted to discuss. It also was very helpful that I carried every handout with me to the group because I always reminded the women that I did this and they would often “shop” for handouts during or after group sessions. Hence, even if a woman would not have a chance to discuss a certain topic during her stay at New Beginnings, she at least was able to grab a handout about that topic. Additionally, I often solicited feedback from the women, and they consistently told me that the Power and Control Wheel was the most “helpful” topic that everyone should see. Thus, I did my best to make sure that the Power and Control Wheel was covered every few weeks (in addition to the topics they chose).

When I trained Sam to start facilitating the group in October 2012, I told her that the women chose and helped to create their own "curriculum." I recommended this format to Sam because DV group members provided great feedback about this approach, and the approach ensured that we focused on relevant and timely topics for them. After providing Sam with comments and feedback about my approach, it was ultimately Sam's decision as to how she wanted to structure the group. In the end, Sam decided to develop a curriculum (e.g., the Power and Control Wheel, the Equality Wheel, healthy and unhealthy relationships, red flags, handling stress, healing and moving on, and safety planning), which she rotated weekly with the DV group. When I asked Sam why she decided to structure the curriculum in the ways that she did (and not leave it more open like I had done), she simply said, "Because I'm not as organized as you" and left it at that. Although Sam chose the topics of the day for the DV group instead of the group members, participants nonetheless reported that they felt like they "owned" the group (as described later in this chapter) because Sam generally let the women lead the discussion. Overall, I was very surprised to find how similarly Sam and I facilitated the group—from our general approach to even specific messages. I often thought while observing Sam, "That is pretty much what I would say and how I would say it!"

In sum, the major components of my intervention with the group stemmed from Bland and Edmund (2008), as well as the DV group members' preferences and needs. I do believe that, after revising the structure and organization of the group, the group became more beneficial for the women, and the feedback I received from the women *and* the staff at New Beginnings confirmed this. (I even heard numerous times that the DV group was a "favorite" group at New Beginnings.) The group became more *their group*, and the women largely directed the topics and conversations. In the following sections I describe how, as part of the intervention, Sam and

I departed from perhaps more "typical" ways of approaching DV advocacy as facilitators (see, e.g., Loseke, 1987, 2001, 2009).

The facilitators' approach. Completing Safe Haven's training greatly broadened my knowledge about DV; although I did not realize it until months later, completing the training had resulted in my acceptance of the "formula story" (or metanarrative about DV) as the only way to view DV (see Loseke, 2001). As described in the following section, Sam and I did not abandon the formula story, but we tried to approach the facilitation of the DV groups in ways that also communicated beyond the formula story to include women whose lived experiences did not neatly correspond with this metanarrative.

Communicating beyond the formula story. As Loseke (2001) explained, in the 1970s, the "social problem of 'wife abuse' was not yet in public consciousness; the 'battered woman' and the 'abusive man' were not publicly recognizable identities" (p. 107). Accordingly "formula stories" of DV (see Berger, 1997) were created to establish the *problem* in public consciousness (Loseke, 2001). Feminist activists began—and continue to—"tell stories [about DV] in order to convince others to take wife abuse seriously and to support calls for social change" (Loseke, 2009, p. 6). These stories are powerful because narratives "can be persuasive, and . . . they can offer individuals templates for understanding themselves and others" (Loseke, 2009, p. 2). These formula stories about DV have "flourished in recent decades" in the public and the media, and they are "told in terms of clearly immoral behavior, with pure victims and evil villains" (Loseke, 2001, p. 107). As Loseke (2001) explained:

> This formula story can be an interpretative resource for women, showing them how to understand their experiences in ways that resonate with the story of typical "wife abuse." In turn, the formula story helps women conceive of themselves in terms of the identity or

> type of person that has come to be called the "battered woman." Similarly, the formula story promotes the use of the category of "abusive man" to describe women's assailants. (p. 107)

Beyond describing what DV "is" and the characters involved, the formula story includes the notions that *severe violence* is experienced by the victim, that the brutish abuser will never stop the abuse, and that the story has a "happy ending when a woman leaves her abusive partner" (Loseke, 2001, p. 118).

The formula story of DV, which I believe Safe Haven adopts as *the way* to conceptualize and explain DV, is extremely beneficial for numerous reasons (for a comprehensive review, see Loseke, 1987, 2001, 2009). Generally, the formula story of DV creates awareness of the problem in society and illuminates the seriousness of the issue (see Loseke, 1987, 2001, 2009). The formula story also may inspire women who identify with the story to seek aid and to escape a potentially dangerous situation. As Loseke (2001) articulated, "Countless women *do* see themselves in this narrative and for those women the wife abuse formula can be nothing less than lifesaving" (p. 124).

However, this formula story does not always correspond with people's actual, lived experiences. Women's lived experiences and their stories about their experiences "often are heard by others as rambling or incoherent; stories repeatedly alternating love and hate, tenderness and violence are heard as illogical" (Loseke, 2001, p. 109). Accordingly, Loseke (2001) explained that "Audiences tire of hearing such women talk of how they are planning to 'leave,' 'stay,' leave,' 'stay,'" and eventually, "Chaos narratives can lead listeners to reject the stories and, in doing, reject the storyteller's reality" (p. 109).

Loseke (2001) argued that many DV advocates try to "encourage women to make sense of their nonunderstandable lived realities by narrating their practical experiences as those of wife abuse, and simultaneously to think of their selves as battered women and their partners as abusive men" (p. 110). As Loseke found in her analysis of 10 DV support group sessions, the DV advocate facilitators often ignored parts of women's stories that did *not fit* the formula story and encouraged the women to reframe their stories to ones that did fit the formula story by asking leading questions and providing responses that reframed the women's stories. The DV advocate facilitators that Loseke studied encouraged women whose stories did not perfectly fit the formula story to recast their stories with plots of extreme violence and characters of the pure victim and vicious villain.

In my experiences at Safe Haven, I often noticed that—and as Loseke (2001) also found—many of the DV advocates pushed the survivors toward the formula story of DV. I observed the previous DV group facilitators at New Beginnings engage in that behavior as well. Generally, when the women did share their stories, the facilitators sometimes ignored information that did not fit the formula story, and the facilitators tended to talk about the formula story as the only version of DV. In theory, Safe Haven allows survivors to decide what counts as DV; however, in practice, some Safe Haven advocates, along with the previous DV group facilitators at New Beginnings, often explained DV in terms of the formula story. This view certainly can be valid in some cases and, as mentioned above, it can be extremely beneficial for those who relate to the story.

However, the formula story does not always correspond with people's lived experiences. In essence, the qualm I had with some of Safe Haven advocates' practices was *how* they communicated with survivors. There is a big difference between providing information as

"truth" and providing information as "theory" or "one way to look at it." During an interview for this project, Sam explained the importance of viewing DV in complex ways and not presenting information to survivors as "Truth." Sam said:

> *I think what I hear a lot at Safe Haven and different places I've worked is, "This is what is going on." Like other advocates say "this is what's happening"...and I hear [survivors] regurgitate—"well they told me this is what I need to do or this is what's happening, and I don't believe that." So [advocates] might say, "what's happening in your situation is power and control and he's trying to have power and control over you." And [the survivor] says, "Okay. This person knows this stuff, so they know what's happening, so obviously it's power and control." I've heard advocates talk about "this is what's happening—say "that's what's happening" and NOT "this is A theory." And they're not super cautious with what they say. They're just trying to be supportive and offer as much information as they can, and I think that it's really well-intentioned, but sometimes it comes across as FACT rather than a THEORY.*

Sam and I then discussed the implications of viewing DV in black and white terms; we believe that DV is not black and white and that it is important to think about it as a complex issue that can take many forms, with many shades of grey. When discussing the complex ways that DV can be experienced (e.g., intimate partner terrorism, substance-related abuse, and situational couple violence), Sam said:

> *But that doesn't exist at Safe Haven. It's very clear there's a man who's controlling you as a woman because he's got patriarchy and entitlement and he's never going to get better and if you go to couple's therapy, he's just going to learn better ways to abuse.*

Additionally, if a woman is experiencing situational couple violence (i.e., where both partners commit violent acts during conflict; see Johnson, 2006), she might not *want* to end her relationship, as the formula story advises that she should. Sam and I discussed the importance of letting women cast their own stories and how DV advocates should not push the formula story—complete with characters of the pure victim and vicious villain—when a woman does not describe her situation as such. Sam explained how, when a woman is experiencing situational couple violence, it is *not* helpful when DV advocates discuss her partner as if he or she were a monster:

> *People do not view the person that they love most in the world as an abuser—as a monster. We come in and say, "This is an abuser and this is what they do to you and this is horrible and you don't deserve to be treated like this." This is the person they love, they married, they choose to be with. So I think breaking it down like this [in terms of different types of DV] happens in these situations, I think it's empowering for some people. I don't know. I think that—not intentionally—and sometimes I'm wrong but when sometimes people when they're super supportive—"an abuser"—"an abuser" —I think it would turn me off if I was talking to someone and they just demonized my partner. Even if my partner's a dick, I can talk shit on them but not you. Breaking it down [for survivors] can be useful then.*

Again, the formula story can be extremely beneficial for some women who relate to it. If a woman is experiencing intimate partner terrorism (see Johnson, 2006), casting the story as one in which a woman is terrorized and manipulated may help a woman make sense of her situation (e.g., "It's not my fault. I'm not crazy") and encourage a woman to seek assistance and/or take steps toward achieving safety. As Loseke (2001) argued, we should not ask "what is wrong with

women who do not want to understand themselves as a character in the wife abuse story?" (p. 122). Instead, it is helpful to examine the formula story and to understand why a woman *might or might not* accept it. For example, if a woman does not believe her situation is dangerous or one of extreme violence, she might not "want to embrace the status of victim with its accompanying images of weakness" (Loseke, 2001, p. 123). Additionally, if a woman's experience is one of mutual combat and she casts it as such, "she is a character who acts and who has some measure of control over her experiences. If she casts herself as a character in a script of marital troubles, she need not totally condemn the partner she still loves" (Loseke, 2001, p. 123). This point is further complicated, however, because some women in the DV group whom I would consider to have experienced *extreme* violence (e.g., hearing threats of being killed or being choked until they passed out) with immense behavioral systems of control (e.g., not allowed to spend time with anyone else besides their partner), nonetheless, *loved* their partners and believed that the abuse *was her fault* because she "pushed" her partner to violence. In those cases, a woman might find it beneficial to eventually reframe the story as the formula story instead of one of situational couple violence.

Thus, I believe that providing information that aligns with the formula story is potentially very helpful; however, women should be able to accept the story or *not* as they see fit. As Sam mentioned above, in practice, some advocates view DV as the formula story and nothing more. Sam and I discussed how we understand that it is beneficial for organizations such as Safe Haven to have guiding philosophies for consistency as well as practical reasons, such as receiving grants. However, Sam and I both believed that these metanarratives used in practice when communicating with survivors are potentially limiting and unhelpful for those who do not "fit" within these categories.

In the DV group, some of the women's stories did indeed "fit" the formula story, but other women described situations of their own aggression or of situational couple violence (see Johnson, 2006). Others looked at the Power and Control Wheel and were afraid that they were "abusers," in the midst of experiencing the same abusive behaviors that they thought they also were exhibiting. If an organization's communicative practices have undertones that all "abusers" are monsters who will never change, what does a woman think of herself if she engages in situational couple violence or violent resistance? I rapidly learned that the formula story can either tremendously help women through relating to the story, or it can create confusion, tension, or resentment when group members' lived experiences do not correspond to it.

For example, during my first day as a facilitator of the DV group at New Beginnings, I quickly learned that some of the women did not consider themselves to be "pure victims." Additionally, I must admit that, like the DV advocates in Loseke's (2001) study, I initially tried to reframe a woman's story as the formula story. As part of the session, we discussed the Power and Control Wheel (i.e., a description of DV behaviors that aligns with the formula story; see Appendix A). The women took turns reading sections of the wheel aloud and they provided personal examples for each section. Then, when we began discussing the last part of the Power and Control Wheel, a woman said, "I'm sorry, but I have something to say. There's a real sense of—okay I'll use 'I language'—I have felt a real sense of victimization in here, but I slug the shit out of him, too, sometimes." I suggested to her that it is quite common for survivors of DV to fight back, possibly in self-defense. That statement was my "push" toward the formula story; my statement implied, "No, you are in a context of domestic violence where you fight back against the vicious villain—you are a pure victim." She replied, "No, this is not defense. I start it or hit him when I get mad. What do you all think?" Many of the women raised their hands, nodded,

or verbally agreed. The woman then said, “I play a role in the abuse, too, and I’ve said and done *horrible* things to my family when I use [alcohol and/or drugs]. So, we know the Power and Control wheel, sure, but what’s beyond that?”

After that exchange, I quit *pushing* the formula story on her because it did not match her lived experience and that is *not* how she wanted to cast her story. I realized that there was no reason to entirely abandon the formula story in the DV group (see Loseke, 2001); however, I needed to refrain from recasting women’s stories, and I realized that it was okay to talk about the difference between extreme violence (e.g., intimate partner terrorism) and “crappy conflict skills” (e.g., situational couple violence). For some survivors, it was extremely helpful to learn about violent resistance (e.g., violence in response to violence; see Johnson, 2006) because it helped them to make sense of the fact that they had “never been like this before” and it gave them relief if they previously were mistaking themselves to be abusers in terms of the formula story. A New Beginnings staff member also advised me that I should “keep things simple” in the DV group, but I thought, “The women’s lives are not simple, though; why not make it complex?”

Soliciting stories. Accordingly, instead of being pushy facilitators who dominated the group and led women toward the formula story, Sam and I solicited the women’s stories by encouraging them “to elaborate [their] feelings and perspective[s] regarding the problematic situation” so that they could better make sense of their own situations (Burleson & MacGeorge, 2002, p. 402). Burleson and MacGeorge (2002) explained that highly effective supportive communication acknowledges and legitimates a person’s emotions, expresses “compassion and understanding,” and encourages the person to describe his or her thoughts and feelings (p. 402). Soliciting elaboration of experiences can facilitate sense-making processes, which can result in

deeper understanding and reappraising the situation in helpful ways (Burleson & Golsmith, 1998; Burleson & MacGeorge, 2002; see also Harber & Pennebaker, 1992). Not only is this approach deemed helpful in the social support literature, but also it aligns with Safe Haven's philosophy of empowerment, as well as with my and Sam's approach that the women truly were the experts of their own lives.

Providing information. Although DV group members deemed sense-making through people's stories to be very helpful, the women also predominantly wanted information. Similar to Dennis et al.'s (2008) findings regarding breast cancer survivors, DV group members (and facilitators) at New Beginnings encouraged emotional and esteem support, but informational support was the type of support the women most frequently solicited and provided. As illustrated later in this chapter, the women thought that it was especially helpful to have informational handouts and to learn about various ways to conceptualize DV, how DV "works," and some considerations of the red flags of an abusive relationship. Additionally, some women who experienced rather severe violence thought that the informational support was most helpful because they did not realize that such behavior could be considered unhealthy; in fact, for some, it was "all they knew." As Ann explained, "*I kind of grew up with it. It was normal. I never knew any different.*" Stephanie said, "*Honestly, being violated is all we really know. So to us that's normal. It's normal for you to crack my skull open and break my jaw and for me to still love you and want to be with you*." Additionally, Joyce said, "*That's why I think it's so important for you guys to go [to New Beginnings] because the education is just priceless. We need that. If we can't get it while we're in treatment we're not going to get it.*"

The women in the DV group consistently provided feedback that they wanted more information, and Sam and I both were fortunate to have advanced educational backgrounds that

exposed us to many studies about DV, healthy and unhealthy relationships, conflict, trauma, coping, and numerous other subjects that might be beneficial for the women. Thus, we incorporated information from various studies on the spot when necessary, and we made sure to provide as much information as possible *without* dominating the group. Usually, we provided information as examples in between the women's insights or as responses to their questions. We also provided information via the handouts that we gave to the women in the group, and we both had a "topic of the day." However, the women took the discussion where they wanted it to go; in some group sessions, discussions were so lively that we did not cover the entire handout. We both agreed that those were some of the best group sessions.

Sam and I made sure to present any information as "just one theory" or "one way to think about it." We also incorporated multiple views in order to facilitate an atmosphere in which the women made sense of their situations themselves. For example, if a woman asked, "Why do abusers abuse?" I would make sure to say that there are *many* theories or ideas about this. I would list various views, and then turn the discussion back to the group, or even start the discussion by asking the group members what they thought. Sam also took this same general approach.

From the time that I first began facilitating the DV group, I tried to provide any requested information for the women in the DV group; thus, I also began incorporating information that did not quite align with the formula story—even when I thought that Safe Haven might disagree with the approach. For example, in a DV group sessions that had unusually low attendance (seven women), the conversation between the women developed into how they felt that a lot of their DV experiences stemmed from "drama" and "bad conflict" and they needed to know how to handle conflict better. One woman said, "Well, hell if I know. That's why we're asking you." I

hesitated for a bit and was unsure of what to do because I had often heard from Save Haven staff that "Safe Haven doesn't do conflict management." I understand the reasoning for *not* wanting to talk about conflict management with some survivors of DV; talking about conflict management with some women might minimize the seriousness of their situations. However, how helpful would it have been if I simply said, "Sorry, but we can't talk about that"? I truly believe that making an overarching judgment call about what is, or is not, "acceptable" to talk about with survivors is *not* empowering at all—especially if they want that information. I believe that any issue can be discussed, if it is paired with thoughtful communication. At that point, I had taught numerous classes about conflict within romantic relationships, so I knew the research well. I knew that Safe Haven *might not* approve of what I was doing, but I was confident that I could handle the situation sensitively. I, therefore, decided to go against my original DV training in facilitating the group.

Thus, within the context of this small DV group (i.e., seven women), we first discussed Johnson's (2006) types of domestic violence, but I reminded the women that these are only *general types* that they may or may not find relatable. After the group heavily discussed the differences between controlling, severally abusive behaviors, and "crappy conflict skills," they began to further make sense of their experiences. After listening to each other's stories and sharing their own, four of them decided that they had experienced "intimate partner terrorism," but as a result, they felt that they were starting to become verbally and physically aggressive during conflict because they had "picked up those habits" from their past relationships. The other three women decided that their relationships had always been pleasant and egalitarian, but when they argued with people, they would say very hurtful things and there was shoving, slapping, and/or throwing objects. After spending about 15 minutes discussing their

relationships, we spent the next 15 minutes talking about ways to handle conflict more appropriately. (Later, I discussed the issue of talking about conflict with several Safe Haven staff members. Although a few people thought that I should definitely *not* discuss conflict, my supervisor at the time said that with my background and how I handle it, she would leave it up to me to decide.)

When Sam began facilitating the DV group in October 2012, she was also diligent about not providing information as "fact" and talking about DV in flexible ways in attempts to create a comfortable environment for those who related to the formula story and for those who did not. For example, before the women discussed the Power and Control wheel, Sam would usually say:

> This is what Safe Haven uses as a way to think about domestic violence. But, it's a theory. The reason I bring it is because a lot of women relate to it. But, it's okay if you don't. If you or someone else has done this it doesn't mean you're an abuser, and if you don't see yourself in this, it doesn't mean you haven't experienced domestic violence.
>
> Does that make sense? It's however you want to see it or define it, but this is just a tool.

Another example is when a woman asked Sam if abusers can change (a very common question). Sam replied:

> I—*we*—wouldn't be here if we didn't think that people can change. So, I'm not going to say that they *never* change. However, what research does show is that sometimes the stats are pretty bleak. So, accountability is a good thing. If the person—just like the first step—if the person admits they have a problem and holds themselves accountable and actively seeks help, that's a good sign. It depends on the situation too: it can be *super* hard for someone who does all kinds of Power and Control tactics to change a *whole system* of behaviors. So, you might ask yourself, "Do I want to be the one who finds out

> if they change? Is it worth the chance that they won't?" And that's up to you because you know your situation and we're here to support you in any decision you make and help you stay safe.

