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ORIGINAL ARTICLE

Examining the Setting Characteristics that Promote Survivor Empowerment: a Mixed Method Study

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Abstract

Many abusers engage in violent behaviors to systematically remove power from and maintain control over their intimate partners. Domestic violence crisis housing organizations aim to increase safety and help survivors regain their power. Yet, little is known about how these settings accomplish this aim. This study drew on empowerment and empowering settings theories to explore how organizational characteristics contributed to empowering practice, and how this practice subsequently promoted survivor empowerment. Researchers employed an exploratory-sequential (QUAL➔quan) mixed-methods design at a domestic violence housing organization. Twelve staff participated in inductive, qualitative interviews. This was followed by deductive, quantitative structured interviews with thirty-three survivors. Qualitative results from staff revealed that the setting was survivor-centered, mission-driven, and distinctive. Staff held basic assumptions about survivors' right to self-determination. The relational culture emphasized partnerships, and people also had opportunities to hold meaningful roles within the organization. Setting leaders encouraged autonomy and creativity among all staff. Policies and procedures were also flexible. These setting characteristics were expected to support implementation of empowering practice. Quantitative results from the second phase supported a positive association between empowering practice and increased generalized, and safety-related, empowerment. This exploratory study suggests that setting characteristics are important to consider when understanding the complicated pathways that contribute to survivor empowerment and well-being.

Keywords Empowering settings · Empowerment · Shelters · Intimate partner violence · Domestic violence

Intimate partner violence (IPV) involves physical, psychological, sexual, and economic abusive tactics that are used to create relationship dynamics that compromise survivors' safety, undermine their power and restrict their access to basic necessities (Sauber and O'Brien 2017). According to the National Intimate Partner and Sexual Violence survey, approximately 6.9% of female survivors, which translates roughly to more than one million survivors, reported needing housing support after an abusive incident (Breiding et al. 2014). Domestic violence (DV) shelters have been a long-standing response to survivors' crisis housing needs. In addition to immediate housing, shelters provide supportive advocacy, counseling, support groups, and connections to community resources (Sullivan and Virden 2017). A national survey of DV shelters found that an estimated 14,000 survivors reached out to DV shelters for help in one 24-hour period (Iyengar and Sabik 2009). Those who sought shelter support reported higher levels of severe violence compared to survivors who did not reside in shelters (Messing et al. 2016). Women who stayed in shelters were more depressed and had greater levels of psychological distress compared to community women (Galano et al. 2013). Many survivors in shelters have little to no access to financial, educational, and social resources (Grossman and Lundy 2011), in turn, shelters often tend to serve survivors who have the least access to social power. In response to this, many DV shelters focus on working with shelter residents to increase their sense of interpersonal and social power (Sullivan 2017).

Ideally, survivors gain power by building social networks, and having the knowledge, skills and supports needed to make the life changes they desire (Cattaneo and Chapman 2010).

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When staff engage in behaviors that facilitate these outcomes through survivor-driven services, it can be conceptualized as '*empowering practice*' (Cattaneo and Goodman 2015; Sullivan 2017). Researchers and practitioners suggest that empowering practice leads to survivor empowerment, yet there has been limited research testing this assertion (Goodman et al. 2016). In addition, advocates' behaviors are guided and either reinforced or prohibited by the settings in which they work. Few studies have examined how setting characteristics (e.g., policies, cultural values) lead to increased empowerment (Nnawulezi et al. 2018). If the organization's policies do not promote empowering practice, for example, the advocate is not likely to behave toward clients in such a manner. It is also possible for DV crisis settings to have disempowering policies that contribute to staff using practices that inadvertently remove survivors' power (Gregory et al. 2017). Drawing on evidence about survivor empowerment and empowering practice within DV settings and empowering settings theory, the purpose of this study was to explore the setting-level characteristics that may contribute to survivor empowerment.