This comment usually resulted in some women saying things like, "Oh, they never change. Once they hit you, they always will." Conversely, other women shared stories about how once their partner received substance abuse treatment or counseling, their relationship was "perfect." During one group session when the women were talking about how they thought abusers *never change*, a woman responded, "Oh yeah? Well I was an abuser and had to go to batterer school. And you know what? I changed! I don't hit my boyfriend or call him names or control him or anything anymore." Thus, promoting an atmosphere where the women made sense of their own stories was helpful when lived experiences did not fit the formula story.

Helpful and Unhelpful Aspects of Facilitator's Communication

As discussed later in this chapter, the women in the DV group reported that some of the most helpful (and unhelpful) communication occurred when hearing others' stories or telling their own. However, numerous participants also reported that some of the most helpful and unhelpful aspects of the group originated from the facilitator's approach and messages to the group. For example, numerous women I interviewed discussed how it was both helpful and unhelpful that Sam avoided telling women what to do and did not assess their situations for them.

Helpful facilitator communication. Nancy, one of the DV group members, discussed how she generally liked Sam's approach to facilitating the DV group. When I asked Nancy if she heard anything in the DV group that she disagreed with, she replied, "*I can't think of anything. I generally agree because you guys are pretty open with your definitions and just got*

your arms open for everybody so it's hard to disagree with anything." Similarly, Kathy liked how Sam emphasized that it was the women's definitions and beliefs that counted. Kathy said:

> *I love the broad range of thinking. . . . For me I think it's good because it's hard to speak about everybody. I think "healthy and unhealthy" you can't—I think that's good for everybody but you have to be careful about defining non-abuse. I think Sam does such a good job with that—if two people are completely in agreement about [what is and is not acceptable] then it's okay, you know?*

Additionally, as Shawna explained:

> *I like how she does the—where she says, "You may be the abuser or you may not," and I mean she doesn't say, "Well, yes you are." I don't know how to better say it, but she leaves it to where you can feel comfortable in decisions. If you're trying to decide if you're an abuser or not, she's very—I just don't have the word for it.*

Shawna paused and shrugged her shoulders. I asked, "So am I getting it right that she doesn't label folks or make decisions?" She replied, "*Yeah, she wants you to be your own person.*"

Other DV group members liked Sam's approach (which is also Safe Haven's philosophy) in that she often said, "We want to support you in whatever way support means to you." Thus, Shawna said:

> *You guys always told us, "If you wanna stay with them, that's fine. We're not gonna try to make you leave them or whatever." For you guys, you make sure that we know whatever we choose, you're behind us 100 percent. I think that's just awesome. You're just there to help and how to deal with it and make safe decisions.*

Additionally, Joyce explained:

> *I like the idea that you're there to help but you're not there to control. You're there to help lead them in the direction they can go in when they're ready to leave the situation instead of being like, "If you want our help then this is what you've got to do. And until you get out of that situation we're not going to help you." That's going to turn people off and they're going to run. But knowing you're there in the aspect of support instead of control, and there's no judgment because they're still in the situation. Just the fact you're giving them the support is helping them gain strength to the point that one day they might actually leave. I think that's important because it takes us time. You don't necessarily know everything; you only know what they're willing to share. That could just be the smallest little sliver of pie you've ever eaten. . . . And it takes so much time to gain that trust. Usually in my opinion if I was leaving an abusive relationship I'm looking for somebody I can depend on, somebody that's not going to pass judgment and somebody I can build a trusting relationship with that's going to just listen, not necessarily even give advice in the beginning but just listen to me for a minute because I just need to vent. I just need somebody to hear my story. Then we can take it from there.*

Additionally, many of the women I interviewed discussed how Sam's approach of not telling women what to do, not judging them, and letting them own the DV group facilitated a comfortable group climate. As illustrated later in this chapter, the comfortable environment helped to create an atmosphere of disclosure and sense-making.

Burleson (1994) asserted that to create an ideal support environment, support providers should: (a) avoid "fixing" the other person's emotional state, (b) avoid dominating the conversation, (c) avoid threatening the other person's face, and (d) solicit elaborations of the

other's feelings via stories. Numerous participants discussed how Sam helped construct to a comfortable environment because she did not judge, she believed the women's stories, and she let the women "own" the group. For example, Shawna said that Sam was most helpful by "*Being able to be on their level with the women and having an understanding and having compassion, for sure. . . . Yeah. You can tell she has a really big heart*." Emily also discussed the importance of being understanding, as well as how Sam believes the DV group members' stories:

> *You guys are very understanding. I feel like I could say pretty much anything and it won't shock you, or whatever. You guys believe what we say, too. . . . Pretty important because you feel invalidated when people don't believe you. And you kind of convince yourself that you're crazy, all that stuff, and that it wasn't that bad.*

As Joyce explained:

> *Well if you talked you weren't being, "Well you did this or you did that," it was more you guys have preventative conversations—not preventative but to me it was more like you empathized. You didn't feel sorry for the individual but you could empathize and understand. You came with a caring heart and an open mind, not a judgmental, cold, "Well what did you do to create it?" Or, "What was going on in your household?" Or, "Why didn't you leave?" that age-old question. So it was easier to be honest and open. Sam would come up with positive resolution, or positive feedback of some sort. She always had something positive to come back with. And then I might share something and that would open up the floor to another girl sharing, which then would open the floor to another girl. So we were all processing and sharing and providing feedback from one*

another and Sam or yourself. So it was just a different environment. It was more comfortable and calm.

Other women discussed how they felt comfortable to go off topic or to say whatever was on their mind during the DV group. Claire said:

I think it's best whenever those doors are left open because nobody's questioning where do I—or should I say anything? Well, this is bothering me. You can talk about anything in it is the best part, because you don't have to go on any kind of a topic or anything like that. It's just what is pertaining to you at that moment, at this time right now…You guys give us that option, so if we didn't wanna do it that way, we'd be like, "This doesn't have anything to do with us. We need to switch it up," and Sam makes that very—she's very blunt that this is your time to speak. We're in here on your time. This is about you guys.

Similarly, Penelope explained:

Just the openness of it and the—it's really comfortable for people to talk in there. Like I mean I've heard some crazy shit brought up in there, and I mean it's kind of a comfortable platform to start throwing those things out.

Furthermore, Shawna said about Sam:

She is so funny. She's just really laid back and she just makes me feel like I can be completely myself and not be judged. I can say whatever I want even if it's crazy. She just allows it and it's okay. I really like that.

Sidney also explained how the comfortable environment is beneficial:

She goes out there, she hands all the information; you don't have to sit here and pull teeth to talk to these people with her anyways. She makes you feel comfortable to where you can open up. It's nice even if we go off topic she doesn't interrupt and be like, "You

need to stay focused." She just lets it go. She's like, "Okay, let's get it out." Because we went way off topic for a while and she's just like, "I'm here to listen." And that' s because sometimes all I really want to do is vent.

Unhelpful facilitator communication. Again, Sam and I both tried our best to approach the DV group by not providing black and white definitions of how DV is experienced and the characters involved. We also facilitated an environment in which the women primarily made sense of their own situations through hearing other's stories and telling their own stories, as well as considering the relevance of information in their own lives. However, some of the women I interviewed found this approach to be unhelpful because they wished that Sam would be more heavy-handed in terms of telling them what to do.

For example, although Echo praised Sam and me for listening well and in a calm manner, she also discussed how she would like us to "get pissed off." As Echo, who experienced severe DV years prior (i.e., she was stabbed by her partner and successfully escaped), explained:

You guys do a good job because I don't know how—you girls do a good job. I've heard some stories you all have heard and I'm like, "You need to blow his thing off," or, "You need to get away from him, run for the hills." I see where you all are coming from. You guys are real good about listening—you guys listen better than my counselor. You guys listen and you give the best advice you can give; I understand that. You can't say, "Oh leave that man," blah blah blah. I do—when I hear them girls talk about it I say, "Get the hell away from that son of a bitch. Run." I don't care, just leave. . . . I want you guys to get pissed off and say, "Leave that son of a bitch. Listen, next time he does it you call us, we'll be right over there with a shotgun, you won't have nothing to worry about." I know I keep saying that but I'm telling you, tell 'em. I don't know how you do that, I

don't know how you sit there and you can be so calm and so sweet and listen like you do and just take it in. Because I'm sitting there going, "I would like to kill him." And I would never kill anybody. I want the tape to know I would never. But I would make him hurt pretty bad. His kneecaps wouldn't be around or something—I don't know how it should be changed. I pray to God for the better, but I hope you guys really help these people out because they really need it. It's hard to leave an abusive person. It's hard to do that. If you give them support and tell them there's no excuse and tell 'em they've always got someone here to help them or listen to them that will be—that's awesome.

Likewise, Lily thought it would be more helpful for the DV group if the facilitators made direct "suggestions." Lily said:

Yeah, but I think it's always helpful to hear suggestions from people, you know what I'm saying? I'd rather you suggest, "Hey, Lily, can I talk to you? I suggest that you —this is my suggestion, that it would be safe for you to stay here and work on you instead of going back to a relationship," you know what I mean? Help me to understand what would be good for me, because we're already people that is in addiction, so we already have problems making the right choice anyway. . . . Because in our thinking, we're already addicts, you know what I'm saying? So we're gonna settle for less anyway. So it's always good to hear somebody that has confidence in you tell you, "Hey, you're better than this, and you deserve so much more" than "Hey, I'm not gonna tell you what to do. Do whatever you wanna do." Of course we're gonna make, initially, the wrong decision anyway because that's just our addictive behavior. . . . I'd rather somebody not push—I'd rather you just be up front with me and let me know right now that I'm in bad circumstances, and "in the long run it's gonna benefit you if you get out now," than "do

> *what you want" and let me go back to continue doing the same thing I'm gonna always do because I have been pushed over. So, yeah…I think you guys should just be honest and tell 'em, "You need to get the fuck out of that relationship." [Laughter] Excuse my language.*

I could relate to Echo's and Lily's statements. Although I often told the women in the DV group that "everyone in here deserves to be happy, healthy, and safe," I would *never* tell someone that she needed to leave—even though sometimes I desperately wanted to do so. Some of the women were experiencing what I would consider to be incredibly severe violence (e.g., they had been stabbed, hit with objects, pushed down stairs, and/or choked until they passed out). There were even occasions where I had intense fear that a woman would eventually be killed by her partner. Sometimes, I wanted to tell them, "Call the hotline. We will pick you up and get you out of there. You *have* to leave." I wanted to save some of them, and the formula story is that once she leaves, the story has a happy ending, right? A photograph by Donna Ferrato (see also Ferrato, 2012; 2013) and caption that appears on *Time Magazine*'s website (Sun, 2012a) reifies the formula story.

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Margo inspired the Unbeatable campaign launch. Her story proved that a woman can break free from violence without much help or money. She knew she had to do this to save her own life as well as her daughters. 2012.

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Breaking "free from violence without much help or money," however, can result in a women being *killed.* Safe Haven trains advocates to never give advice, and Sam and I whole-heartedly agreed with that approach. Giving advice to a survivor can potentially be dangerous. For example, many women asked me if I thought that they should file a protection from abuse (PFA) order (a type of restraining order). In those cases, I always made sure to let them know that it had to be *their* decision; however, I also wanted them to be informed. Thus, I would also let them know that for some women, filing a PFA greatly helps their situations, but for others, it can make the situation worse because the partner tries to retaliate. Then, I would offer to help them create a "safety plan" if they wanted to file a PFA. I still question how I handled some of

these situations because I always wanted them to make their own decisions, but I tried to help them make informed decisions. I never wanted to scare them out of taking certain steps, but I also did not want to make it seem like taking those steps were the absolute right thing to do. I would tell them, “It’s up to you because you know your situation far better than I do.” Frequently, I did not even say anything about the issue besides, “We can help you fill one out if you would like” because other women in the DV group usually immediately shared a scary experience related to PFAs or said something along the lines of, “A piece of paper won’t stop a bullet.” Even recently, a devastating story from the area in which I was raised warned of the atrocities that can result from a woman’s efforts to protect herself (Redden, 2012).

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November 20, 2012

Joplin woman begged for her life before being shot; estranged husband charged with murder

By Susan Redden news@joplinglobe.com

JOPLIN, Mo. — Monica Webb reportedly begged for her life before she was shot three times in the head on Saturday.

A witness said she heard Webb say “No, Ron, please” before hearing a gunshot about 10:20 p.m. come from Webb’s apartment at 1315 E. 15th St.

On Tuesday, Rondias Leon “Ronald” Webb was charged with first-degree murder and armed criminal action in connection with the shooting death of his estranged wife. Monica Webb had obtained an order of protection against her estranged husband, and the Jasper County prosecutor’s office had sought a summons for an alleged violation of the order.

Preliminary autopsy results show that Monica Webb, 36, was shot three times in the head inside her apartment, according to Joplin police Lt. Darren Gallup.

Rondias Webb, 35, 1502 S. Michigan Ave., Apartment 7-2, was shot underneath his chin. Police believe the injury was self-inflicted, Gallup said. Police found a .25-caliber semi-automatic handgun at the scene.

According to the probable-cause statement filed with the charges, police responded Saturday

night to a call from a friend and co-worker of Monica Webb's, who told authorities she had gone to meet her at the apartment where she had moved after separating from her husband.

According to Gallup, the two women were on the phone with each other because the friend was unsure which apartment Monica Webb lived in. The friend said Monica Webb opened the apartment door and stuck her head out, and that a man came from a patio area and forced his way into the apartment.

The friend said she heard Monica Webb say "No, Ron, please," and then heard a gunshot. The friend said she went back to her vehicle, but she could see through the open apartment door the man standing over Monica Webb. She called police moments later, authorities said.

Rondias Webb has not yet been arrested. He remains hospitalized in stable condition, Gallup said.

Monica Webb obtained a protection order against her husband in September after he was arrested and charged with misdemeanor domestic assault in connection with a Sept. 23 incident at an apartment they shared at 1731 E. 33rd St.

Monica Webb wrote in her request for the protection order that he would not let her leave the apartment, then chased her down and tackled her after she managed to sneak out the back door.

"He was on top of me, telling me to stop yelling or he was gonna put a bullet in me," she wrote. "I continued to yell. He then grabbed a rock and told me to shut up."

A probable-cause affidavit alleges that he threatened to bash her head in if she screamed. She ended up walking away, but he followed her and kept trying to take her phone away, she wrote in the request. He told her that if she called police and he was arrested, she would be sorry, her application stated.

Newton County Circuit Court records indicate that Rondias Webb failed to appear at a hearing Nov. 7 in his domestic assault case, and a warrant for his arrest was issued. Three days earlier, he allegedly violated the protection order by approaching his wife in J.B.'s Piano Bar at 112 S. Main St.

A probable-cause affidavit states that he told her that he knew where she was living, and "I will be at your apartment."

Court records show that the Jasper County prosecutor's office sought a summons to be served on Rondias Webb for the alleged violation of the protection order. A summons does not require an arrest and can be mailed to a defendant.

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As mentioned previously, Sam and I both agreed that advocates should not tell women explicitly what to do, and Safe Haven encourages advocates to never give advice because it can actually be more dangerous for a woman to leave. According to Campbell et al. (2003), "The risk of intimate partner femicide was increased 9-fold by the combination of a highly controlling abuser and the couple's separation after living together" (p. 1090).

Importantly, Claire raised an interesting point when she explained how the approach of women making sense of their situations themselves can be both unhelpful and helpful. Claire and I discussed this matter in the following conversation:

Claire: It's like making you do it by yourself, because at times, you're not gonna have somebody be able to sit there and tell you what you can do. But yet too, that's part of us used to being in that situation that we were in because we were so controlled that we don't have our own thinkings anymore. We still need somebody to tell us what to do and I think that that's maybe why they get so frustrated, is because, "You know what? Dang it, I've been told my whole life what to do. Why can't you just tell me what to do? This person over here's telling what to do and this person—and then I'm coming to this person from a hotline that's supposed to be helping. You're still not telling me what to do. What do I do?" I think she's just providing you with more tools to use so that you can kind of weigh out those things yourself. And then too, your [substance abuse] counselor, she's gonna do the same thing, but she's also gonna be like, if you can't get it yourself, she's gonna be like, "No. You need to do this." If you can't filter out those thoughts yourself and you need that much help into getting there, they're gonna be like, "No. Girl, you need to open up your eyes. This is what you need to do. It's over here. This is what I'm

telling you. Come on." You just need that extra little thing of "No, this is what we're gonna do."

Jenny: Are there some cases where you wish Sam would?

Claire: Yeah. Just not to me, because I know some of these girls are just so lost. I think sometimes it helps having somebody that's going through—or I don't know what her story is, but especially somebody that's going through something like that, to be like, "Yes. You do need to do this. You do deserve better. You are worthy of having something that is better than that."

Sam often told the women, "I cannot give you advice." Perhaps Claire understood "advice" as feedback or help discussing options.

However, Sam and I both agreed that we could help the women to weigh options. Regardless, Claire raised an important issue. According to Fazzone et al. (1997):

> Poorly developed decision-making skills is a problem for many substance abusers. When a client is a battered woman, that inadequacy may be compounded by the domestic abuse (American Medical Association, 1993). For some battered women, every aspect of their lives has been controlled by the batterer, and a "wrong" decision (as perceived by the batterer) may have served as another excuse to batter her. . . . Thus one of the first steps in the process of empowering the survivor client is to help her develop, strengthen, focus, or validate her decisionmaking skills. . . . It is important for the treatment provider to avoid underestimating the importance to the survivor of making even seemingly mundane decisions, such as what to wear or when to eat. (p. 21)

Again, I do not believe that DV facilitators should tell women what to do. However, as Fazzone et al. explained, DV survivors who are also experiencing issues with substance abuse might

appreciate and benefit from others asking questions and offering help providing options in order to facilitate their own sense-making (see, e.g., Burleson & Goldsmith, 1998; Burleson & MacGeorge, 2002; Harber & Pennebaker, 1992).

My and Sam's perspective about DV influenced our communication practices within the DV group. As shown in the following sections, other perspectives arose from the group's interaction such as: adopting a broad definition of DV; understanding that DV is "wrong" and people should strive for more equal relationships; believing that people should examine their relationships and "options"; and people *can* break free from the cycle of violence. Through numerous discussions with Sam, I found that we both believe that adopting a complex conceptualization of DV and legitimizing all "types" of DV stories set the stage for trust, open and honest communication, and sense-making within the group. Numerous women found it helpful that Sam, unlike the facilitators mentioned in Loseke's (2001) study, did not provide information in narrow terms and encouraged the women to make sense of their own situations.

Helpful and Unhelpful Communication within the Domestic Violence Group

Overall, the women reported that the most helpful and unhelpful aspects of the DV group at New Beginnings involved learning about and discussing: conceptualizations of DV, experiences of DV, and how to prepare for the future (and break the cycle of DV). The following sections examine how participants found it helpful to recognize their own abuse, hear and share stories of DV, make sense of their situations, and, eventually, sometimes heal.

Recognizing abuse. Although numerous women mentioned that their definitions of DV *before* participating in the DV group included only physical violence (which aligns with the formula story, or public story of abuse), many of the women nonetheless adopted a broader definition of DV *after* attending the group. For those women, their DV definition closely aligned

with how the Power and Control Wheel conceptualized abuse. For example, Sidney defined DV as:

Any kind of relationship where you've been emotionally, physical and mentally abused. I mean the Power and Control Wheel is a huge thing. It is very specific and it is very true…I mean it's the basic consensus that everybody has usually, in some form of domestic violence relationship, has, whether you have addiction problems or not.

Similarly, Dawn said:

My definition of domestic violence is, I guess, any type of belittling or inflicting fear on a person to try and get them to do what you want them to do or "You did this, so I'm gonna hurt you" and crossing the line of respect. If I don't wanna be touched, then don't fucking touch me—or something like that. Don't call me names. You know?

Furthermore, Allison said: "*Domestic violence is a very big term for what it actually means. It can be anything, really, anything that puts you down, more or less*." Shawna said she found it helpful that:

You guys give the whole different ways domestic violence can be and it's not just physical and how it can affect you in life and very—you just see the big picture. You give the big picture. It's not just pieces of it.

I then asked Shawna if she thought about her experiences as DV before attending the DV group, and she replied:

With the physical, yes, and some of the verbal I knew was abusive, but I didn't know the extent of it as bad as I thought. I didn't think it was as bad as it really is, because it can completely just change your whole personality. I'm just like, "This is him. This is every

little thing," and it just clicked to me. I'm like, "Oh, gosh. I should've known this all along." Just the explaining the different types of power and control was huge for me.

Additionally, Kathy, who had previously escaped two DV relationships, also found it helpful to consider a broad definition of DV. She said:

And it's not just physical violence, I mean just all of the education you guys bring in about early warning signs of violence and the different types of domestic issues that are negative that people don't see as domestic violence. People think getting hit or beat up, but there's so much more to it than that. So I love…that it's so much more, that you can be in a domestic situation and not even realize it, or understand that it could be headed in this direction or just you need to be aware. You need to be conscious of what's going on in your relationship.

Other women explained that it was helpful to conceptualize DV beyond just physical abuse. Ruth explained how she previously had conceptualized "radical beatings" (i.e., the formula story) as only constituting DV:

I didn't even—back then, I mean, you never really heard about it, and what you did hear were radical beatings and stuff, and I never really associated my situation as being violent, domestic—any altercation at all, until now that I'm older. But I'd had—this is my second marriage now. So it's kinda like history's repeating itself. But my first marriage was fine. In fact, I hadn't tiptoed through that type of environment at all, relationships, dating, or my first marriage, but this one that I have right now—it's kinda that same feeling. It's weird. And being older and having gone through that, I now can look at it and think it's just the same kind of situation. There's no excuses. It is what it is. It's so bittersweet, because I always associate domestic violence with running for

your life, basically, and being bludgeoned to death, damn near. But it's all of the above. It's everything. So it starts out little, and then it ends up being not so good. . . . If you were to ask me a couple years back, I would say bruises, scars, injury, physical injury, apparent injury. And now I would say domestic violence is—it's a lot of emotional, a lot of mental, non-communication, non-support, isolation from family, anything that would have a person act out in any kind of anger, hatefulness, belittling, condescending. I mean, it's a big, big thing, and I don't really know—unless there were more people like Save Haven out there that would talk about that, the vast majority of people really associate domestic violence with police records, bloody faces, black eyes. And in the back of my mind I've always thought, I'd rather be punched than be put through just the grasping at what I think is healthy, and it's not. Does that make sense?

Similarly, Claire explained what she thought was most helpful about the DV group:

It lets you know that it's emotional and physical abuse, especially if that emotional one. Physically, bruises can be healed. Emotional things are internal and internal things take a very long—or if not, never healed. He doesn't necessarily have to put his hands on you because I guess in here—I could take 1,000 blows to the face, but it's all the other things that he left me with that won't go away.

Penelope reflected:

When I was getting high I thought it was just like physical. I mean he'd just want to hit me. But now I know it's like because he would go every day to make me cry. Anything he could do. I used to tell him, "Is that your goal is to make me cry?" He would just say off the wall, hurtful things. I never understood it but I know now it's a form of abuse. Even when I came here I went a whole week without talking to him. And the first time I talked

to him he told me I was a whore and I was cheating on him. . . . I just asked him, "Why do you do that?" I mean he just says the most hurtful, off the wall things. I used to tell him that's his goal every day was to make me cry. That was how it felt to me.

Birdy once asked the group if it "counts" as rape if the perpetrator is your husband. The group discussed the issue and agreed that, yes, it does count. Birdy discussed this during the interview and how she did not consider her experiences as DV until attending the group. She said:

My first husband —it was sexual. But it's really traumatizing—it's very traumatizing. Because you feel like, well, he's your husband. But it's really not that way. I mean he actually raped me twice. So. And then I entered into a relationship with [a] fellow. . . . And he was just really controlling. He choked me once. He punched me in the face once and then tried to run me over with a car once. . . . And you know, I never thought that—I never really looked at my abuse as anything too serious. Because I have friends that have been literally beaten to within inches of their lives. I've been choked that way. . . . And in fact—and it seemed to get worse. They seemed to—every man I—they want to choke me. . . . I never really—like I said, I've never really considered domestic violence as one of my issues.

Accordingly, because Birdy was not "*beaten to within inches of*" her life, she did not believe that her experiences of being raped and choked were DV. Additionally, Nancy said, "*When I first heard we were going to have [DV group] I was like, 'I don't need that. I've never suffered any domestic abuse.' I'm like, 'Oh wait, I guess I have.'*"

Furthermore, Emily discussed how conceptualizing DV in broader ways was helpful because it also helped her make sense of her past experiences. Emily explained:

I really like the Power Wheel thing you guys did because…I realized that I've probably been a victim of more than one kind of domestic violence and opened my eyes to it at least. That was cool. Because I could rewind in my head and figure out why I maybe did some of the things that I did, and why certain things affected me so much.

Rachel also felt that the DV group, and the Power and Control Wheel were helpful because they helped her to make sense of her past experiences. When I asked Rachel what she thought was most helpful about the DV group's communication, she said:

Power and control wheel. I love that because it opened my eyes to different power and control that my ex-boyfriends had, and things I did for my kids and my parents did, used me and my sister to get back at my stepdad or my dad.

Overall, numerous women spoke about how they previously thought of the formula story when conceptualizing DV in that DV was strictly severe violence. However, several women reported that broadening their conceptualization of DV helped them make sense of emotional abuse and controlling behaviors that they had experienced. Additionally, a participant reported that conceptualizing DV in broad terms helped her to appreciate her boyfriend's healthy behaviors and encouraged her to examine her behaviors. Emily reported that discussing the Equality Wheel was one of the most helpful aspects of the DV group's communication. She said, "*That one opened my eyes to how great my boyfriend is, and to not take him for granted. I'm kind of shitty to him sometimes.*"

Additionally, on two occasions in the past year, a woman saw me in public and told me that she and her partner discussed their relationship after she graduated from New Beginnings. Both women "went through" the Equality wheel with their partners and told me that their relationships were "better than ever!"

Helpful aspects of the message that domestic violence is "not right." Some women found it helpful to reappraise their current or previous experiences as DV, and others found it was helpful to hear about how DV is "not right." For example, Allison recalled a moment during the DV group when she attended New Beginnings almost a year prior to her then current stay and the interview. She said:

> *I cried the first time 'cause, it just like, whoa, because I think that moment I just really realized that I knew all that wasn't right, and yeah, you weren't supposed to do that to me, but I think it was at that moment that I was like, whoa. And I don't remember what we were talking about that day but somebody said something. I think it was isolation. I think we were doing the Wheel. . . . I'm a lot stronger now than what I was then, since the last time I was in here compared to now, yeah.*

When I asked Echo what she thought was most helpful about the DV group, she replied:

> *A lot of these women here have been through hell. Every single one of us have been hit. Every single one of us girls have been hit. And that ain't good. That's a big number, right? That's a bullshit number. It's true, every single one of us have been hit. And it's not our fault…because there are women out there and every day a woman is getting hit. If they have this knowledge, if they know about things like this my gosh, they will use them; I know they will. You guys coming in and helping women, talking to them, listening is freaking awesome. I can't believe—it warms my heart how it's out there today, how it's out there where you just don't have it; it ain't allowed. There's no excuse. It's not normal. You deserve better. There is no excuse, no reason why he should touch you in any way, shape or form. You should not be touched in a mean manner, no way. It just ain't normal.*

Additionally, Penelope said, "*It just helps us understand the warning signs and that it's not okay for it to happen no matter who it's from, whether you're the one doing it or the one taking it.*"

Lily, who had previously been arrested for domestic battery for what appeared to be—at least to me based on numerous conversations—mutual combat, said:

> *Because not only being a domesticator, but there's so many girls that you hear "Oh, my boyfriend beat the shit out of me," they're like, "It's okay." It's not okay. I mean, I've beat the shit out of my girlfriend; she's beat the shit out of me. And it just wasn't right for either one of us.*

As Muehlenhard and Kimes (1999) explained, "Terms like *date rape* and *wife beating* provide people with words to describe and understand their experiences. Definitions of these terms influence what behaviors are considered unacceptable . . . and what behaviors are acceptable and normal" (p. 243). Muehlenhard and Kimes also contended that with broader definitions of DV, such as the Power and Control Wheel,

> the line between abusive and nonabusive relationships is not as clear as it would be with narrow definitions requiring severe physical violence or injuries. . . . When only the most blatantly violent behaviors count, subtle forms of power and control become acceptable. (p. 239)

Accordingly, some women found it helpful to reappraise (Lazarus & Lazarus, 1994) their experiences as DV—perhaps because it helped them make sense of how those experiences made them feel and because it helped them to accept that these behaviors are indeed "unacceptable."

Unhelpful aspects of the message that domestic violence is "not right." Recognizing experiences as DV was helpful for some DV group members; however, hearing about how a broad range of behaviors can "count" as DV was confusing for others. For example, Ruth, who

was trying to make sense of her experiences in a current relationship at the time of the DV group and the interview, was questioning if she should end the relationship and appeared to place blame on herself for “allowing” these “unacceptable” behaviors. She shared:

> *I’m still struggling a little bit with would I even take the chance of that happening again. Not to the degree it did, obviously. I hope to be stronger from that, but to have someone say, “Okay, this is violent. This is not right.” From those little actions that lead up to the big actions. Why do we put up with that? Why do we allow the little things to escalate to the bigger things, when we should know that that behavior is not right, that’s domestic violence?*

Similarly, Hannah described in the interview that she was trying to make sense of her relationship with her ex-girlfriend, whom she still loved and with whom she frequently spent time. She also explained how it was uncomfortable for her to think of “labels” for the situation and people involved. When I asked Hannah what was helpful about the DV group, she replied:

> *I wouldn’t even classify myself in some sort of domestic abuse relationship with [my ex]. Even though I knew things were fricking crazy I would never like label it that or never like feel like I was qualified to—it would have never occurred to me to think, “Maybe there’s a support group I could go to,” because it just seemed like—yeah, like I just didn’t —I don’t know. I think I didn’t – I don’t know really what I’m trying to say. But you know what I’m saying? Like I felt like—I mean even myself and like—I know things. I already know all of these things, but you know when you’re in this situation, then it’s really hard to—well, it’s really hard to label yourself, first off, and—because you know I don’t want to label myself as a victim or a survivor because I wasn’t always that, that role in this situation, but yeah. I think it’s helpful. I think it—I mean like the second*

group that I was in, when I was like, "Oh, wow. Really, I should call this what it is," you know just maybe being able to put a word to the drama, I guess—I don't know, being able to sum up the situation was a little bit easier, just because I really didn't feel like I qualified in the DV group. I mean I've had tons of abuse as a kid, but that didn't even—I didn't think that—I just thought—I really thought domestic violence as just being you and your girlfriend have a fight, the cops get called and that's that, like all the emotional and stuff like that. I mean I knew it was crazy and I knew it was not right, but I could never really make myself call it what it really was, maybe. So I think it's helpful, yeah.

Later in the interview, Hannah further explained:

It makes it really kind of hard to—it makes it really hard for me to see her as an abuser, a lot of times, because I think the pain of me leaving and doing drugs and being dishonest about that is no different than the pain that I felt with her…And so it made it really hard to notice her as the—I don't know. It's really hard to say I'm a victim in that situation because I'm an addict, and I am fucking up a lot of things. I'm putting our kids at risk and my whole family at risk, and so it's kind of hard to.

For Hannah, the guilt of having a substance abuse issue made it difficult for her to assign labels to her relationship. As Loseke (2001) argued, accepting the formula story often results in the placement of blame and sympathy, and Hannah's lived experiences of emotional abuse and controlling behaviors combined with occasional violent resistance perhaps made it difficult to have clear cut labels and a neat story.

Feeling guilty about one's own abusive behaviors. For others, talking about DV as "unacceptable" made them feel guilty. Libby extensively discussed how the DV group's

communication about these issues can be very unhelpful. In the following conversation, Libby and I discussed this issue:

Libby: I became very—if I drank I would be violent. I'm like, well I'm the one who is violent. I'm the one who needs domestic violence. And that wasn't the case; I was just angry and upset and didn't know how to handle it. Then I just got out of—it was three years ago but I had a stalker. Like he's just crazy, and I kind of allowed that situation to happen and just—no I didn't—yeah, I did. I don't know, it's some heavy shit. . . . I think the Wheel is very good at approaching women and kind of setting that light bulb off like, "Hey, that could be me." I definitely think you have a good start there. . . . It's—to me it reminds me when I was in [Juvenile Detention Center] when I was a teenager and they'd just pass out this wheel and they're like, "Okay, you fit in there? Cool. Talk about it." People are like, "Uh, no, because I'm going to tell you probably everyone is in that situation, is in domestic violence." Because when you're an addict it goes hand in hand, the dysfunction of relationships, period. So it just seems like everyone can relate but it's not getting across in a way that they want.

Jenny: What would be a way they would want it, then?

Libby: No, these questions maybe—I don't know. That would be something I have to think of. But um, it's very boring. I know a lot of people don't want to necessarily, when they get here, just they're still in the fog still [from detox and being sober] because I've been here two weeks and I'm just now, "Aha" getting it: I need to change. I think the one-on-ones are definitely beneficial. People don't always want to share what they've been through in front of everyone when they just got here, they see, "Okay, this has happened to me. This has happened." But is that okay? Is that normal? Am I weird? Is that wrong of

me?. . . . Like, you just definitely feel bad, I guess, and singled out because that's—usually what some of that Wheel has been a way that we've all been living, just thinking it's healthy. And when we come in here the smack of reality is like, "Okay, I've been living this way and that's totally not okay." But you have the other spectrum of how a healthy relationship should look, and—I don't know.

Jenny: Yeah. And when you said the women say like, "That's my life," is it they experience it, or they do it, or both?

Libby: Both. And then we act it out in those ways, so we seem like, "Okay, we're the batterers" when usually something's happened to make us—not make us, because we all have our own free will—but to do those things. And we feel bad. We're like, "Okay, we shouldn't say anything because we all usually fit into some category here." That's how I feel. I don't—it's just a pattern we get into, and we know no other way. Usually we're really victimized, and then we feel that way over and over, so what can I do to change that, then? How can I control the situation so it doesn't happen again? We usually—I—act out. . . . Just like I've said: girls, we get in there, we see the sheet, we can identify with it. And then the negative feelings that we're not used to feeling come about and we're dealing with so many other negative, like if we're processing for three hours before that and we have to deal with a guilt letter to our son, which is traumatizing. And then to go sit in a DV group and, "Okay, I am a bad person because I'm on probation for, you know, violence. But I'm not a bad person." And it's just—then we have to totally take another look at ourselves and it's just something we don't want to touch with. And sitting around in a circle is not a good way of doing it. I can't tell you what is, but—I don't know. I just know whatever approach you guys are using definitely just shuts everyone

down. . . . If you can come across—and I know that's why you're doing this—in a way that reaches someone, like, "Hey, I want to do this." Like how you're doing the interviews and you get more of a one-on-one basis with the girls…Yeah. You guys—I don't know if you guys see the process groups and kind of see our schedule and how it happens and think, "Okay, we're just going to have a DV group and talk about it, and we're gonna win all these girls over." We're here every day, all day, and we're getting to know each other, getting to trust each other and trust is huge here because we haven't been able to trust on the outside. It takes two weeks to even start to trust yourself or trust other people. Um..I don't know where I was going with that.

Jenny: No that makes sense. And you said the Safe Haven folks come in and try to win over people?

Libby: Yeah. No, not "win over" it's just they come—you guys come with your Wheel and all of us we get that "Aha" moment, then we get the, "Okay, I can fall into that. I'm a bad person." It's just not something that you want to identify with and "Oh" in front of everybody, "This is my situation." Everyone's situation is different. That's—I don't know, I can't give you any bright ideas on how to change this right this second…I think your approach is good, just that's a second approach is that initial approach. But then when you sit around for an hour and start getting bored, and, "Okay, I can identify with this," ding ding ding ding, and then can you share with that? Well, no. Because is that going to make me sound bad? Am I wrong? And I think a lot of girls feel that way because we all get out of there and we're like, "We're the abusers." And we feel that way when we're not; we're just protecting ourselves. . . . I know you guys all are trying to help women and that's why I'm in here talking. I want to help women too in every way. I

want to understand myself; I want to understand life; I want to protect myself from just shit happening. Because it's bullshit, you know? We're just victims. I don't know. I keep forgetting the questions you ask.

Sam and I discussed how such situations as described by Libby were the *most complicated* issues presented in the DV group. During the group, occasionally a woman would say, "I think I'm the abuser." Upon expanding on their situations, it sounded like some of them indeed were abusive to their partners—physically and emotionally. However, perhaps as a function of the substance abuse treatment philosophy to "find their place in their problems" (Bland & Edmund, 2008) or simply self-blame for abuse, other women thought that they "caused" violent reactions and that they were "abusers" because they "instigated it" during conflict. Others used violent resistance (e.g., hitting back after first being hit) and thought they were "abusers" as well. When I asked Sam, the other DV group facilitator, about the most difficult part of facilitating the DV group, she said:

Knowing how to deal with when people disclose they're an abuser or they've been abusive. Knowing an actual way to handle that would be really helpful. I know there's not a great answer, but to find one would be good.

I whole-heartedly agree with Sam's perspective.

I addressed the issue of how to handle these disclosures with staff at Safe Haven within a few months of facilitating the group, and we addressed the issue in a joint meeting with staff at New Beginnings. Safe Haven staff members feared that learning about abuse tactics might "help abusers abuse better," and they believed that women at New Beginnings should be screened into the DV group so that only *survivors* attended the DV group. However, the staff at New

Beginnings believed that women who were "abusive" should be in the group because it might help them to change their ways.

Accordingly, if a woman thought she was an abuser, I usually solicited a bit more information to hear *why* she thought that this was the case. During the time that I facilitated the group, only three women sounded like, yes, perhaps they were "abusive" in terms of the formula story. Almost every other time, the women explained situations of violent resistance or situational couple violence. Although I do not condone "common couple violence," I do believe there is a difference between committing intimate partner terrorism and throwing a cell phone at someone when fighting. Thus, I would run through a "spiel" about a continuum of DV severity and Johnson's (2006) typologies, depending on how the disclosure was framed. The women in the group then usually would discuss how we "don't want to be in situations where we have to defend ourselves"—first, because it is wrong and, second, because it could result in someone being arrested, even if the violence was perpetuated as self-defense. Additionally, the women in the group typically discussed how even behaviors that occurred in situational couple violence were "wrong," and that they should not do those behaviors anymore. When this issue arose, I also told the women that they should talk to their counselors if they believed that they were an abuser (because I fully understood that I was absolutely not qualified to provide support to "abusers"). Usually, the conversation then turned to the Equality Wheel and developing healthy relationships. However, I will never know if this approach was beneficial or not for the women; perhaps it helped women to recognize that the atmosphere was not healthy but gave them hope that they could: (a) behave in more healthy ways if experiencing situational couple violence, or (b) behave in more healthy ways in different circumstances if experiencing intimate partner

terrorism and perpetuating violence resistance. Perhaps, however, these conversations *excused* someone's behavior when it possibly should not have done so.

This issue, thus, can be complex. When I asked Sam if she thought explaining Johnson's (2006) typologies was useful or could "just make things worse" she said, "*Yeah, absolutely. It could make it worse. ' It's not my fault, I'm just reacting' . . . .they could choose to look at it like it's not my fault [if they are abusers].*" I then asked Sam if it "hurts" to provide information such as Johnson's typologies. She replied:

> *No, no, no. I don't think any information hurts ever. I don't think anything bad can happen from providing information. Some people I think could argue that it could excuse people's behavior, but I think that if you're going to try to excuse your behavior, you can take anything to do that, so I think providing as much information as possible is good. . . . It's not simple. It's not black and white. People want things to be—people don't do well with ambiguity.*

Needless to say, the issue is a difficult one indeed.