Survivor Empowerment

Empowerment is a "meaningful shift in the experience of power attained through interaction in the social world" (Cattaneo and Chapman 2010) and is widely theorized as both a process and an outcome (Kasturirangan 2008). An empowerment approach suggests that survivors who have sought out support from shelters will gain power by (1) being able to do more things on their own, (2) knowing more about the dynamics of domestic violence, (3) gaining more access to community resources, and (4) feeling like they have established meaningful relationships with others in the community (Cattaneo and Goodman 2015).

Safety from violence is an integral component to building survivors' power. However, for many survivors, the process of keeping safe from an abusive partner can be complex because they are often forced to make difficult choices to attain or maintain safety (Thomas et al. 2015). High levels of empowerment as it relates to safety means survivors believe they have the skills necessary to support their safety aims and can obtain effective community resources and support from their social networks. Goodman and colleagues (2015) described the collective assessment of internal skills, available external supports, and perceptions of difficulties to keep safe as safety-related empowerment. When survivors are high in safety-related empowerment, they also report greater self-efficacy, social support, and satisfaction with DV services (Goodman et al. 2015).

Empowering Practice

Empowering practices are activities that staff intentionally engage in to facilitate survivors' empowerment process (Sullivan 2017). Survivors can receive supportive counseling and get help increasing their social networks to decrease feelings of isolation. Staff can help survivors identify their strengths, encourage the use of those strengths to support their safety, personal goals and aspirations, and build skills. A necessary component of empowerment is the focus on critical consciousness. Survivors are made aware of the ways that power and oppressive social systems make it difficult for them to get access to the resources that they need to improve their lives, rather than engaging in self-blame about their own capacities and abilities. Staff also engage in social change work at the institutional and community levels to eradicate oppressive systems that impact survivors' lives.

Evidence from some studies suggested that when staff engage in practices that align with empowerment, positive results occur. For example, Bybee and Sullivan (2002) found that empowering advocacy led to increased safety, access to resources, and enhanced quality of life for survivors over time. Other studies have demonstrated that empowering practices are associated with decreased depression and increased self-efficacy (Goodman et al. 2016), and lessen the negative impact of PTSD severity following abuse (Perez et al. 2012). The use of empowering practice by staff members, however, is shaped by the settings in which services are being delivered.

Empowering Setting Theory

Empowering setting theory describes the characteristics that can be expected to promote empowering processes for all individuals within a setting, across levels of analysis (Maton 2008). Empowering community settings are defined by six characteristics (Maton 2008). They have *group-based belief systems* based on values that inspire change, are strengths-based, and focus beyond the self. These settings focus on *core activities* that are engaging in nature, focused on active learning, and of high quality. Empowering settings are also *relational*, meaning that the development of caring, holistic relationships between people are prioritized. This generates a sense of community among members. These settings also have an *opportunity role structure*. There are various roles for people to engage in and that are accessible as members' skills develop. There is ample time and space for members to build and practice skills. *Leadership* that is inspiring, talented, committed, empowered, and invested in power sharing is key to the maintenance of an empowering setting. Last, *mechanisms to help sustain the setting* are vital. These mechanisms must be sensitive to internal and external pressures, be adaptable to change, and help maintain alignment with the

organizational mission. Empowerment settings theory has been applied and tested in a variety of setting contexts, including religious settings, mutual health organizations, international political organizations (Maton and Brodsky 2011), and first grade classrooms (Silva and Langhout 2016).

Current Study

This study integrated both inductive and deductive approaches to document the setting characteristics supporting the use of empowering practice among staff, and examined whether empowering practice related to both generalized empowerment and safety-related empowerment for survivors. Researchers employed an exploratory-sequential (QUAL➔quan) mixed-methods design within one DV housing setting. A single-site study design was used to explore the viability of empowering setting theory. The broad question guiding this research was: How do setting characteristics influence empowering practice and subsequently promote survivor empowerment? Specifically, the initial qualitative phase of the study explored: (1) What, if any, setting characteristics influence empowering practice? (2) How do these characteristics align, or not align, with an empowering setting theory? (3) How do service providers define and implement empowering practice? The second phase of the study tested the following hypothesis: The more that advocates engage in empowering practice with survivors, the greater the survivors' generalized, as well as safety-related, empowerment.

Method

Study Context

This collaborative study was conducted in partnership with the District Alliance for Safe Housing (DASH), a large, urban, housing organization that works with survivors of DV, sexual assault, torture, or sex trafficking. Their housing program contains 42 studios and one-bedroom apartments available for survivors and their children. DASH adopts inclusive screening and entry policies (low-barrier). All survivors are considered for housing services regardless of circumstances that might make them ineligible to receive services from other organizations (e.g., having a chemical addiction or mental illness). Residents may participate in direct advocacy services, support groups, counseling, children's services, and parenting classes, but all such services are voluntary.

DASH's organizational philosophy encompasses seven principles that work in tandem to ensure that survivors receive optimum services. "Implementing the DASH model means that employees are behaving with a survivor in ways that are responsive (accountability), consistent (integrity), empathetic (compassion), mutually cooperative and respectful (partnerships) while also providing tools to promote personal power (empowerment) and supporting the survivor's right to be self-governing (sovereignty)" (DASH 2013). DASH leadership decided to collaborate with DV researchers on this study because of their investment in exploring whether empowerment theory aligned with organizational and advocate practices.

DASH created a technical assistance (TA) team to work directly with advocates to help them work most effectively within the DASH model. The TA team created professional development opportunities, supervised, and provided information and tools to advocates so that they, in turn, could work in alignment with DASH model principles.

Mixed Method Overview

The study was a multi-level, exploratory-sequential (QUAL➔quan) mixed-methods design. We used inductive, qualitative methods in the first study phase to explore empowering setting characteristics and understand how empowering practices were implemented among employees, and deductive, quantitative methods in the second study phase to examine how empowering practice related to survivor empowerment.

Phase 1 Procedures

We recruited employees to participate in individual, face-to-face interviews using a purposive, theory-based sampling technique (Onwuegbuzie and Collins 2007). Employees were eligible if they (a) provided direct services to survivors, or provided direct supervision to employees who provided direct services to survivors, (b) had been employed at DASH for at least 2 weeks, and (c) were currently employed at DASH. There were 26 employees at the organization, 13 of whom were eligible for the study. Twelve employees (92% of the total eligible) participated in semi-structured interviews. Six were direct service providers and six were direct supervisors. Eight participants (67%) chose to be interviewed on site, and four (33%) chose to be interviewed in local coffee shops or restaurants. Interviews ranged from 1 h and 15 min to 4 h, with an average of 2 h and 30 min. Given the length of the interviews, participants were given ample opportunities to take breaks and the interviewer offered to reschedule for other times if needed. DASH leadership allowed for participation in interviews to be considered work time, rather than volunteer time. All interviews were confidential, and all participants gave permission to be recorded. Interviews were transcribed verbatim by an outside transcriptionist. This study was approved through the university's research protection program.

Phase 1 Interview Guide

Interview questions were formulated based on conversations with upper management at DASH who were not participating in the study, as well as a review of the literature. The semi-structured interview guide covered staff perceptions of the following areas: organizational philosophy (e.g., In your own words, what is the mission of DASH), organizational structure (e.g., Thinking about what actually happens on the ground at DASH—how, if at all, does the DASH model impact how the organization operates as a whole?), organizational culture (e.g., What characteristics must an employee have in order to be successful at DASH? How did you learn these?), how policies and practices were expected to lead to client empowerment (e.g., Broadly speaking, what are the rewards, if any, for putting the DASH model into practice?). Interviewers also asked participants about each component of the DASH model, and used these responses as the basis for the second phase of the study (e.g., In your opinion, how does DASH define [MODEL component] across the model? How, if at all, do you use this principle in your day to day interactions with survivors?).