However, a member of the DV group, Ruth, reported that she found it very helpful to hear about Johnson's (2006) typologies. For several weeks, Ruth had described her partner's actions; he frequently played mind games, was emotionally and physically abusive, and even was eventually charged with "assault with a deadly weapon" after a particularly violent episode. However, because Ruth became "fed up," she began to "stand up for herself" and "slapped him back" when he slapped her. Thus, throughout the interview, her story sounded like a chaos story where she framed her "fault" in the issue as being equal to his fault. For example, Ruth said:

> *I mean, there's times where we'll be in group, where you and Sam will come in and I'll look at some information. I'll think, "That's me." And then I'll think, "No, that's him.*

Oh, no, really it's both of us." And even now, if I NEVER threw that first argument out or threw that slap out, boy, I was there to stick up for myself, unlike the first time that that happened back when I was young. But it was very bittersweet. Just trying to appease the situation, trying to say, "It's okay. Everything's all right. It's gonna be all right. You just need to blah, blah, blah," kinda lightheartedly, and then really just kinda freaking out towards the end, like "You've had enough," only I wouldn't be so scared. I would be more like pissed off. I'd go from kinda being a little bit scared to really being pissed off. That's where the alcohol would come in… 'Cause I was, like, drinking at the situation more than I was drinking just to drink. Blow it off or walk into another room and be able just to turn the other cheek, but yeah, I would say [it was like] "The Shining" 'cause it would just be instantaneous, and he'd change his mood real quick…That's something I'm struggling with right now is how to classify it. Is there any classification? Do you look at it as a whole? I mean, can you dissect it down and just break it up into increments or into categories? And maybe that's where my OCD kicks in, 'cause I'm thinking, "Okay, what do you excuse? What's not excusable?" I don't know. That's kinda tricky…I think—and this is primarily based on the last session I had. I think it's when you and I talked regarding this session that we're having right now. I stayed back from the group and just let you both know, Sam and you, that it was finally really in my mind that this is—it was some literature that you gave us that had something about different types of situations or different types of violence and what it broke down into being like, like the behavior pattern or blah, blah, blah, and it just really opened my eyes up. That was a real good thing.

Throughout the interview, Ruth described how she was confused about the situation and needed time to think about it. After we had discussed the interview questions, I told her about Johnson's typologies. She then elaborated more on her situation and said, "*No, that's great. I'm like, 'Finally. Somebody hit home.' No, it answered my question that I asked [my counselor] today.*" I then asked, "Do you mind me asking what the question was?" Ruth replied:

> *I just wanted her to kind of take me from the DV part, the emotional roller coaster I've been on, and why I reacted and why things got to the point they did. And she did never make—she just didn't know. See, I knew I did this [interview] for a reason. The answer, somehow.*

A week later, Ruth excitedly approached me at New Beginnings and began discussing how helpful our conversation had been for her. I asked her if I could record the conversation, and she agreed. She explained:

> *At any rate, when I met with you last time, at the end of the interview, and you went ahead and said, "Okay, this is"—from that—So I just kinda thought of the things that you said to me, and I thought about it for I'd say at least a week. And I have no contact with my husband, which has been helpful. Out of sight, out of mind. But it really helped me put things in perspective, and also just to kinda breathe, 'cause I haven't been able to really—not, like, diagnose the whole thing or known how to sum it all up, but it really helped me immensely, and it goes without saying…So it helped me a great deal…Yeah. I mean, and that's what I've been looking for through counseling here, but they don't assess that first. . . . You're so sweet. Well, you did me very good. I mean, you really helped me immensely.*

Making sense of domestic violence experiences. Participants reported that it was both helpful and unhelpful to recognize their DV experiences once their definitions were broadened, and that this recognition facilitated helpful (and unhelpful) communication that enabled them to further make sense of their situations. As explained below, generally, numerous women reported that it was helpful to share their stories and to hear others' stories in order to make sense of their experiences.

Helpful sense-making through stories. As mentioned in Chapter Four, an important aspect of support groups is that sharing experiences with those who have "been there" and "done that" can normalize and validate experiences (Burleson, 1994) and it can decrease a sense of isolation (M. A. Dutton, 1992; Helgeson & Gottlieb, 2000). According to M. A. Dutton (1992), "Support from well-intentioned professionals or family members sometimes cannot compare with the support that comes from knowing and hearing about other battered women and their stores" (p. 120; see also A. Jones & Schechter, 1992). DV group members' reports reflect these findings from research because numerous women reported that the most helpful aspect of the DV group's communication was sharing and listening to other members' stories.

Ann discussed how it was helpful in the healing process, "*to talk to other women about it, compare.*" Additionally, Emily said:

> *Well I do feel open to talk and you guys offer a lot of resources. That's pretty much all I need. . . . I felt open to do it, and that was just a good thing in general. I don't know, just getting it out, because it's not something you just talk about on an everyday basis. So to have a place to do that is cool.*

Sidney explained how disclosing her DV experiences was helpful because:

> *I do think a lot of my problems stem from just having my whole life having to keep secrets in domestic violence issues, or violence in the family. It does make it difficult because it affects your coping mechanism and you use alcohol or drugs as a coping mechanism instead of what you really should do. So it just masks the pain, that's all it is it's just a mask. I drink for a reason; it's not because I like getting drunk and blacking out and doing stupid shit and getting in trouble. I don't like that thing. Just because I don't want to feel.*

Stephanie described how telling stories of her DV experiences in the group was helpful for her own benefit and made her feel good to know that it might help someone else in the group as well. Stephanie explained:

> *I mean, yeah, it affected me. I spoke about all the abuse I've seen in my life and what I've felt, how I've felt. But yeah, it even affects me. In fact, it was even better to talk about it knowing that if I said something, somebody else could be encouraged to say how they felt so that they could feel strong enough to move on.*

Numerous other women discussed how hearing others' stories of abuse made them feel that they were "not alone." For example, Ruth thought the DV group's discussions were helpful because the communication assists with:

> *Recognition. And that you're not the only one, that it's common, very common, and that it is okay to reach out for support… I just think that we tend—I tend—and I'm speaking on my behalf again— to single myself out in any kind of situation, and embarrassment, ashamed, guilty. I just think that knowing that it's out there makes you more brave, makes me more brave to come to terms with that being a part of my life.*

Claire described the most helpful aspect of the DV group:

> *It's a place to admit that you have these things going in your life and not feel like it's the wrong thing, that you're still that wrong person for doing it. . . . Shame. There's shame in it, but too, that's an issue that's not —if you brought it up, there's only more punishment for it, so therefore you don't feel like you're gonna be punished for that and you feel because there's other girls in there with you that you don't feel so outcast by it . . . . I don't think that people really understand how many people actually go through that in their lifetime and I guarantee you, everybody at one part of their life went through a sexual, mental, or physical part of it…It might not be to the certain degree that the ones sitting beside you went through, but everybody has felt it in some way. I truly believe that. . . . That you don't feel alone, and too, the more that the group opens up and talks about it, you can relate pretty much to everybody that's talking. I think it brings the bond of us girls closer. . . . I've been here for a long time, but yet too, I guarantee you the girl that just walked in tonight could teach me something.*

Additionally, Penelope described the benefits of individual meetings:

> *Individual meetings are nice but sometimes you just don't want to be singled out. I know in the beginning I didn't want to be, I thought, "Okay, I'll go to this group" just because I had to. And then it's easier to talk about things when there's other people that are going —because I know the first couple of times I was in there I didn't say nothing, and I was listening to [someone] telling me about how she got shot. Then other people put up with being beat and like wow. There's a bunch of people in here that put up with it. . . . Just hearing people's stories. That's a big thing for me because I thought I was the only*

> *one getting beat up and the only one getting talked to the way I was. I know that I'm not and I knew I wasn't but that's just the way he made me feel and that's just the way I felt.*

Penelope further described how hearing stories of positive examples can facilitate hope:

> *It's kind of nice to hear that people do make it through it and are okay with not going back. That was my biggest things was, "Oh, I'll put up with it. Oh, but I know I'm going back to it, so why should I care?" But now I'm not high anymore. I think that's one of the main reasons I stayed was because of the drugs, but because I just felt like I wouldn't be accepted anywhere else. I mean everybody knew he was doing it to me. I mean my mom tried to stop him but none of my so-called friends tried to stop it. And I honestly never thought I deserved better than that.*

Providing positive examples of how a woman *can* be happier outside of a severely abusive relationship can potentially bring hope and increased optimism. Such social comparison can be helpful for group members (see, e.g., Helgeson & Gottlieb, 2000; Loseke, 2001).

Additionally, sharing stories of experiences of DV helped other women to realize that the abuse was not their fault, that they were not "crazy," and that they deserved to be safe. Stephanie thought that it was helpful to hear messages in the DV group that communicated, "*You are not alone. You are not the only one, and you are not alone. It is not your fault*." Moreover, Emily discussed that the DV group was helpful by:

> *Letting women know that they're not alone and that they're not crazy, and it's not their fault. That guy isn't the only one out there. I know it seems like it at the time, but it's pretty much how I felt with that.*

Furthermore, Penelope's interview reflected the "chaos story" of intimate partner terrorism, and she discussed how the DV group's communication was helpful. Penelope described:

> *[After receiving severe injuries to my head], I refused to go to the hospital after he did it to me because I didn't know what I was going to tell him because I didn't want him to go to jail because of me. I finally went [to the hospital] and I told them [an excuse]. They believed me, because they asked me if it was abuse from a boyfriend or anybody and I told them no, which was probably dumb…He used to tell me all the time, "Well you made me hit you. You know what you say to make me beat you." I mean he'd always say that, and then immediately would tell me he was sorry. But immediately right after that would do it again. I know he felt bad about it because he watched his mom get beat. But I mean it never stopped him . . . .He [would] ask me if I had told anybody and I [would tell him], "No." And [he would be] like, "Well just remember it was your fault; you made me hit you." And I would get to thinking, "Well maybe it was." Because I'm mouthy; I am. And sometimes it's not any better to like be mean back but that's what made me feel like I got my side of the story out. But yeah, sometimes I felt I made him hit me because I would call him [names] and that really made him mad…Which I mean I feel bad about it but I mean I had to hurt him as bad as he was hurting me is what I felt . . . .But I know now that you can't make somebody that mad for them to hit you like that. Especially when you say you love them. . . . Just listening to everybody, and then the group that you guys come do. I don't know, my self-confidence is kind of coming back sort of. But I mean it's nice to hear that I am worth it. . . . Yeah, I don't know how to explain it. Just because I mean I've seen people who make it through being shot, like somebody was*

shot. I mean mine was never that bad, but I mean she knows she's worth it now and it just makes me feel better about myself. . . . Yeah, I mean when I came in here I thought that I made him hit me. I mean I thought I made him mad enough for him to be like that. And I mean other girls have said that they've felt like that but they know that it's not them. . . . Yeah, it does, it helps a lot to know that. I mean not that they have it worse than you but some of them had it pretty, actually really bad, and they have the courage to say that it happened to them. But they know what to look out for now. It's really inspiring to me because I would have probably never told anybody. . . . "It's not my fault." I had a really, really hard time even letting that go in my head. It was just like, "Oh, no, you're not talking to me," the first time I was there. It not only makes you think, "Oh, was it my fault?" but I mean later on it's like, "Well that really wasn't my fault." And I mean it doesn't really make you happy but it doesn't make you feel so bad.

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Donna Ferrato
“The mirror of pain.” (as featured in Sun, 2012b)

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Finding resolve. For some women, making sense of their experiences within the DV group influenced them to decide to leave a current abusive relationship or to take legal action against their partners. For example, Shawna explained:

> *Well, for me, it helped me come to the realization for myself so I can stand up for myself and be able to say, “No, you can’t do that to me anymore. I’m done with it.” After I spoke with you and Sam that one day and got the number for legal, I talked to Ron and I was able to just not let him talk to me like that anymore and not manipulate me, because I knew that’s what he was trying to do. Yeah, so it helped me stand up for myself. . . .*
> *It was one of the handouts and I think it was the power control wheel where it tells you the different types of —like the manipulation and all that. I’m just like, “This is him. This*

is every little thing," and it just clicked to me. I'm like, "Oh, gosh. I should've known this all along." Just the explaining the different types of power and control was huge for me. I was like, "What the?" I think that's about the time I started to stay for HIOP, because I wasn't—I was gonna go back home and—which would not have been good for me, but yeah. I've been so scared to take him to court and get my kids back…I can do this. I'm strong enough and so I think you guys in a sense gave me my strength back…Well, for me, it helped me come to the realization for myself so I can stand up for myself and be able to say, "No, you can't do that to me anymore." I'm done with it.

As Hannah explained:

You know like I mean with my ex, I think one of the first times I was in here, we were talking about the control and this and that, you know the losing of the keys and that sort of a thing, and you know it's like I've always known that that's an issue. But it really kind of helped me put into action the fact that I just need to stand up because she's not going to stop. I just need to stand up and say, "You know, I know we're not together anymore. I know that da, da, da, da, so this is really stupid that we're even continuing any of this." So I think it's maybe just a way to break the ice, so.

Similarly, Penelope explained:

Well it's personally helped me. I mean obviously I'm getting a divorce but I mean I'm not saying that's what women should do. But it will help you realize, I mean you don't have to deal with it. It's just—I don't know. I mean I know now that it's not my fault that he was hitting me; it's not my fault that he was an asshole. I felt like—I was telling people what [he] and other people have done. I keep referring mainly to [him] because I've been physically abused before and mentally but never as bad or as long as [he]'s

done it. And I mean it's just gotten worse and worse and worse and worse. But I mean I'm not so much scared because I still am scared but it just gets easier to realize that I don't have to put up with that; I don't deserve it. I keep sounding really weird saying that but it really does; it helps a lot. Sometimes I would get high just because my face would hurt or my ribs would hurt so bad. Getting high really just numbs you and you don't—you have too much other things to think about than hurting, and the words and everything. Just being high around him, I looked at him completely different. I've never looked at him as like, "Oh, you're the one that made me hurt," when I was high I looked at him as like, "Oh, you're my husband, and oh, I love you and oh, we're going to get through this." But now it's just like it's really hard to explain but it makes it a lot easier to be able to look at [him] and know that he's not really [him] but it still doesn't make an excuse for him. . . . Yeah because I thought it was just when he was coming down or wanting to get high and couldn't find nothing. I mean even when he was high he would do it. Just sometimes I would think "He's too high," or, "He just isn't high enough," but really it was just because he has a problem. It just kind of opened my mind that domestic violence isn't necessarily a physical thing; it can be emotional, it can be mental. And I wasn't seeing that in a true light until probably my first or second DV group because I wasn't recognizing those signs as domestic violence. But then it hit me—and if I was to even say something to him like that he would be, "You're crazy. You're insane. What are you thinking? You're just making excuses.". . . . But then it was like, "I can't change him." That's what the DV group taught me was he is who he is and he's been who he is for a really long time. If he doesn't want to make that change then I don't need to be there to go through the abuse that I'm going to go through because I'm trying to

make something work that in reality is not going to work. I'm the one that's getting hurt in the long run.

Unhelpful stories. Although hearing others' stories was very beneficial for some women in the DV group, other women explained situations in which hearing others' stories was unhelpful. For example, Ruth referenced a time in the DV group when the women were laughing and joking about times when they were high and were involved in violent situations. Ruth said:

I mean, there were times in group where I kinda got aggravated 'cause you can tell people that have been through it and people that haven't been through it. It's nothing to joke about. You know what I mean? It's nothing to laugh at. It's nothing to say, "Oh, when I was messed up, this is what happened." It's like, oh, no, it's there. And I think [the DV group] kinda helped me see that it was there, be it through substance or not.

When I asked Kathy if there was anything "unhelpful" about the DV group's communication, she referenced the same issue as Ruth. She said:

Absolutely not. Absolutely not. I think it's wonderful. And I don't even know if you remember—this is when I was in in intermediate four or five weeks ago—and it was irritating when people were laughing and talking about what they did when they were high and all that. I finally was like, "Anybody that's been in a domestic— this is not funny." Because you and Sam were both sitting there straight-faced and everybody else was just having a good old time. I'm like, "This is so inappropriate." . . . .I don't find anything humorous or comical whatsoever about domestic things. . . . I don't get emotional; I don't get—but it's just a matter of respect for everybody else. And I have been through it and I am—I mean I have been through some pretty crazy stuff. And just

because I'm not outwardly showing emotions and stuff doesn't mean that you should disrespect what this is about.

Ann referenced another specific incident in the DV group when a woman was speculating about why a man would choke a woman. The woman was talking about this point in rich detail, and it started to make some women very upset. Ann explained how certain situations can be unhelpful:

> *When things are going a certain direction that they shouldn't be going, like too dark or a trigger or something like that. When they start talking about why certain men choke and see the light go out of somebody's eyes and someone was like, "You need to stop." I was like, "That's too dark. We need to not do that."*

As Ann mentioned, someone in the group started getting very upset, so Sam said that she did not want anyone to be upset and that anyone who was upset could talk to her after the group. The conversation picked up again and the woman who was upset whispered to me, "Can I leave? I gotta get out of here." In the past, other women had left the room when others' stories they heard triggered a negative reaction. Hence, although hearing other women's stories can be greatly beneficial, certain details can inadvertently trigger a stress response in others.

Additionally, Allison, who had attended the DV group previously that year during her first stay at New Beginnings, mentioned how during her second stay at New Beginnings, the "chaotic" telling of stories was unhelpful, and that she wished there had been more informational support. She said:

> *I don't know. I don't want to down it but I feel like it gets out of control in there. Everybody's just shouting out things and that's why I never really talk this time 'cause I'm like I don't really get involved in stuff when it's just so chaotic. My life is so not*

> *chaotic anymore. People talk over people and things like that and it's just irritating. . . . Like I said, I just feel like honestly, I really didn't get anything out of domestic violence group this time, and I don't know, maybe that might be 'cause I was here last time and now I'm back or what it is, but I didn't really get anything. Because we hand out papers but we never get through one paper and it's even like now, the group is longer than what it used to be. It used to only be an hour. . . . Yeah, because I feel like…to be more educated on domestic violence instead of, oh, let's talk about everybody's experiences. I feel like a lot of it is people saying what they went through and all of this, which is fine to hear but not when everybody's trying to do it all at once and there's not any information on, "Hey, oh, I can relate with this and this and this." It's the same thing every single time. . . . It didn't used to be but it is now. I'm not gonna lie. I almost dreaded going to DV group this time. I'm sure I probably fell asleep in most of them 'cause I was like I'm not learning anything in here. All of us girls can run around here all day and sit and smoke and talk about our experiences but let's learn something about it. . . . It's not that I don't like Sam. It's just more, like I said, conversation instead of support and information, identifying.*

As mentioned previously, some women liked that they could say "anything" in the group and share their stories, but Allison perhaps wanted a bit more structure and informational support. Ruth also agreed that there should be more informational support. She said, "*Ideas? I don't—I think it just goes with saying with what I had said before, yeah, that as far as being a little more adamant about getting knowledge packed into everybody's brain.*"

Making sense through attribution. As mentioned previously, substance abuse counselors often encourage those in treatment to "find their place in their problems" whereas DV

advocates want survivors to understand that experiencing DV is never their fault (Bland & Edmund, 2008). Hence, I was very surprised to find that, at New Beginnings, some counselors encouraged the women to complete homework assignments that answered prompts such as "Why I allow people to control me" or that focused on their codependence on men (including men who have been abusive). Moreover, whether it is a function of the 12 Steps (12steps.org, 2013), substance abuse counselors' philosophies, or self-blame from DV, many of the women spoke about their experiences in terms of "putting up" with abuse or "allowing" someone to control them. The aforementioned issues regarding working with women in substance abuse treatment who are survivors of DV are complex, and, as a feminist and an advocate against DV, I never want to venture into blaming the victim. However, as I observed as a DV support group facilitator at New Beginnings, some women find it empowering to think of their experiences as "once letting" someone control them. Although this view may seem harmful from the standpoint of a DV advocate, the question is whether the women should be convinced that they should not think this way when they find it empowering to say, "and I will never let someone control me again."