Phase 1 Analysis

We selected an inductive thematic analysis, a data-driven analytic approach that explores a phenomenon without using a pre-existing coding scheme to analyze the data (Braun and Clarke 2006). The first author read the staff transcripts multiple times and then organized the data by sections: setting description, interpersonal relationships, and staff practices. At each level, she completed first-cycle coding (initial data reduction) and second cycle coding (making inferences from codes generated in the first cycle; Miles, Huberman, & Saldana, 2016). A research assistant separately coded 10% of the data using the inductive coding scheme developed in the first cycle coding. Codes were compared and refined until there was at least 75% agreement between the first author and the research assistant. Themes were created for setting and practices separately. We established credibility in numerous ways: The results were written with thick description, and preliminary themes were shared at a staff meeting. The first author asked for the staff to refine the themes as needed. In addition, the second, third, and fourth authors, who are experts in the setting as well as in the empowerment field, reviewed the final themes. The preliminary themes were also shared with survivors to elicit feedback.

Phase 1 Results

Using an empowering setting theoretical framework, results revealed critical setting characteristics designed to influence empowerment practices (see Table 1).

Group-Based Belief Systems

Three belief-systems arose that were intended to increase survivor empowerment. Staff believed the setting was *survivor-centered*. They also described a *collective investment in the DASH model* and an understanding they held a *distinct position* among other DV and social services housing organizations in the city. There were additional beliefs and values held by staff that they thought contributed to survivor empowerment. Each belief is described next.

Survivor-Centered Survivors are complex, mature, multi-faceted people with their own personal needs and life circumstances. Staff stated that DASH required them to spend time learning survivor needs, and to trust that survivors are competent and capable of making their own choices. Employees also frequently relied on survivors' opinions to build and improve housing services. Rebecca,[1] a supervisor, stated:

> *I feel like survivors are the #1 priority. They are the most important people, then we come next. It's not about, 'we have to do this,' and 'we have to do that,' and 'we're important.' No, they are the most important people. I think they're valued more than any other program I've ever worked in. That we listen to them, they're heard. That we believe them. That we're not that program where, 'oh, she was using [drugs] in the building, [so] then she has to go right away'. No. Let's sit down and talk. Let's try to figure out how we can make this still work for you, still keep you safe, and still keep the community safe. It's not that hard and fast, oh, she messed up and she's gone, 'cause then I don't value you. I don't value your life.*

Collective Investment in the DASH Model All participants described the investment they held, individually and collectively, in implementing the DASH model. The model inspired change by providing a set of shared assumptions as well as desired outcomes at every organizational level. Staff stated that the model provided a roadmap for how to interact with other employees, survivors, and community partners. It was also flexible, and encouraged staff and survivors to build on their personal strengths.

[1] Pseudonyms are used to protect employees' confidentiality.

Table 1 Empowering setting characteristics applied to a domestic violence housing setting

Empowering setting characteristics	Components
Group-based belief systems	Survivor-Centered
	Invested in the DASH model
	Distinctive
Setting culture	Survivor self-determination
	Survivor autonomy
	Survivor power
	DASH model guides all organization practice
	Responsiveness
	Staff innovation and creativity
	Trust
Core activities	Accountability
	Compassion
	Empowerment
	Integrity
	Partnerships
	(Re)centering
	Sovereignty
	Harm reduction
	Trauma-informed
	Survivor-centered
Relational	Build relationships with survivors, staff, and community
Opportunity role structure	Draw on personal interests to create new setting roles
	Shared power in decision making
Leadership	Invested in the DASH model
	Emphasize autonomy
	Facilitate a learning environment
	Belief that staff were competent
Mechanisms to sustain the setting	Creation of an in-house TA team that did not provide any direct service
	Did not apply for grants that do not align with the mission
Structure	Upside-down leadership model
	High level of procedural flexibility

Distinct Position within the Community DASH provided services in a way that other DV programs and human service agencies in the community did not. Staff agreed that many other formal helping systems disrespected, policed, and discriminated against survivors.

> *DASH does things in very different ways, and treats survivors with so much more dignity and respect. It's part of why I wanted to come here. I feel like we're treating survivors with more dignity. I feel much more respected when I'm able to treat people with respect.* (Karen, Supervisor).

Basic Assumptions and Values All participants held basic assumptions—the taken-for-granted beliefs—that all *survivors had the right to self-determination, autonomy, and power*. Givn the crisis-orientated nature of services, all staff described that, in accordance with the DASH model, they were *expected to be responsive to one another and to survivors*. Cultural values included an emphasis on *staff innovation and creativity*. *Trust* was another cultural value. All participants stated that they were trusted to make decisions.

These group-based belief systems, assumptions and values guided core activities (empowering practice) and were tied to leadership, which is the driving implementation force in the setting. When an employee, policy, or practice was out of alignment with these cultural characteristics, it was very apparent to all staff. Participants mentioned numerous times knowing when someone was behaving outside of the model intentions.

Core Activities

Core activities were the practices used to implement the setting mission. They linked setting characteristics to survivor outcomes. Participants stated that the main organizational focus was to actualize the DASH model, the empowerment-based setting mission, with survivors. Participants identified how they practiced each component of the DASH model with survivors: accountability and professionalism (responding to survivors needs promptly), compassion (listening and believing), empowerment (encouraging self-sufficiency), integrity (being consistent), partnerships (building relationship with survivors as a team), re-centering (changing course when things are not working, finding a balance), and sovereignty (having survivors guide the work). In addition to the practices associated with the DASH model, staff used harm reduction techniques to provide directed support to survivors with addictions. They provided trauma-informed, survivor-centered care that focused on individualized needs and promotion of survivor autonomy. Establishing trusting relationships with survivors was an integral part to implementing these core activities.

Impact of Core Activities on Staff While describing the importance of building relationships with survivors, many staff simultaneously discussed the importance of developing boundaries with survivors to combat burnout. A small number of participants (25%) described that the complexity of the advocate position and the types of service provision required contributed to high workload stress.

Relational Environment

Staff stated that they were expected to be in partnership with survivors, the community, and each other. Temple, a supervisor, summarized the essence of this theme:

> *I feel like it can be a little nontraditional because we value the relationship with the* [survivors] *as a partnership. So, we're a partner with you. We are not here and you're [there]. We are partners, and for this to be successful for both organizational outcomes as well as your potential outcomes, we have to value this partnership. Then the other piece is that we also value and understand that our mission is to provide access to safe and affordable housing. And we can't do it all. So, we need partnerships with other community service organizations to help survivors through other processes of their life that's happening simultaneously with housing support. Then also with staffing. I feel like it's a known factor that we're all partners in this process and DASH's perspective is that one person just doesn't go around making all the decisions. That it really takes a partnership among staff to, you know, address a concern, give their perspective, and then come up with an outcome as a group.*

Relationships with Survivors Staff were expected to be in high quality, deep partnerships with survivors because these relationships were valuable. As a result, nine employees described collaboratively working on tasks with other staff to support survivors.

Relationships among Staff Participants felt part of a team or community. Each reported feeling emotionally supported, and offering emotional support. This helped them to deal with difficult job experiences. Many stated that since the staff was so small and relied so heavily on one another, there was a noticeable difference when people were missing from their jobs. A minority of participants described that the close relationships, and subsequent relaxed environment, could also blur professionalism. Some staff described that there were a few times when those who provided direct services might not feel prioritized or valued at the organization.

Participants also described explicit ways that their relationships with supervisors were critical to their job satisfaction. Staff were offered ample vacation time, and supervisors encouraged them to use it to find balance in their lives. Supervisors also offered a non-judgmental space to process their feelings about the work.

Relationships with Community The value on relationships also extended to how staff reported engaging with community organizations. Employees believed that the external alliances they built were crucial to getting resources to help survivors meet personal goals. Most staff, no matter their organizational position, could name at least five community partnerships that supported the organization.