For example, numerous women I interviewed spoke about how it was helpful to make sense of their experiences; in doing so, they often revealed how it was helpful to shift blame to external attributions (i.e., beyond their control) for the time during the abuse, but then focus on internal attributions (i.e., within their control) for the future. In other words, women tended to express more positive emotions and progression in healing when they had reasons for why the abuse was not their fault (e.g., they didn't "know better," they were "codependent," and/or their "picker is broken"), but spoke of how they had changed as a result. Conversely, a woman who reported being confused or upset about her situation typically began speaking about her story in

terms of internal attributions for the time of the abuse (e.g., "It was my fault" or "I made him do it"). However, as soon as the attribution shifted to external reasons for the abuse, the "chaos" story made more sense and she typically felt better about her situation. An example of this is when Sidney said:

> *Just because you were naïve or fed into this that wasn't your fault; it was part of the control, it was—like me I would stay because I just wanted to be loved, and being grown up in that kind of environment sometimes you have a negative outlook on what love really is. So I stayed just because I thought I was in love. And they clarify with everything that's not love; you don't have to deserve to be like this. You deserve to be happy. That's great.*

Similarly, Echo said:

> *"Oh my goodness, you don't have to put up with that." I know what they're doing, I see it because I did that. But I didn't know any better. They don't know any better. They really don't. . . . I always thought it would stop. There were a couple times I thought it was my fault. I was young, stupid, but I always thought it would stop. "I won't do it no more," he would say he won't do it no more. Give it a day or two, he'd do it. So kind of like that honeymoon, he'd say, "I'll never do it again," and you believed what he said. I believed it.*

Allison, whose partner sex-trafficked her, said:

> *And that's just how weak I am around him to this day. I know if I get around him, I'm a completely different person. I'm quiet. I look at the ground all the time. I make sure I'm not looking at nobody around me 'cause I'm just like, "I don't want to piss you off." Even though we're not together, it's I'm a whole different person when I'm around him.*

It's crazy. I don't understand it. I don't understand how that happens, how you just flip like that. That's why I don't talk to him because I don't want to be that person. That's not who I am. I'm not the shy little girl in the corner. . . . Then? A scared little girl. I never stood up for myself and I stand up for myself all the time. When I first got with him, I would stand up for myself, but after things started getting —when he broke my phone and stuff like that and I took off running, after that, I just slowly but surely stopped standing up for myself…It was fear and then it was like I don't like to be alone, so here I am in this relationship and I really like this guy. I thought I loved him. . . . His character? A pimp, more or less. That's just the persona that I see now when I think about him or I see him. I'm just like what the hell? He thinks he's the shit and he's really just nothing. Nothing. . . . Really when I think about it, I don't even really see it as a relationship anymore. Yeah, he's my ex-fiancé but I don't really see it as a relationship anymore 'cause more or less, I was just tricking and he was just putting me through all of it and then all the money was going to him, everything was going to him. It wasn't even really a relationship when I really look at it. . . . I'm a lot stronger now than what I was then, since the last time I was in here compared to now, yeah…I'm my own person now. I don't let other people control the way I think, the way I act, the way I feel, just pretty much me.

Kathy explained:

I think that so many victims try to blame themselves. That's different, it's okay to be a victim because you don't have to take the blame. It's better to be in a domestic violence situation and be convinced you are the victim—I don't think that's unhealthy. . . . I mean you're a victim but you can be a survivor, which gives them the strength, like "I don't

want you to be the beat down weakling; you're the victim, the beat down weakling but you can be the survivor, which is the giant." Let's look at what you can be. You don't always have to be a victim; you can be a survivor.

Sidney explained how things might have been different in the past had she known what she knows now. She said:

I didn't know they would help you in every process of every aspect of everything. That's just amazing. If I had known that and actually spoke to somebody and have the courage to do that at that time I probably would have done that instead of going the route I did with my situation. . . . Yeah because I didn't get that until after my hospitalization. If I had got that sooner then I could have saw a lot of the signs sooner and got out faster and I wouldn't have had to go through that again. So that's very, very helpful because now I don't have to go through that again.

Other women expressed how learning that the abuse was not their fault was helpful because DV was all they had ever known. Numerous times during the DV group, women earnestly—sometimes in tears—asked if the Equality Wheel (which demonstrates healthy relational behaviors; see Appendix H) existed and if there are really "nice men" out there. Sidney said:

I kind of grew up with it. It was normal. I never knew any different. . . . But that's where most of the damage is; my dad never laid a finger on me but when he and my mom were married, beat the crap out of her. And my brother was really physically abusive later on too. My dad was just verbally abusive, called me a cunt or whatever. I never knew that wasn't normal. I realized it later in life that that wasn't okay but I remember thinking that was how people were behind closed doors…I thought everyone's family did that in

their own home. I think—I don't know, my only thought that comes to mind is like I know with me personally and a lot of other women like if you put up with it once and you put up with it more than once and it's usually been in our childhood or in our family or—a lot of women it is just circumstance happens and they don't know the person's like that until they've already married them or something and they try and get out. But a lot of us have just fallen into it and are used to the turmoil and the chaos; it's almost an addiction or a fear. I'm not saying it's our choice but it kind of is half the time.

Additionally, Penelope said:

> *I think it was a habit of mine to find somebody because that's what I was used to. My dad did it to my mom. And then it's not that I wanted it to happen to me, it's just—and it's not —this may sound wrong—it felt comfortable just because it's what I put up with since I was 18. But I mean—and every time I would find somebody that was too nice I would break up with them thinking, "Oh" because if I thought it was too good in the beginning then I just didn't stay with them because I figured it was just going to be even worse. . . . Yeah, they were just being too nice because later they were going to be complete assholes. Yeah, it just felt like they were really showing their true colors in the beginning. But it always ended up really bad.*

As Nancy also explained:

> *Then I just started thinking it must have affected me because normal people don't do that. I never—I seem to—when I get some guy that's real safe he's never really very safe but at least it's somebody I like to spend every day with. Then that gets boring and really I just want to go off with some bad guy for a while but didn't actually want to be with him. That might be really common. . . . Yeah. I think especially girls in here have a hard time*

with—if it's a nice guy, "there's got to be something wrong with him in order to be with me because I'm fucked up. I don't have a lot to offer because I've got this big crutch that I'm leaning on with my alcoholism or drug addiction." Like who would want to be with somebody like that unless there's something wrong with them, like maybe they have something like that going on, or maybe they want somebody to fix, or something's got to be wrong with them. Maybe they're just like some decrepit old man that wants to be with some girl.

When I asked Julie if she had experienced unhealthy or abusive relationships in the past, she replied:

Oh yeah, like all of them. Because if I met a guy who was healthy I didn't like him. He made me feel uncomfortable. . . . I don't know. I would think either he's a dweeb or he's a loser or he's an idiot or he's a wimp. Of course I don't think that why anymore.

Similarly, Stephanie explained:

No, I don't go looking for love now because I was looking for love in all the wrong places every time, and it failed. So now I have to learn that eventually love will find me. I was just looking too hard for it, so I kept ending up with all the bad guys because you know . . . . I was—we are attracted to thugs. [Laughter]

Similarly, during the DV group, women would talk about their experiences in terms of attribution. During the group, one woman's statement contained both messages of self-blame and other-blame: "I allowed him to control me for years, but I mean, I know it's not my fault and all." Another woman said, "I realized it was his fault and all—the abuse—but I didn't have the self-esteem, the self-worth, to realize that I deserved better. Once I figured that out, it was easier to—quit loving him I guess—and leave."

Further, another woman said:

> I'm sorry ladies, but I used to only go out with gangstas. You know, tattoos, dealers, real thugs. And I always got the shit beat out of me. So, I started dating nice guys. They're boring, but I'm the happiest I've ever been. Sometimes you gotta think about your own standards and what you're willing to allow.

Overall, as I discuss in the following chapter, participants' narratives about their experiences often included messages of *both* "fault" and "not fault." In Chapter Seven, I describe how this construction of narrative has great implications for the dialogic perspective (see, e.g., Baxter, 2011). Griffin (2008) described how a single utterance that includes *both* opposing forces of a phenomenon is rare; however, the women in the DV group often talked about the opposing forces of "fault" within the same utterance. As Loseke (2001) mentioned, some women may not want to adopt an identity as the "helpless victim" because they may not "want to embrace the status of victim with its accompanying images of weakness" (p. 123). Thus, by saying that they "know better now" or "won't let someone control me again," it is helpful perhaps because they feel a sense of empowerment or that they have control over their future. In addition, questioning why they "allowed" someone to abuse them may also make them feel like they have agency over their situation.

Additionally, as further discussed in Chapter Seven, the women's sense-making processes have tremendous implications for appraisal theory and attribution theory. As mentioned in Chapter Four, social support from others may help people to reappraise stressful situations in different ways, and that reappraisal may help them to feel less stressed and more positive about their situations (see Burleson & Goldsmith, 1998; Lazarus, 1991; Lazarus & Lazarus, 1994). By framing their DV experiences as something that was "not their fault" for

various reasons, but now something that they have control to prevent from occurring again, the reappraisal seems to make them feel "stronger" (e.g., as demonstrated by Allison and Ruth). This reappraisal seemed to also be intertwined with attribution and attribution theory (see, e.g., H. H. Kelly, 1972; Manusov & Spitzberg, 2008; Nisbett & Valins, 1972; Sillars, 1982). Again, by making external attributions to explain the time of abuse and internal attributions for the time of leaving the abuse and the future, the women are able to reappraise their situations in positive and meaningful ways.

Moreover, participants' reports of "being used" to violence and feeling "uncomfortable" with "nice guys" provides implications regarding a habituation model (see, e.g., Kowalski, 2009; Vangelisti, Maguire, Alexander, & Clark, 2007). According to Vangelisti et al. (2007), "The case put forth by the habituation model is that with repeated exposure to hurtful stimuli, people become accustomed to feeling hurt. As a consequence, when they encounter hurtful stimuli, their feelings are less intense than they might be otherwise" (p. 358). Whereas some participants explained how their DV experiences seemed "normal," they also expressed how they did not trust "nice guys." In the DV group, women who often explained that they did not date nice guys said that the reason was because they either: (a) feared that a "worse monster" would appear later because the men they "usually date are assholes upfront. I know what to expect," or (b) expressed that they felt there must be "something really wrong with a nice guy. Like how fucked up are *you* if you like *me*?"

Preparing for the future. As the previous sections illustrated, many women from the DV group explained how it was helpful (and unhelpful) to recognize their experiences as DV and to make sense of those experiences. Additionally, as explained in the section below, numerous women reported that the communication within the DV group was helpful because they felt

better prepared for their future. Conversely, other women mentioned how a lack of feeling prepared was unhelpful.

Helpful preparation. For example, Shawna thought that one of the most helpful messages of the DV group was how to stay safe in potentially dangerous situations. She said it was helpful to know "*how to make a safe environment, like a safe escape or if you don't wanna leave, then you make sure you're in a safe area*." Nancy also found it helpful to learn how to develop a "safety plan." During one DV group session, she shared how a partner would often threaten that he would commit suicide if she did not do certain things. Thus, Nancy said one of the most helpful messages of the DV group was:

> *Maybe that you should have a plan. I heard you guys talking about that and the thing about the suicide it's like, "Yeah, if I knew what to say I might feel a bit more safe." Also I would avoid having to talk to him all the time whenever he's terrorizing me with guilt and threatening me with guilt. It would be pretty useful; it would be a good way to set boundaries to know I can handle it and everything would be okay.*

Sidney also mentioned how it was helpful to discuss safety plans. She said:

> *They give you the tools, like our last group that we had was the safety plan. I never would have ever thought about making a safety plan on what I need to do. . . . I mean I had never thought about stuff like that ever. I wish I would have had a safety plan and that would have saved me a lot of hassle with some of my situations.*

Other women discussed the importance of "stopping the cycle" of DV. By discussing experiences of DV and "red flags" for an abusive relationship, numerous women found hope that they could recognize abuse earlier in order to prevent possibly dangerous situations. Ann said that one of the most helpful messages of the DV group was:

what they can do to avoid it or stop it in their lives. That we don't have to put up with it. That's what I would think. . . . To never have to stay in that kind of relationship, again. Like do you see any sign or similarity of that to get out right away.

When I asked Stephanie if the DV group's communication had affected her or her relationships, she said:

Yeah, tremendously because, for one, if you hit me, you are out my front door, you will not come back, and don't let the door hit you on the ass on the way out…Any other time, "Oh, yeah, I know you're sorry. Yeah, come back over." No, don't call me because I will not answer the phone. And you know, if you try to come over, I'm as strong as you are now, so come on. Let's see who's the bigger person this time. [Laughter] So yeah. Now that I know that I'm worthy—and I am somebody that I've been told I was nobody my whole life, boy, you better watch out. I'm a whole new person.

Additionally, as Lily explained:

It's just let me know that I don't have to settle for less in a relationship that is gonna be domestic, where I'll be a domesticator or the victim. Yeah, I'm different. . . . Because I can say no now. No, I don't wanna do that, or no, it's not gonna be that way; or no, we both are equal, so if you don't like my opinion, then we'll have to come a conclusion to where we both have a fair share in it.

Sidney said the most helpful message of the DV group was:

To stop the process early, to not be in another unhealthy relationship, to know that you are worth something and deserve something more than that kind of abuse, no matter physical or mental or emotional, whatever, just it doesn't have to happen anymore. Because I know I can't keep going through life in this unhealthy relationship after

another; I can't keep doing that. I can't do it for myself and I can't do it to my kids or anything. The Power and Control Wheel—That's a huge thing because that can stop the process of abuse before it can even start. So getting that known and set into your brain you will look at the next relationship you get into and like, "This is not good." Catch the early warning signs so you can get out a lot faster and not have to go through—and keep repeating the cycles, repeat the cycles of unhealthy relationships and actually have a genuinely good one. . . . And hopefully after all this learning and things I will be a good judge of character, so I won't continue the same path, or stay as long in an unhealthy relationship.

Additionally, Shawna commented:

My kids' dad, he's very verbally and mentally, emotionally abusive and there's been some very short relationships where they have physically, but never again. I know what to look for because of your group now. Yeah, so I know the red flags now and I'm just gonna be single for a while.

Similarly, Claire said:

I think that as far as me being here, New Beginnings gives me the tools to deal with my sobriety and things like that. DV brings in attention as to a hard course to maybe avoid situations that are gonna draw us back into what we were. Then too, I like how both parties, they will give you tools to further on out of here.

Rachel mentioned how it was helpful to have the perceived support of knowing she can seek services from Safe Haven if needed. She said it was helpful that: "*I just know what to do and if that does happen again I know who I can go and get help with and where I can go and get*

help and I know it will be confidential." Kathy said the DV group's communication was helpful because it

> *is more specific about what I'm going to be looking for in a relationship and what I should be looking for when I get in one, just making me more aware. I certainly don't want to get in another violent relationship or abusive relationship or controlling relationship or anything like that.*

Penelope explained that the DV group was helpful because:

> *I think the more people talk about it the more they're going to be aware of what to stay away from. I mean some of the girls that have never been in abusive relationships have never been in a relationship period. I mean I think it would help them to recognize the signs of, "Hey, he's abusive." I mean not only physically but mentally and verbally. I mean I would rather have had my husband beat me up every day physically than some of the verbal things he said to me because I will never forget the words he said to me. Never. But bones heal and bruises go away; that's the way I think of it. I would just rather be beat up then ever have some of the things said to me that he said. . . . It's helped a couple of girls, I know, because they've asked to talk to me and Tracy about just signs of it happening before it happened. And it helps them understand some of the warning signs. . . . I'll know the warning signs now and I won't take for granted somebody being nice to me.*

Lack of preparation. Numerous women who attended the DV group explained how the group's communication helped them to prepare for their future. However, Julie attended the DV group for several sessions at New Beginnings before being "*kicked out*" of New Beginnings. After that occurred, a few weeks later she started a relationship with a man who eventually

became violent. When the police were called after the violent outbreak, they recommended that Julie contact Safe Haven. Julie, who was currently staying at Safe Haven's safe shelter during the time of our interview, did not remember Save Haven or its services from the DV group at New Beginnings. Julie and I discussed this; after she told me her story, I asked, "And, like, did you remember Safe Haven from the DV group at New Beginnings or anything?" Julie replied:

> *I have no idea this is how life worked with domestic violence. I thought that when wives get beat up by their husbands, or wives and children I always thought that the domestic violence organizations put them in their own home and like pay the rent and all that stuff. I didn't know it was an actual shelter. I had no clue. This is a first time deal for me. . . . But when I'm in those —when I was at New Beginnings I was coming off of drinking vodka and beer every single day, just drugs, drugs, drugs for so many years my head was in a fog. . . . But this experience woke me up real quick.*

Perhaps because of numerous factors (including the "brain fog" that New Beginnings staff say is common during treatment), not every woman who attends the DV group remembers Save Haven's services or the supportive information conveyed during the group.

Chapter Summary

When I came in here, I was very timid and just a scared little girl. I wasn't confident and just kept to myself, reserved, and I am a completely different person. I mean I have completely turned into somebody that I am proud of. . . . I'd just like to stay consistent in myself and keep making progress and don't fall short. Don't settle for anything less than me, because I am—I have the confidence. I have the self-worth and everything about me is—I lost that along the way—and I finally have it now. . . . I'm back to being myself and it's awesome.

-Shawna-

***

I've learned to be able not to be— I mean, it's a matter of opinion. Life is a matter of opinion for everybody. But my opinion does matter, you know what I mean? So I mean, that feels real good—I'm gonna be a productive person in society; that I'll be able to go and leave here with the tools that teach me to not subject myself to lower standards than—I'm more worthy of that.

-Lily-

***

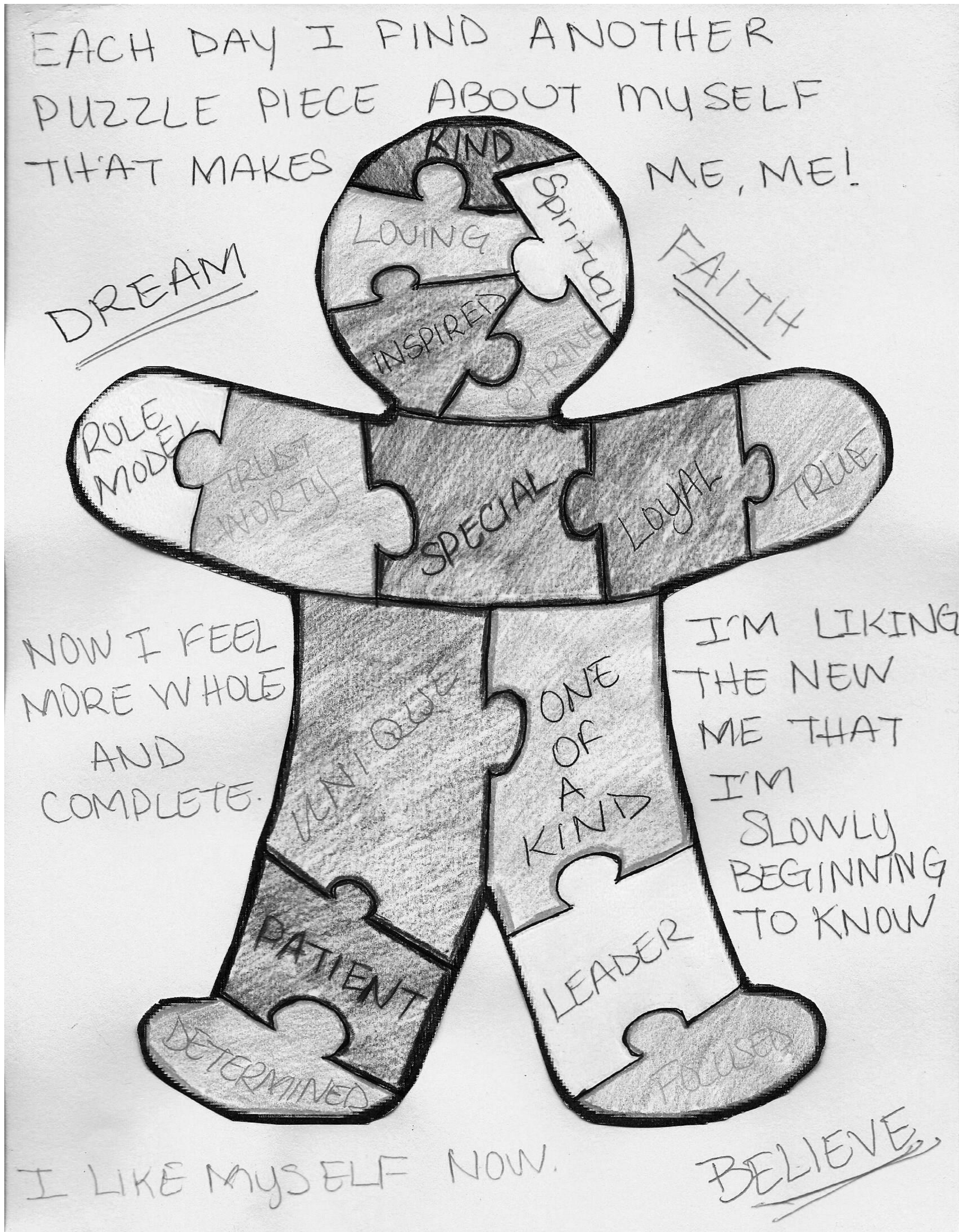
I became like a flower that dried up. . . . No more trapping me; I'm free as a bird.

-Rachel-

***

My trials and tribulations—I didn't go through that for no reason. I'm stronger today because of it and I'm thankful that I did go through those things because I wouldn't be that woman today without 'em.

-Stephanie-



Original artwork by Stephanie

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Overall, the women who attended the DV group at New Beginnings perceived that it was beneficial in numerous ways. The "comfortable" group climate facilitated a safe environment of learning and sense-making through others' stories and discussions about DV in general. The DV group was a place where women supported each other about an issue that was currently not their "main concern" (i.e., recovery from substance abuse); however, as numerous women explained, some believed that the DV group was a necessary part of their recovery from substance abuse. At the beginning of every group session, Sam said, "You don't have to raise your hand if you don't want to, but who in here has experienced physical or emotional abuse?" In almost every group, every week, every woman raised her hand—and the average group size was around 16 to 18 women. The correlation between DV and substance abuse, thus, was evident in the DV group at New Beginnings (as explained in the scholarly literature; see, e.g., Chase et al., 2003; Coker et al., 2000; D. H. Coleman & Straus, 1983; Fals-Stewart & Kennedy, 2005; Gondolf, 1995; Hamilton & Collins, 1981; Holtzworth-Munroe et al., 2000; Kantor & Straus, 1989; Leonard & Jacob, 1988; Logan et al., 2001; NCADV, 2011; Pernanen, 1991; Stuart et al., 2006; Testa et al., 2003).

Some women thought the group was boring and found various aspects of the communication within the group to be unhelpful; however, the women generally reported in interviews that the positive aspects of the DV group outweighed the unhelpful aspects. Furthermore, many women reported that they could not "think of any" unhelpful aspects of the group's communication. Many of the women who attended the group previously conceptualized DV in terms of the formula story (or public story) in which a woman experiences severe physical violence from a vicious man (see, e.g., Loseke, 1987; 2001; 2009). Numerous women's lived experience did indeed align with the formula story, and some women reported that this

explanation of DV helped them to make sense of their experiences. For Penelope, it helped give her the courage to escape her potentially dangerous situation while she "had the chance." Other women who did not "fit" the formula story found the discussions of *various* lived experiences of DV to be helpful because it helped them to make sense of situations beyond the formula story. Conversely, sometimes women who did not "fit" the formula story found it difficult to relate to the group, and some even believed that *they* were "abusers" (although some potentially were). Communication within the DV group was often messy and complex—the topics of conversation often changed quickly depending on the women's questions, comments, or stories—but I believe the process mirrored the often chaotic stories of survivors of DV. Many of the women had never conceptualized their experiences as those of DV, and the process of recognizing DV and making sense of those experiences was at times, both difficult and rewarding.

The next chapter (Chapter Seven) provides the theoretical and practical contributions of this project. I also describe the strengths and limitations of this study, as well as directions for future research.

Chapter Seven: Discussion and Implications

This intervention-oriented research project, which began in January 2012, examined the helpful and unhelpful communication within a domestic violence (DV) support group in a substance abuse treatment center. Researchers and advocates have acknowledged that there is a correlation between DV and substance abuse (see, e.g., Chase et al., 2003; Coker et al., 2000; D. H. Coleman & Straus, 1983; Fals-Stewart & Kennedy, 2005; Gondolf, 1995; Hamilton & Collins, 1981; Holtzworth-Munroe et al., 2000; Kantor & Straus, 1989; Leonard & Jacob, 1988; Logan et al., 2001; NCADV, 2011; Pernanen, 1991; Stuart et al., 2006; Testa et al., 2003), and that these issues can "interact and exacerbate each other" (Engelmann, 1992, p. 6). Thus, Fazzone et al. (1997) argued that these issues should be addressed simultaneously when both issues are present; however, there is little interaction between DV and substance abuse agencies across the United States, and DV and substance abuse agencies "do not usually address the complementary problem" (Collins & Spencer, 2002, p. 1).

As noted earlier, this project was part of a larger endeavor to bridge the services between a DV center (Safe Haven), a rape crisis center (Mending Together), and a substance abuse treatment center (New Beginnings) in a community in the Midwestern United States. The Domestic Violence and Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services (2005) and Bland and Edmund (2008) recommended that DV advocates should provide support and services for people in substance abuse treatment programs, and that substance abuse counselors should provide support and services for those seeking services from DV agencies, with support groups being a recommended way to provide such cross services (Bland & Edmund, 2008). Accordingly, this study sought to examine the DV group at New Beginnings in order to answer the call for more research and models of effective bridging of

agencies in communities. Specifically, this study examined DV group members' perceptions of the helpful and unhelpful communication that occurred within the DV support group at New Beginnings (RQ).

This intervention-oriented project began when Safe Haven (the DV center) asked me to begin facilitating the DV group at New Beginnings (the substance abuse treatment center). Before I began facilitating the group in April 2011, the staff at New Beginnings asked me to modify the group so that it would be more helpful for the women at New Beginnings. Ultimately, this intervention became more of a collaborative effort with the DV support group members (see, e.g., Frey, 1994) because they helped to guide the curriculum and provided feedback regarding the helpful and unhelpful aspects of the group throughout my time as the facilitator so that we could adjust accordingly.

In January 2012, the ethnographic component of this research project began. In September 2012, I trained Sam, a staff member from Safe Haven, to facilitate the DV group, and she began facilitating the group in October 2012. I observed Sam and the DV group until May 2013, and I conducted interviews with 20 DV group members (past and present) between February and April, 2013. Ethnographic data and interview data were analyzed in an iterative, inductive process via line-by-line, constant comparison coding (Glaser & Strauss, 1967; Miles & Huberman, 1994). I then used axial coding to further construct categories of helpful and unhelpful communication (Charmaz, 2006).

In the following sections, I first provide a brief summary of the results. I then address the theoretical and practical implications of the findings. Finally, I address the limitations of the study and provide recommendations for future research.

Summary of Findings

Broadly, participants' perceptions of the helpful and unhelpful communication within the DV group centered on the facilitators' communication and the communication among DV group members. Overall, participants found Sam's communication helpful because she: facilitated a comfortable environment; solicited the women's stories; provided a broad range of information about DV; and conveyed messages that the women were the experts of their own lives, she would not assess their situations for them, and she would provide support in "whatever way support mean[t] to [them]." Conversely, some women found it unhelpful that Sam was not "heavy-handed" and would not assess their situations or give them direct advice.

Regarding communication within the DV group as a whole, participants reported that the most helpful aspects of the communication within the DV group at New Beginnings involved discussing and learning about different conceptualizations of DV, experiences of DV, and how to prepare for the future (and break the cycle of DV). These discussions facilitated participants' recognition of their experiences as DV, and sharing stories provided a way to help them make sense of their experiences of DV. However, some participants reported that hearing others' stories could potentially trigger negative emotional responses and that some women found it unhelpful when others discussed their DV experiences in a joking manner. Additionally, some women were uncomfortable conceptualizing or labeling their experiences as DV. The overarching implications of the helpful and unhelpful communication with the DV group are further examined in the subsequent sections of this chapter.

Theoretical Implications

The findings from this study have implications for a dialogic perspective (Baxter, 2004a; 2004b; 2006; 2011; Baxter & Montgomery, 1996; Griffin, 2008), attribution theory (H. H. Kelly,

1972; Manusov & Spitzberg, 2008; Nisbett & Valins, 1972; Sillars, 1982), and a habituation model (Kowalski, 2009; Vangelisti et al., 2007). The following sections examine the theoretical implications of the study.

A dialogic perspective. The findings from this study have implications for elements of Baxter's (2011) dialogic perspective, which is an expansion of relational dialectics theory (RDT; Baxter 2004a, 2004b, 2006; Baxter & Montgomery, 1996). As Baxter (2004a, 2004b) explained, the major assumptions and components of RDT draw heavily from Bakhtin's writings (e.g., Bakhtin, 1981a; 1981b; 1981c; 1981d). An important aspect of RDT is that social life is constitutive. This idea closely resembles *symbolic interactionism* (Mead, 1934) in that communication and relationships are socially constructed; as we shape our relationships, our relationships, in turn, shape ourselves, as well as our experiences. In this view, the self is not monadic, nor is the self "sovereign" in relationships because we learn ourselves (i.e., who we are) through communication and relating with others (Baxter, 2004b, 2006, 2011).

Accordingly, discourse is an important element of RDT because it is through discourse that we make and create meaning (Baxter, 2011). As Baxter (2011) explained, a discourse:

> is a system of meaning—a set of propositions that cohere around a given object of meaning. . . . All meaning making is similarly complex; the meaning of any concept is embedded in a larger web of meaning—a system of integrated bits of meaning. . . . RDT's core theoretical principle is that meaning in the moment is not simply the result of isolated, unitary discourses but instead is the result of the interplay of competing discourses. . . . Discourses are in competition when the meanings they advance negate one another in some way, more or less in a zero-sum manner. . . . According to RDT,

> what something means in the moment depends on the interplay of competing discourses that are circulating at that moment. (pp. 2–3)

As DV group members shared their stories, two major competing discourses were illuminated: discourses *before* the DV group and discourses *during* the DV group. First, in telling their stories, group members revealed the competing discourses that they heard—and, thus, made meaning of their experiences—before attending the DV group. Group participants often told stories that involved what other people had told them about their situations, what their partners had told them about their situations, and what they believed based on the context of those discourses. Throughout my time facilitating and observing the group, women often reported hearing messages that reflected the larger discourse that abuse is "normal." For example, three women mentioned in their interviews that they had been told by others that their partner's abuse of them could be considered to be a positive aspect of the relationship because he would not be so violently reactive if he did not love her so deeply, offering the message that only intense love equals intense reactions. Additionally, women often heard others blame them for the abuse (e.g., "You're not trying hard enough" and "What did you do to set him off?") or minimize their abuse (e.g., "You should just be grateful that he provides for you, and really, it's not that bad."). Those messages reflect larger societal discourses that tend to blame the victim in DV situations or cast such abuse as a normal, private matter. Moreover, other women compared their situations to others who had experienced more severe violence; thus, the discourse that DV is severe physical violence with pure victims and vicious villains (see, e.g., Loseke, 2001, 2009; Muehlenhard & Kimes, 1999) sometimes influenced women to believe that their situations were not DV even when it could be considered DV by legal or broader definitions. Further, in cases of intimate partner terrorism (i.e., when one partner terrorizes the other with physical, emotional,

and sexual abuse, as well as via controlling tactics; see Johnson, 2006), abusers often also blamed the victim or minimized the severity of the abuse. Within these contexts, the messages that formed this discourse often resulted in meaning making that minimized the abuse or blamed the victim for the abuse.

However, when a woman attended the DV support group at New Beginnings, a competing discourse was presented and the context of the group changed the meaning of abuse. In the context of New Beginnings, discourses reflected ideas that: DV entails more than just physical violence (e.g., the Power and Control Wheel), DV is unhealthy or wrong, and the victim should not be blamed for abuse. Accordingly, the support group context, which included discourses that competed with previously learned discourses, typically changed the meaning of the women's experiences. Although the messages surrounding a woman's DV experiences nonetheless reflect larger, competing discourses (e.g., a woman is to blame for her abuse, abuse is normal, abuse is wrong), the discourses of the DV group became salient in that specific moment of the woman's life, and thus changed the meaning of her experiences.

Another important underlying concept of RDT is that social life is in a state of constant flux. In RDT's view, there is no dichotomy between opposing forces; instead, the *interplay* of opposing, contradictory forces is key (Baxter, 2011). However, RDT views contradiction not as opposing, dichotomous forces, but as the interplay between unified oppositions (Baxter, 2004a, 2006, 2011). In social life, we experience the both/and of opposing forces (Baxter, 2006). For example, Baxter (2004a) remembered her professor teaching her a Burkean concept that seeing "A" equals seeing "Not A." However, RDT assumes that "A" and "Not A" are intertwined, and thus the interplay is important in helping us to learn about ourselves and our social worlds.

Although RDT views the importance of the interplay and unity between opposing forces, it is rare that utterances express both voices of opposing forces simultaneously (Griffin, 2008). Most utterances only express one voice (Griffin, 2008). For example, if a husband tells his wife that he has to get off the phone because he has to work, this utterance only implies a voice of difference and autonomy; however, if he were to say, "I'm looking forward to spending time with you, but I need to finish my work first," he has just expressed *both* a desire for autonomy and connection (Griffin, 2008). Baxter (2011) referred to these types of utterances as a *transformational hybrid* (p. 5). According to Baxter, a transformational hybrid is "a way in which seemingly competing discourses are somehow merged through their interplay in a way that achieves a both/and hybrid meaning" (p. 5). In these utterances, "the discourses are distinct, yet they are no longer framed as oppositional. Instead their interplay constructs something new" (Baxter, 2011, p. 139).

Throughout my time observing the DV group at New Beginnings, women often conveyed messages that were both/and—the unity of oppositional forces. In these cases, the oppositional forces were: "not fault" and "fault." As illuminated in Chapter Six, although it is rare for a single utterance to include *both* opposing forces of a phenomenon (Griffin, 2008), the women in the DV support group often communicated messages that contained discourses reflecting that the abuse was not their fault but also of how they played a role in the abuse somehow. For example, a woman said, "*I allowed him to control me for years, but I mean, I know it's not my fault and all.*" Although the woman acknowledged that the abuse was "not her fault" she simultaneously said, "I allowed him to control me." The word "allow" reflects the competing discourse that she is somehow responsible for the abuse or for how long it continued.

Baxter (2011) argued that the dialogic perspective as an analytic tool is meant to examine the dominant discourses that are at play (and in competition) within utterances. Accordingly, I believe these utterances reflect both the discourses of self-responsibility (or victim blame) as well as the DV group's discourses that conveyed messages of "it's not your fault." Moreover, as mentioned in Chapter Six, the women's tendency to talk about their DV experiences using phrases such as "putting up" with abuse or "allowing" someone to control them may also reflect one of the dominant discourses of substance abuse treatment: find your place in your problems (see, e.g., Bland & Edmund, 2008; 12steps.org, 2013). Because the DV group is a bona fide group that is interdependent with its larger environment (see Putnam & Stohl, 1990, 1996), the discourses of New Beginnings and the 12 Step Program may influence the women's sense-making within the DV group as well.

Baxter (2011) argued that the dialogic perspective is not meant to examine individuals' motives but rather the competing discourses that are illuminated in the utterance. However, Baxter also argued that researchers should examine the meaning in the interplay of competing discourses, and I believe that the interplay perhaps is best examined in terms of the individuals' motives in this case because the utterances perhaps reflect the desire to find control in, and make sense of, a chaotic experience.

As described in Chapter Six, feminists began (and continue) to tell the "formula story" of wife abuse (Loseke, 2001). This formula story includes a plot of severe violence and abuse and the characters of the pure victim and the vicious villain (Loseke, 1987, 2001, 2009). The formula story was and continues to be necessary because it raises awareness about the atrocities of intimate partner terrorism, and it is beneficial for women who relate to the formula story because it might inspire them to seek aid. However, as Loseke (2001) explained, some women

may not want to accept the formula story as their own because they may not "want to embrace the status of victim with its accompanying images of weakness" (p. 123). Thus, when the DV group women say things such as they "know better now" or that they "won't let someone control" them again, perhaps the formula story is empowering for them because they: (a) feel that they have control over their future, and (b) have a reason for why the abuse happened to them. Additionally, questioning why they "allowed" someone to abuse them (e.g., "my picker's broken," "I am codependent," and/or "I try too hard to fix them") may also reflect a desire to view themselves as having agency over their situation. As illustrated in the women's interviews, many women mentioned how it was helpful to acknowledge "their place" in revictimization (e.g., why they have had numerous abusive relationships), while simultaneously acknowledging their agency in moving forward.

Attribution theory. The dialectic of "not fault" and "fault" in the findings from this research study has implications for attribution theory as well. As Manusov and Spitzberg (2008) explained, an attribution is "the internal (thinking) and external (talking) process of interpreting and understanding what is behind our own and others' behaviors" (p. 38). Attributions are based on numerous dimensions, but the one that is most relevant to the findings from this research study is that of *locus of control*, which is "whether or not we think a person was able to alter the cause" (Manusov & Spitzberg, 2008, p. 39).

Throughout my time observing the women's communication and listening to how their narratives adapted via the process of symbolic interaction (e.g., Mead, 1934) and amidst competing discourses, I often observed changes in how the women made attributions for the duration of the abuse and for the time after the abuse. Those changes primarily involved the

locus of control. Internal attributions assign personal responsibility, whereas external attributions assign responsibility as beyond a person's control (Manusov & Spitzberg, 2008).

Numerous women I interviewed (and six women with whom I conducted member checks; see Lindlof & Taylor, 2011) discussed how they experienced more positive emotions and generally "felt better" when they made external attributions (i.e., the abuse being beyond their control) for the time during the abuse, but then focused on internal attributions (i.e., the abuse being within their control) and personal responsibility for the future. Generally, I observed that many women tended to express more positive emotions regarding how they felt about their experiences when they had reasons for why the abuse was not their fault (e.g., they didn't "know better," they were "trying to fix them," and/or their "picker was broken"), but spoke of how they had changed as a result. Ironically, as they were "finding their place in their problems," they were simultaneously finding a reason for why the abuse was not their fault—another dialectic. For example, although saying "I was trying to fix them," is at face value an internal attribution, it nonetheless served as an external attribution because the message conveys the meaning that, at the time of the abuse, the woman was "trying to fix" something that was nonetheless beyond her control. Conversely, a woman who reported being confused or upset about her situation, or someone whose narrative reflected a "chaos story" (see, e.g., Loseke, 2001), typically began speaking about her story in terms of internal attributions for the time of the abuse (e.g., "It was my fault," or "I made him do it"). However, as soon as the attribution shifted to external reasons for the abuse, the "chaos" story became coherent, and she typically began to feel better about her situation.

Accordingly, many women felt better by reframing their attributions from internal/external to external/internal. In this sense, a woman experienced more negative

emotions when she thought that the abuse was her fault (internal) and that there was nothing she could do in the future to stop the cycle (external). Conversely, when the attributions changed, she felt better when she viewed the abuse was not her fault for various reasons (external), but that she had the knowledge, strength, or self-worth to stop the cycle of abuse in the future (internal). This finding also has implications for appraisal theory because altering attributions regarding the experience of DV ultimately led to reappraisal about the time during the abuse and for the future; the positive reappraisal then led to increased acceptance of past experiences and optimism for the future (see, e.g., Lazarus, 1991; Lazarus & Lazarus, 1994).

A habituation model. Part of how women explained their revictimization (being in numerous abusive relationships or only experiencing abusive romantic relationships throughout their lives) was that they were "used" to violence because it was "normal" and they "didn't know any better." Many women who reported being "used" to DV also had experienced rather severe violence (e.g., being punched or "beat up"), but they did not conceptualize their experiences as DV before attending the group. This notion has important implications for a habituation model (see, e.g., Kowalski, 2009; Vangelisti et al., 2007). According to Vangelisti et al. (2007), a habituation model posits that, "with repeated exposure to hurtful stimuli, people become accustomed to feeling hurt. As a consequence, when they encounter hurtful stimuli, their feelings are less intense than they might be otherwise" (p. 358). As the women are constantly exposed to emotional and physical abuse, they become more accustomed to it and perhaps less hurt (or at least surprised) by those actions.

However, this model may trivialize other women's experiences. Those who are experiencing severe violence and intimate partner terrorism may experience effects from prolonged stress, complex trauma, or even post-traumatic stress disorder (PTSD). In such cases,

the “habituation” is more than a desensitization of hurtful communication—it is changes in brain chemistry that can result in: avoidance, numbing and disassociation; intrusive thoughts and flashbacks; an “inability to modulate arousal” (van der Kolk & McFarlane, 1996, p. 13); “compulsive reexposure to the trauma” (p. 10); and revictimization (van der Kolk & McFarlane, 1996). Although I am absolutely not qualified to diagnose someone with PTSD or complex trauma, this might explain why many women throughout my time observing and facilitating the DV support group reported how “nice guys” and healthy relationships were either too boring (e.g., compulsive reexposure to the trauma because chemicals in the brain adjust to the trauma and become addictive; van der Kolk & McFarlane, 1996) or made them feel uncomfortable (e.g., inability to modulate arousal and thus feel “unsafe” when “safe”; van der Kolk & McFarlane, 1996). Accordingly, it can potentially be helpful for group facilitators or support providers to be aware of the effects of prolonged revictimization and trauma for DV survivors in order to communicate with them in sensitive and informed ways.

Practical Implications

Given that this project is an engaged scholarship endeavor (see, e.g., Applegate, 2002; Cheney et al., 2002; Frey & SunWolf, 2009; Hartelius & Cherwitz, 2010; Simpson & Shockley-Zalaback, 2005; Van de Ven, 2007), this project has practical implications as well as theoretical implications. In this section, I identify the major practical implications from this study. First, I address the bridging process between DV and substance abuse agencies. I then address my general recommendations regarding what is helpful and unhelpful communication for a DV support group for women who experience the co-occurring issue of substance abuse.

Bridging agencies to address domestic violence and substance abuse. First, I believe this study strongly confirms that there is need for addressing issues of DV and substance abuse

simultaneously. As illustrated in Chapter Six, many women reported that they believed the DV group was an imperative part of their treatment plan for substance abuse recovery. As discussed in Chapter Three, a possible, yet major, reason that DV and substance abuse agencies do not collaborate more often is that "basic differences in philosophy and messages of the two fields have . . . blocked the collaborative care that is critical for treating substance abusing clients who are survivors or perpetrators of violence" (Fazzone et al., 1997, p. 7), and vice versa.

However, as part of the interview protocol (Appendix F), I asked the women from New Beginnings about their perceptions regarding any conflicting ideas or approaches between the DV advocates and substance abuse counselors and staff. Besides a few women who explained that their substance abuse counselors are more "heavy-handed" in helping them to make decisions, the women overwhelmingly reported that the DV advocates and substance abuse counselors seemed to have similar approaches and definitions of DV and substance abuse, although each group of "experts" stuck closely to the issues relevant to their field. At the time of the interviews, however, the agencies had participated in a "joint discussion" where advocates, volunteers, interns, and staff from all three agencies (Safe Haven, New Beginnings, and Mending Together) discussed possible differences in philosophies as well as their hopes, fears, and concerns about collaboration. Accordingly, perhaps some basic training about conflicting philosophies and increased awareness regarding being sensitive to those possible conflicts mitigates any potential clashes of ideas. In short, I do not believe that "basic differences in philosophies and messages" (Fazzone et al., 1997, p. 7) should hinder any DV agency or substance abuse treatment center from working together, especially when the demand for addressing co-occurring issues is so paramount and when knowing about these differences and acting in sensitive ways regarding them seems to mitigate the issue.

Numerous participants did report that the issues of DV and substance abuse were handled separately in the groups; thus, perhaps the best way to ensure that experts from each field is providing support for the respective issues is to have traveling advocates, or members from one agency who travel to the other in order to provide support, services, or facilitate support groups. As Kathy explained:

> *What I really like is that the substance abuse counselors are not trying to teach the DV group. Because that's your specialty. You don't have an English teacher teaching a math class even though it's all education and you're all in one school and it's all part of the same program you don't have the English teachers teaching the math class.*

Additionally, based on participant responses, it appears that inter-agency support groups may be an effective way to simultaneously address the co-occurring issues of DV and substance abuse. Ideally, the groups would be cofacilitated by a DV advocate and a substance abuse counselor, to have an expert from the other field present to address any philosophical differences or questions, comments, or stories related to both DV and substance abuse (e.g., Bland, 2012).

Numerous participants also recommended that individual meetings with a DV advocate would be beneficial as well. Although Sam (the other support group facilitator) mentioned that she could meet individually with anyone upon request, women might not choose to ask for a meeting for numerous reasons (e.g., anxiety and timing issues). During the time that I observed the DV group, very few women ever requested an individual meeting. However, when I was conducting interviews, I often spent quite a bit of time in the lobby of New Beginnings waiting for or recruiting participants. During those times, numerous women spoke with me about their experiences or asked questions. Accordingly, I think it would also be beneficial for advocates or staff from each agency to have something similar to a professor's "office hours" at the other

agencies in which women could drop by to talk or ask questions because this scenario may be less intimidating for some than setting up an appointment.

Communication within the support group. Overall, I believe the most important practical implication of my findings is that it truly is best to have the women choose their topics of discussion instead of having a set curriculum—at least for situations that are similar to the DV group at New Beginnings. I feel that when the women chose their own "curriculum" every week, there was a broader range of topics discussed because topics were tailored to suit the women's needs at that time. However, I would advise a facilitator who takes this approach to "know your stuff." Because facilitators can serve a role of helping to manage information, conducting as much research as possible about different studies, views, and experiences regarding many issues of domestic violence can help facilitate a domestic violence group that embraces the complexity of domestic violence while simultaneously providing the information that members appear to desperately want.

Additionally, these findings imply that, as Dennis et al. (2008) found, informational support is a fundamentally important component of a support group. Helgeson and Gottlieb (2000) recommended that support groups should also entail some sort of educational component, and the DV group members' reports align with this notion because many of them discussed how information was a helpful aspect of the DV group's communication.

Moreover, my findings imply that sharing stories of past experiences did indeed encourage the women "to elaborate [their] feelings and perspective[s] regarding the problematic situation" so that they could better make sense of their own situations (Burleson & MacGeorge, 2002, p. 402). By elaborating on their experiences, the women often turned their chaos stories into more coherent stories (see, e.g., Loseke, 2001) by talking about their experiences. As

participants illustrated in Chapter Six, narrating their experiences and listening to others' stories helped facilitate deeper understanding and reappraisal of their situations in positive and meaningful ways (Burleson & MacGeorge, 2002; see also Harber & Pennebaker, 1992; Lazarus, 1991; Lazarus & Lazarus, 1994). Furthermore, based on participants' reports, facilitators should affirm the variety of group members' experiences. As previously discussed, some women may embrace the formula story of domestic violence (see Loseke, 2001) because it relates to their experiences, but others may not embrace the story for various reasons. I believe that facilitators should encourage women to make sense of their own situations, and facilitators should generally avoid telling group members what they should do or telling them how they should think or feel. Although facilitators can play an important role in managing and providing information, the group members should ultimately make sense of their situations themselves—whether their experiences fit the formula story or not.

Finally, putting the theoretical implications into practice can be beneficial within a support group for women experiencing the co-occurring issues of DV and substance abuse. DV group members overwhelmingly reported that the most helpful "take-away" message of the DV group was that "you are not alone" and "it is not your fault." Because DV and substance abuse are both stigmatized issues (Fazzone et al., 1997), discussing them with others who have similar, yet different, experiences can normalize and legitimate experiences, as well as reduce shame (see, e.g., M. A. Dutton, 1992). Moreover, support groups can facilitate a switch in attributional processes, as women learn the dynamics of DV and come to realize that—no matter what they did or did not do—no one deserves to be abused. Additionally, support groups can help "clear" competing discourses (see, e.g., Baxter, 2011) so that the group members can symbolically construct their own discourse of empowerment, strength, and hope.

Limitations

The first limitation of this study is that observation and interviews occurred at only one site in the Midwestern United States. Accordingly, the findings from the DV group at New Beginnings cannot necessarily be generalized for all DV support groups within addiction treatment centers, or to all support groups in general. However, this 16-month study, nonetheless, can contribute to understanding how agencies can better work together to effectively help women with co-occurring issues of DV and substance abuse.

Additionally, Helgeson and Gottlieb (2000) argued that more assessments of support groups should examine the actual nature of support group discourse by means of recording and transcribing, because researchers still need information regarding basic communicative exchanges (and messages) that occur within support groups. This study would have benefitted from having the DV group sessions recorded and transcribed, because doing so would have added richness and depth to the data collected and their analysis. However, as mentioned in Chapter Five, I decided that, ethically, I could not impose a situation that could potentially hinder group members' open and honest communication. Accordingly, ethnographic participant observation and global assessments via interviews were used instead.

Another limitation of this study is that participants' responses were based on recall, and several women reported that they had "brain fog" resulting from detox and their first few weeks of sobriety. For example, there were several instances during the interviews that I remembered a certain message that a woman said or how she reacted to a message, but she did not. Accordingly, numerous participants were not able to recall specific messages within the DV group, and generally provided global assessments.

A final limitation of this project is that I was personally invested in the project. My involvement with Safe Haven, New Beginnings, and Mending Together was one of the most nerve-wracking yet important endeavors in which I have ever participated. Since October 2010, I have been terrified, overjoyed, and deeply inspired by my volunteer work as a DV advocate. The women I worked with are some of the most inspirational people I have ever met; they taught me that the human spirit can demonstrate the most incredible resilience in the midst of oppression and adversity, and I am incredibly grateful for everything they have taught me throughout the years. Deetz (1992) argued that an "immaculate perception" (p. 148) does not exist, and my values, biases, and personal experiences nonetheless shaped how data were collected and analyzed.

Directions for Future Research

Although this project provided a preliminary, exploratory examination of helpful and unhelpful communication occurring within a DV support group at a substance abuse treatment center, more research is needed regarding actual messages exchanged during support group sessions. If audio recording actual group sessions is not practical or deemed to be unethical, researchers could distribute quantitative measures or open-ended qualitative questionnaires at the end of group sessions to mitigate some of the limitations of prolonged recall of events. Researchers also could distribute various quantitative measures to participants before and after attending the DV group to assess pretest and posttest outcomes. Additionally, researchers could follow up with participants at various points in time following members' attendance of the DV group in order to assess long-term effects. Furthermore, focus group interviews could also illuminate helpful and unhelpful communicative aspects of support groups, and, therefore, could be an effective means for gathering rich data.

Moreover, future studies could employ Baxter's (2011) contrapuntal analysis to more closely monitor the competing discourses that exist within support groups, how prominent or silenced discourses emerge, and the interplay of competing discourses (for a description of that analytic technique, see Baxter, 2011). Addressing DV support groups from a dialogic perspective could also further illuminate the formula story of DV (see Loseke, 1987, 2001, 2009) as a competing discourse.

Conclusion

This multimethod, intervention-oriented project explored helpful and unhelpful communication within a domestic violence support group at a substance abuse treatment center. The findings from 16 months of ethnographic participant observation, coupled with 20 interviews conducted with domestic violence group members, illuminated the importance of continued efforts to address co-occurring issues of domestic violence and substance abuse simultaneously. This study contributed to theoretical and practical understandings of the helpful and unhelpful communication within a domestic violence support group. Additionally, this project provided practical suggestions for the sites of study regarding helpful and unhelpful aspects of the domestic violence support group, as well as for further bridging their agencies' services.

Overall, group members generally reported that the domestic violence support group was a necessary part of their substance abuse treatment, and that the group provided a comfortable atmosphere in which to discuss their experiences of domestic violence. Group members also reported that the most helpful aspects of the group's communication was the facilitation of recognizing domestic violence, making sense of domestic violence experiences, and preparing group members for the future in order to prevent, or break the cycle of, domestic violence.

Although much research remains to be conducted regarding this area, this project provided a preliminary analysis that can hopefully inform other agencies that wish to bridge their services. This project illuminated the power of social support within groups and its potential to help people make sense of their experiences, cope, and for some—heal.

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List of Appendices

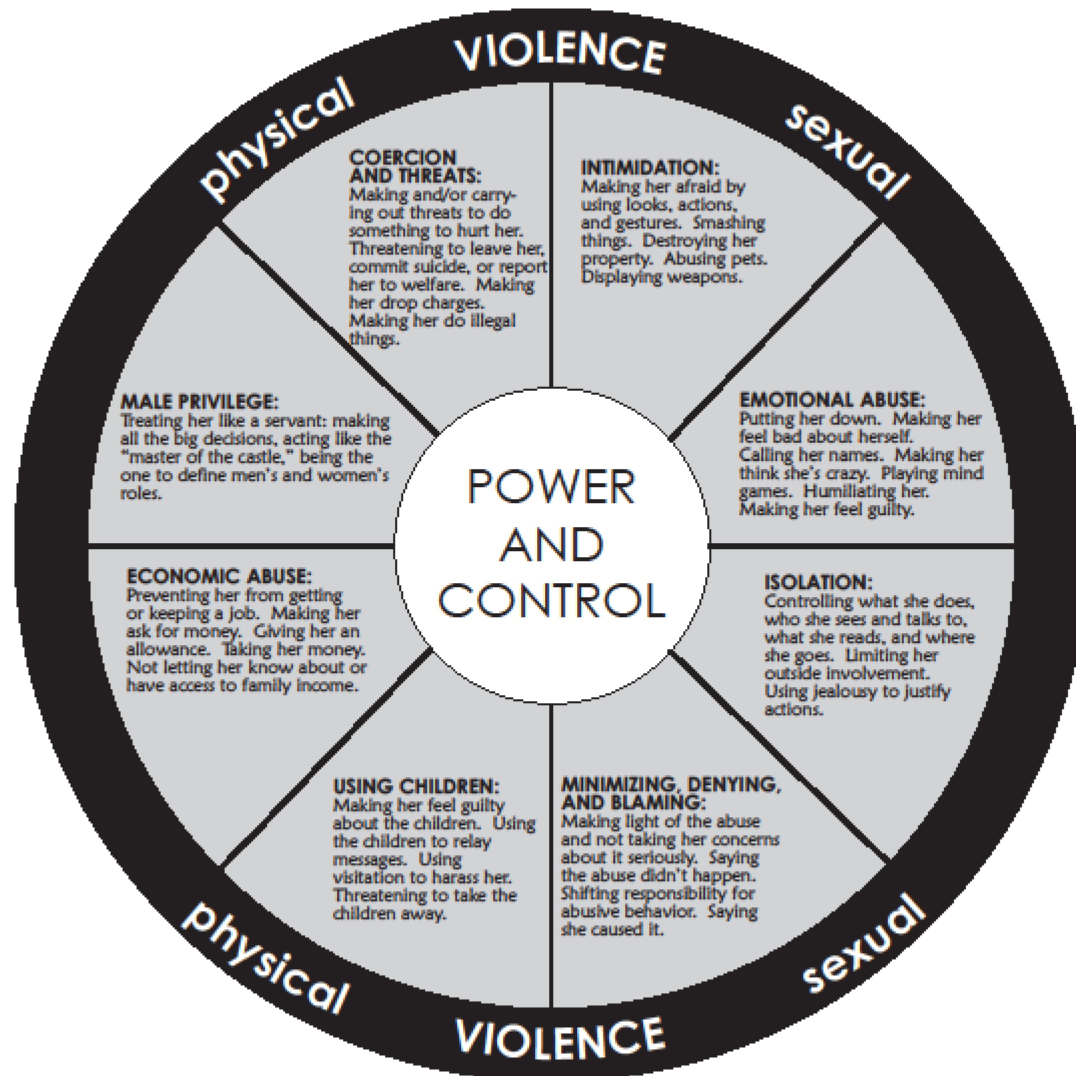
Appendix A: The Power and Control Wheel
Appendix B: HSCL Approval Letter
Appendix C: Staff/Support Group Facilitator Consent Form
Appendix D: Staff/Support Group Facilitator Interview Protocol
Appendix E: Resident/Client Consent Form
Appendix F: Resident/Client Interview Protocol
Appendix G: List of Local Counseling Services
Appendix H: The Equality Wheel
Appendix I: The Power and Control Wheel for Women’s Substance Abuse

Appendix A: The Power and Control Wheel

POWER AND CONTROL WHEEL

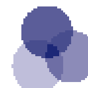
Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill threat of future violent attacks and allow the abuser to take control of the woman's life and circumstances.

The Power & Control diagram is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.



Developed by:
Domestic Abuse Intervention Project
202 East Superior Street
Duluth, MN 55802
218.722.4134

Produced and distributed by:



NATIONAL CENTER
on Domestic and Sexual Violence
training • consulting • advocacy

Appendix B: HSCL Approval Letter

1/9/2012
HSCL #19797

Jennifer Guthrie
COMS
Bailey Hall

The Human Subjects Committee Lawrence reviewed your research update application for project

19797 Guthrie/ Kunkel (COMS) Safety, Sobriety, and Wellness: A Model for a Coordinated Community Response

and approved this project under the expedited procedure provided in 45 CFR 46.110 (f) (7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. As described, the project complies with all the requirements and policies established by the University for protection of human subjects in research. Unless renewed, approval lapses one year after approval date.

The Office for Human Research Protections requires that your consent form must include the note of HSCL approval and expiration date, which has been entered on the consent form sent back to you with this approval.

1. At designated intervals until the project is completed, a Project Status Report must be returned to the HSCL office.
2. Any significant change in the experimental procedure as described should be reviewed by this Committee prior to altering the project.
3. Notify HSCL about any new investigators not named in original application. Note that new investigators must take the online tutorial at http://www.rcr.ku.edu/hscl/hsp_tutorial/000.shtml.
4. Any injury to a subject because of the research procedure must be reported to the Committee immediately.
5. When signed consent documents are required, the primary investigator must retain the signed consent documents for at least three years past completion of the research activity. If you use a signed consent form, provide a copy of the consent form to subjects at the time of consent.
6. If this is a funded project, keep a copy of this approval letter with your proposal/grant file.

Please inform HSCL when this project is terminated. You must also provide HSCL with an annual status report to maintain HSCL approval. Unless renewed, approval lapses one year after approval date. If your project receives funding which requests an annual update approval, you must request this from HSCL one month prior to the annual update. Thanks for your cooperation. If you have any questions, please contact me.

Sincerely,

Jan Butin
HSCL Associate Coordinator
University of Kansas

cc: Adrianne Kunkel

Human Subjects Committee Lawrence
Youngberg Hall | 2385 Irving Hill Road | Lawrence, KS 66045 | (785) 864-7429 | HSCL@ku.edu | www.rcr.ku.edu/hscl

Appendix C: Staff/Support Group Facilitator Consent Form

Approved by the Human Subjects Committee University of Kansas, Lawrence Campus (HSCL) on 1/2/2013.
Approval expires one year from 1/9/2013. HSCL# 19797

[Consent Form for [Safe Haven/New Beginnings] Support Group Facilitators – INTERVIEW]

RESEARCH PARTICIPATION CONSENT FORM
"Safety, Health, and Wellness: Assessing the Goals, Messages, and Dilemmas of Domestic Violence Support Groups for Women in Substance Abuse Treatment"
Jenny Guthrie, M.A.

INTRODUCTION

The Department of Communication Studies at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to sign this form and not participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or the University of Kansas.

PURPOSE OF THE STUDY

The purpose of this study is to employ constructs recognized in organizational and interpersonal communication scholarship for the exploration of how organizations within a community can effectively "bridge" their organizations through support groups in order to more effectively help community members who are coping with the co-occurring issues of domestic violence, sexual assault, and substance abuse. Specifically, this project aims to provide a model for providing holistic care by examining the support offered to women regarding the co-occurring issues of addiction, domestic violence, and sexual assault.

PROCEDURES

Your participation in this study includes two parts. First, a researcher from University of Kansas will observe and engage in work activities with your organization. She will take field notes about her observations that will be transcribed and analyzed. Only the researcher will see these transcriptions.

Second, she will interview you about your ideas about providing coordinated, holistic care to residents/clients. The interview will last about 45-60 minutes. She will ask you if she can digitally record and transcribe the interview. Only she will hear your interview and see your transcript.

Appendix C Continued

RISKS

Participation in this research does not pose any foreseeable risks for you greater than those you would encounter in everyday life. You can continue to work for [Safe Haven/New Beginnings] whether or not you choose to take part in this study. This research should not make you feel embarrassed or uncomfortable. If for some reason it does, you can stop participating at any time without penalty. The researcher will protect your confidentiality by not including your name in reports.

BENEFITS

Participation in this study will not benefit you directly. However, the lessons learned from this study may provide valuable feedback to the researcher about coordinated responses to holistic care and services provided for community members.

PAYMENT TO PARTICIPANTS

There is no financial compensation for participation in this study.

PARTICIPANT CONFIDENTIALITY

Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from this study. Instead, the researcher will use a study number or a pseudonym rather than your name. Your identifiable information will not be shared unless required by law or you give written permission.

Permission granted on this date to use and disclose your information remains in effect indefinitely. By signing this form you give permission for the use and disclosure of your information for purposes of this study at any time in the future.

REFUSAL TO SIGN CONSENT AND AUTHORIZATION

You are not required to sign this Consent and Authorization form and you may refuse to do so without affecting your right to any services you are receiving or may receive from the University of Kansas or to participate in any programs or events of the University of Kansas. However, if you refuse to sign, you cannot participate in this study.

Appendix C Continued

CANCELLING THIS CONSENT AND AUTHORIZATION

You may withdraw your consent to participate in this study at any time. You also have the right to cancel your permission to use and disclose further information collected about you, in writing, at any time, by sending your written request to:

Jenny Guthrie
Department of Communication Studies
102 Bailey Hall, 1440 Jayhawk Blvd.
University of Kansas
Lawrence, KS 66045-7545

If you cancel permission to use your information, the researcher will stop collecting additional information about you. However, the researcher may use and disclose information that was gathered before receiving your cancellation, as described above.

QUESTIONS ABOUT PARTICIPATION

Questions about procedures should be directed to the researcher listed at the end of this consent form.

PARTICIPANT CERTIFICATION:

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 864-7429 or (785) 864-7385, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7568, or email hscl@ku.edu.

I agree to take part in this study as a research participant. By my signature I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form.

_______________________________ _____________________
Type/Print Participant's Name Date

____
Participant's Signature

Researcher Contact Information:

Jenny Guthrie, M.A.
Principal Investigator
Dept. of Communication Studies
102 Bailey Hall, 1440 Jayhawk Blvd.
University of Kansas
Lawrence, KS 66045-7545
(785) 864-9888

Adrianne Kunkel, Ph.D.
Faculty Supervisor
Dept. of Communication Studies
102 Bailey Hall, 1440 Jayhawk Blvd.
University of Kansas
Lawrence, KS 66045-7545
(785) 864-9884

Appendix D: Staff/Support Group Facilitator Interview Protocol

Staff/Support Group Facilitator Interview Protocol

[Interview Protocol for [Safe Haven/New Beginnings] Staff/Support Group Facilitators]

Demographic Questions

1. What is your age?
2. What is your sex?
3. What is your ethnicity/race?
4. What is your occupation?
5. What is your highest level of education?

Life Before [Safe Haven/New Beginnings]

6. What kind of training/educational background/previous work experience do you have?
7. How did you end up working at [Safe Haven/New Beginnings]?
8. Why [Safe Haven/New Beginnings]?
9. What else would like to add about your life before [Safe Haven/New Beginnings]?

Working For [Safe Haven/New Beginnings]

10. What is [Safe Haven/New Beginnings]'s approach regarding domestic and sexual violence?

- ➢ How do you incorporate that approach into your work?
- ➢ What do you like about this approach?
- ➢ What do you dislike about this approach?
- ➢ How do you conceptualize domestic violence?
- ➢ Does your conceptualization of domestic violence conflict or align with [Safe Haven]? How so?
- ➢ What does empowerment mean to you?
- ➢ What do you think it means to help or *empower* the women you work with?

11. What is [Safe Haven/New Beginnings]'s approach regarding substance abuse?

- ➢ How do you incorporate that approach into your work?
- ➢ What do you like about this approach?
- ➢ What do you dislike about this approach?
- ➢ How do you conceptualize substance abuse?
- ➢ Does your conceptualization of substance abuse conflict or align with [New Beginnings]? How so?
- ➢ What do you think is the biggest message that will help the women you work with?

Appendix D Continued

12. Do you feel there are any conflicting philosophies between DV advocates and substance abuse counselors, or do they view the issues in similar ways? How so?
➢ [If yes, conflicting] How would you advise someone to overcome those challenges when working with clients/survivors?

13. We all have ideas about workplaces before we begin working. What were yours about [Safe Haven/New Beginnings]?
➢ What has ended up being true? What ended up being not true?

14. What are some of the rewards of working with [Safe Haven/New Beginnings]?

15. What else would you like to add about working for [Safe Haven/New Beginnings]?

<u>Bridging Through Support Groups</u>

16. How do you feel about [Safe Haven/New Beginnings]'s bridging process?
➢ How do you feel about bridging services through support groups?

17. To you, what is a support group?
➢ In your opinion, what makes a GOOD (or effective) support group?
➢ In your opinion, what makes a BAD (or ineffective) support group?

18. How would you describe the support groups here at [New Beginnings]?
➢ What's a typical group session like?
➢ What did you think the group would be like?
➢ What would you prefer to do more of? Less of?
➢ What's exciting about your work with the group?
➢ What drives you crazy or frustrates you about your work with the group?

19. What is the structure or format of the group?
➢ How do you feel about the structure or format of the group?

20. What role do you think you play as the facilitator?
➢ What makes a good facilitator of a support group?

21. What are some of the challenges of working with women with co-occurring issues of domestic violence and substance abuse?

22. What are the benefits of support groups for women with co-occurring issues of domestic violence and substance abuse? The drawbacks?

23. What do you think is most helpful about the group for the participants?
➢ What is unhelpful about the group for participants?

Appendix D Continued

24. What topics do you think need to be addressed in the group?
   - Are there other issues that you think should be addressed?
   - What are the most important ideas to convey to the group?

25. What should be the goals of the group?
   - What are the outcomes you would like to see from the groups?
   - What should the women ultimately take away from the group?
   - What do you think are the actual outcomes?

26. What do you think the BEST support group at [New Beginnings] would look like?

27. Anything else you want to add about support groups?

The Future of Holistic Care: [Safe Haven/New Beginnings]

28. What does the future of the support group look like?
   - What would you like to see happen? Why?
   - What would you like [Safe Haven/New Beginnings] to do in the future? Why is this important to you?
29. Is there anything we haven't covered today that you'd like to add?

Appendix E: Resident/Client Consent Form

Approved by the Human Subjects Committee University of Kansas, Lawrence Campus (HSCL) on 2/5/13. Approval expires one year from 1/9/13 HSCL # 19797

[Consent Form for [New Beginnings] Residents/Clients – INTERVIEW]

RESEARCH PARTICIPATION CONSENT FORM
"Safety, Health, and Wellness: Assessing the Goals, Messages, and Dilemmas of Domestic Violence Support Groups for Women in Substance Abuse Treatment"
Jenny Guthrie, M.A.

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PURPOSE OF THE STUDY

The purpose of this study is to employ constructs recognized in organizational and interpersonal communication scholarship for the exploration of how organizations within a community can effectively "bridge" their organizations through support groups in order to more effectively help community members who are coping with the co-occurring issues of domestic violence, sexual assault, and substance abuse. Specifically, this project aims to provide a model for providing holistic care by examining the support offered to women regarding the co-occurring issues of addiction, domestic violence, and sexual assault.

PROCEDURES

Your participation in this study includes three parts. First, a researcher from University of Kansas will observe and facilitate support groups with your organization. She will take field notes about her observations that will be transcribed and analyzed. Only the researcher will see these transcriptions.

Second, she will interview you about your ideas about providing coordinated, holistic care to residents/clients through support groups. The interview will last about 45-60 minutes. She will ask you if she can digitally record and transcribe the interview. Only she will hear your interview and see your transcript.

Appendix E Continued

Third, the researcher will collect copies or photographs of any artwork, poems, letters, stories, or other creative works you wish to contribute to the study. The researcher will provide you with a small notebook for you to use if requested so that you can use the notebook to record these creative works or your thoughts about your time at [New Beginnings], attending the DV group, or your recovery process in general. The researcher will also provide you with a sealable envelope. You may either submit these documents in the sealed envelope directly to the researcher, or you may leave them at the front desk at [New Beginnings] to be collected by the researcher.

RISKS

Participation in this research does not pose any foreseeable risks for you greater than those you would encounter in everyday life. You can continue to utilize the services of [Safe Haven/New Beginnings] whether or not you choose to take part in this study. This research should not make you feel embarrassed or uncomfortable. If for some reason it does, you can stop participating at any time without penalty. The researcher will protect your confidentiality by not including your name in reports.

BENEFITS

Participation in this study will not benefit you directly. However, the lessons learned from this study may provide valuable feedback to the researcher about coordinated responses to holistic care and services provided for community members.

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Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from this study. Instead, the researcher will use a study number or a pseudonym rather than your name. Your identifiable information will not be shared unless required by law or you give written permission.

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Appendix E Continued

REFUSAL TO SIGN CONSENT AND AUTHORIZATION

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______________________________ ____________________
Type/Print Participant's Name Date

____
Participant's Signature

Appendix E Continued

Researcher Contact Information:

Jenny Guthrie, M.A.
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Appendix F: Resident/Client Interview Protocol

Resident/Client Interview Protocol
[Interview Protocol for [New Beginnings] Residents/Clients]

Demographic Questions

1. What is your age?
2. What is your sex?
3. What is your ethnicity/race?
4. What is your occupation?
5. What is your highest level of education?

Life Before New Beginnings

6. Tell me about your work/training/educational background.
   - Are you currently employed? In school?
   - Where do you work/what do you study?

7. Tell me about your family.
   - Do you have any kids? Are they at [New Beginnings]?

8. How did you end up coming to [New Beginnings]?
   - Was there a factor or factors, or even a thought process or realization that triggered you contacting/coming to [New Beginnings]?

9. Have you experienced unhealthy or abusive relationships in the past? [If so] Were you offered services/care regarding this?
   - If not, did you seek services?

10. [If YES to 9] If your relationship was the story for a movie, how would you describe the characters of you and your partner (and any other actors/actresses, like your children or anyone else involved)?

11. Is there anything you'd like to add about your life before coming to [New Beginnings]?

Life At [New Beginnings]

12. Why [New Beginnings]?
    - Did you have any "options" to pursue other than [New Beginnings]?
    - Have you been to [New Beginnings] before? If so, what were the circumstances?

13. What is a typical day like at [New Beginnings]?

14. How would you describe the services/help offered to you at [New Beginnings]?
    - What did you think it would be like?
    - What is the best part of receiving services from [New Beginnings]? The worst part?
    - What kinds of changes (or improvements) would you make to the [New Beginnings] experience?

Appendix F Continued

15. Do you feel like you are receiving all the help you need or want? How so or not?

16. If you could get a meeting with the [New Beginnings] Director, what would you want to tell her?

17. How does [New Beginnings] define substance abuse?
- What do you like about this definition?
- What do you dislike about this definition?
- How would you define substance abuse?

18. How does [New Beginnings] approach substance abuse treatment?
- What do you like about this approach?
- What do you dislike about this approach?

19. What do you think is [Safe Haven]'s definition of domestic violence?
- What do you like about this definition?
- What do you dislike about this definition?
- How would you define domestic violence?

20. What do you think is [Safe Haven]'s approach regarding domestic violence?
- What do you like about this approach?
- What do you dislike about this approach?

21. Do you feel DV advocates and substance abuse counselors differ in their views of substance abuse or do they view substance abuse in similar ways? How so?
- [If yes, conflicting] How would you advise to overcome those challenges when working with clients/survivors?

22. Do you feel DV advocates and substance abuse counselors differ in their views of domestic violence or do they view domestic violence in similar ways? How so?
- [If yes, conflicting] How would you advise to overcome those challenges when working with clients/survivors?

23. Do you feel DV advocates and substance abuse counselors have similar or different approaches when working with you and the other women? How so?

24. What advice would you give them regarding how to better help the women at [New Beginnings]?

25. Is there anything you'd like to add about what it's like to receive services from [New Beginnings] and [Safe Haven]?

Appendix F Continued

Support Groups

26. How would you describe the DV group here at [New Beginnings]?
- What's a typical group session like?
- What did you think the group would be like?
- What do you like about the group?
- What drives you crazy or frustrates you about the group?
- What would you prefer to do more of? Less of?

27. Do you think the DV group is necessary at [New Beginnings]? Why or why not?

28. How do you feel about the structure or format of the group?

29. What role does the facilitator play?
- What makes a good facilitator of a support group?
- What do you like about the facilitator of the group?
- How is the facilitator helpful?
- How could the facilitator be more helpful?
- Are there things the facilitator could improve on? If so, what are they?

30. What topics do you think need to be addressed in the group?
- Are there other issues that you think should be addressed?

31. What do you think is most helpful about the group?
- Are there certain ideas presented in group that are especially helpful?
- Are there certain handouts presented in group that are especially helpful?
- What do you think are the most important ideas that should be discussed in the group?

32. Is there anything unhelpful about the group? If so, what and how so?
- Is there anything discussed in group that you disagree with or made you uncomfortable or even mad?

33. Are there ever conflicting ideas presented in the DV group? If so, what are they?
- Are there ever ideas in the DV group that conflict with ideas you hear in other [New Beginnings] Groups?
- Are there ideas you learn in other [New Beginnings] groups that help you in DV group? What are they?

34. What should be the goals of the DV group?
- What do you think is the ultimate take away idea from the group?
- What should the ultimate take away idea be?
- What are the outcomes you would like to see for yourself or others from the groups?
- What do you think are the actual outcomes?

Appendix F Continued

35. Has attending the DV group changed you in some way (the way you think about some issues, how you will act…)?

- Do you think the dynamics of your relationships will change after being in [New Beginnings] and attending the DV group?

36. [If told story for question 10] Think back to the character you described earlier. Has that character, based on you, changed since you've been here?

37. What do you think the BEST DV group would look like?

38. Do you feel like you are receiving all the help you need or want from the group? How so or not?

39. If you could get a meeting with the group facilitator, what would you want to tell her?

40. Is there anything else you want to add?

<u>Life After [New Beginnings]</u>

41. What does your future look like?

42. What would you like to see happen? Why?

43. How have the [New Beginnings] and the DV group helped you plan for your future?

44. What do you wish they would have helped you with?

45. Is there anything we haven't covered today that you'd like to add?

Appendix G: List of Local Counseling Services

In case you have questions or issues about any of the topics in this study that you would like to discuss further, we provide contact information for community organizations that offer counseling services. Moreover, these services can assist with any type of physiological and/or psychological stress that may have been prompted by participation in this research.

Counseling services:

- Headquarters Counseling Center, available 24/7, free of charge, for any concern: (785) 841-2345
- Bert Nash Community Mental Health Center, available 24/7, for any concern: (785) 843-9192
- KU Psychological Clinic, 340 Fraser Hall, small fee per session, for any concern: (785) 864-4121
- KU Counseling and Psychological Services (CAPS), Watkins Health Center, small fee per session, for any concern: (785) 864-2277

Appendix H: The Equality Wheel

EQUALITY WHEEL

NONVIOLENCE

NEGOTIATION AND FAIRNESS:
Seeking mutually satisfying resolutions to conflict. Accepting changes. Being willing to compromise.

NON-THREATENING BEHAVIOR:
Talking and acting so that she feels safe and comfortable expressing herself and doing things.

ECONOMIC PARTNERSHIP:
Making money decisions together. Making sure both partners benefit from financial arrangements.

RESPECT:
Listening to her non-judgmentally. Being emotionally affirming and understanding. Valuing her opinions.

EQUALITY

SHARED RESPONSIBILITY:
Mutually agreeing on a fair distribution of work. Making family decisions together.

TRUST AND SUPPORT:
Supporting her goals in life. Respecting her right to her own feelings, friends, activities, and opinions.

RESPONSIBLE PARENTING:
Sharing parental responsibilities. Being a positive, nonviolent role model for the children.

HONESTY AND ACCOUNTABILITY:
Accepting responsibility for self. Acknowledging past use of violence. Admitting being wrong. Communicating openly and truthfully.

NONVIOLENCE

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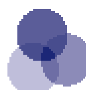
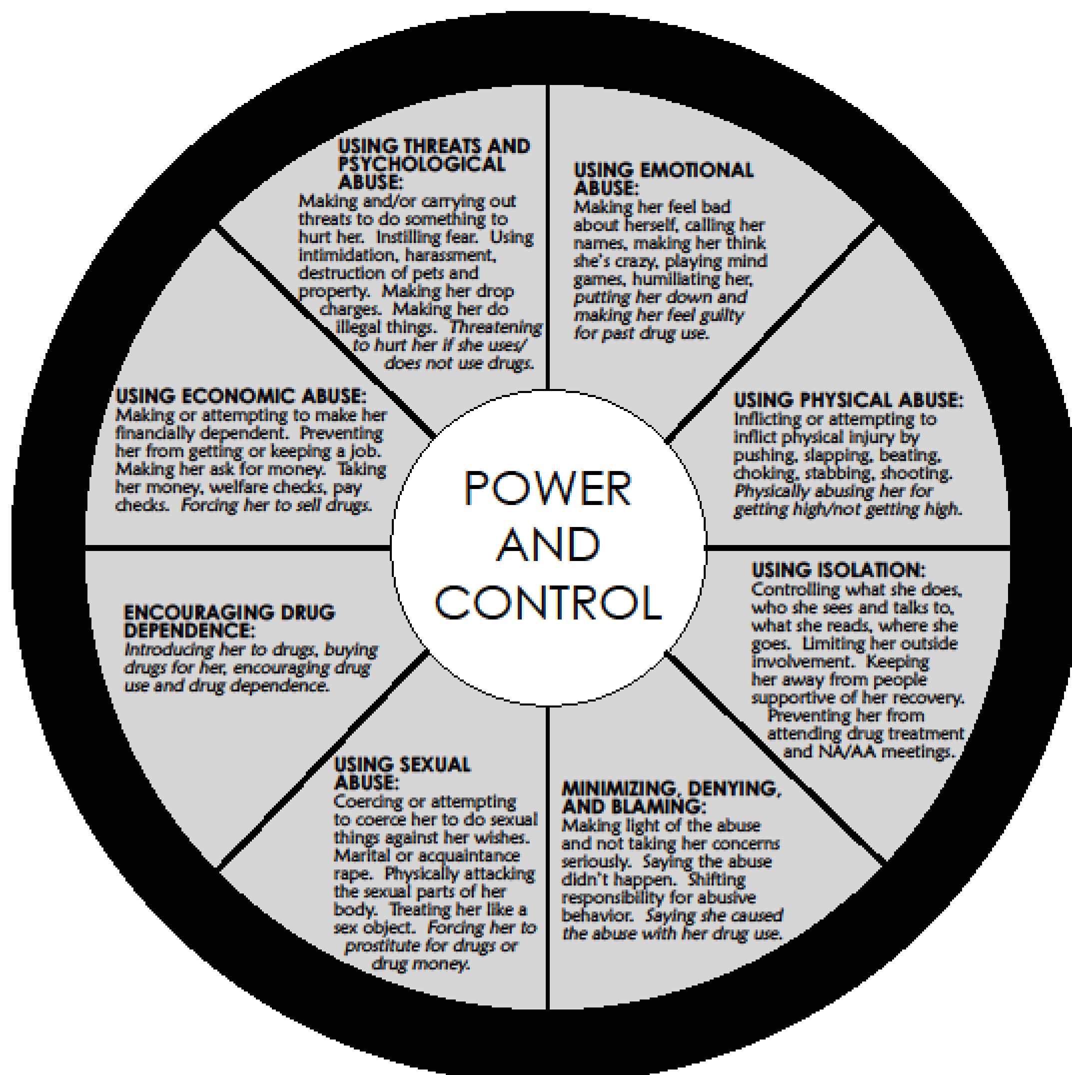


NATIONAL CENTER
on Domestic and Sexual Violence

Appendix I: The Power and Control Wheel for Women's Substance Abuse

POWER AND CONTROL MODEL FOR WOMEN'S SUBSTANCE ABUSE



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Excerpted from:
"Safety and sobriety: best practices in domestic violence and substance abuse," p. 66,
Domestic Violence/Substance Abuse Interdisciplinary Task Force, Illinois Department of Human Services.

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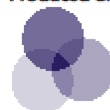

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