Opportunity Role Structure

A key component to opportunity role structure is the ability of setting members to engage in and actively contribute to the mission through a diverse set of meaningful roles. Supervisors stated, and advocates confirmed, that leadership created numerous organizational opportunities based on staff strengths. For example, a staff member invested in wellness and healing work became the wellness coordinator.

This setting also valued sharing power around decision making. Many described that no single person made all the decisions. Some felt that decision-making power was embedded within their job, and a few believed that they did not have decision-making power in their role, but were often asked their opinions on changes happening within DASH.

Leadership

Participants respected and trusted the leadership. They believed that upper management was deeply invested in, and behaving in alignment with, the DASH model. Most stated that the setting hierarchy rarely felt palpable. Instead, many felt leadership encouraged staff to make their own decisions. Staff could freely interpret the DASH model, and provide services that aligned with their interpretation. Additional supervisory support, outside of regularly scheduled meetings, often had to be explicitly elicited; otherwise, advocates felt their supervisor assumed they were competent in decision making. Chanel described how the level of autonomy influenced the creativity that she applied to her work.

> *One thing I really enjoy about my work here is that we are given a lot of freedom in terms of what I do on a day-to-day basis. Which I think in a certain way is a support because I don't come in to work every day with a list of what I'm supposed to do. [It] allows me to kind of interpret the model and be a little bit creative with the work that I do.*

Participants also described the leadership creating a learning environment. People were rarely formally reprimanded for mistakes; instead, they were encouraged to discuss their mistakes and move forward. Some participants also described learning occurring with one another, and in their supervision. Overall, the setting leadership promoted empowerment among staff. Staff created and defined their roles, had autonomy about how they did the work, felt support from supervisors and other colleagues, were able to make decisions that would influence the entire setting, and were provided opportunities to learn in the environment.

Mechanisms for Setting Maintenance and Change

An important component to setting maintenance is the capacity for the setting to respond to external threats to the mission. The TA team provided direct and specific support to counter external assumptions about how to treat survivors in programs. Participants described few, if any, other programs in the city that held the same beliefs about survivors and delivered services in the way that DASH did. Although challenging, one way that DASH leadership combatted threats to the organizational mission was not applying for funding that did not align with DASH values.

Empowering Structure

Empowering structure describes the policies, procedures, and managerial mechanisms used to support the implementation of an empowering mission. DASH used an *upside-down leadership model*, shifting much of its organizational resources to supporting advocates. Participants described the setting as having a *high level of procedural flexibility.* Many staff described working in a "grey area." This helped staff provide adaptable services with minimal interference from restrictive procedures. At DASH, "the rule is not more important than the survivor." Procedural flexibility promoted a high level of trust among staff to make decisions about service provision. Joy, a supervisor, describe:

> "*A lot of the policies expect for you to use your best judgment. A lot of the policies may suggest things, but it's not cut and dry. You know, so it allows you to be able to draw from these policies and procedures, and use the model, and use the compassion, using your own best judgment, with integrity and sovereignty and your professionalism – to move forward.*"

Phase 1 Summary

Overall, results from staff suggest DASH was survivor-centered, mission-driven, and distinctive. The setting held basic assumptions about survivors' right to self-determination. It required members to cultivate deep relationships with one another, and outside of the setting. Members were encouraged to pursue their personal interests in service of the empowerment mission. Setting leaders encouraged autonomy and creativity. Policies and procedures were flexible, which communicated trust, and there was high quality internal support for advocates. These components were expected to support implementation of DASH model practices. The second phase of this mixed-methods study was to determine whether, consistent with empowering settings theory, these practices were associated with survivor empowerment. Specifically, we hypothesized that the core activities (DASH model) identified by DASH staff would be associated with increased generalized survivor empowerment and safety-related.

Phase 2 Methods

Phase 2 Procedures

Recruiters invited survivors to participate in interviews if they were over the age of 18 and had been living at DASH's residential program for at least 2 weeks. Thirty-nine survivors resided at the program when recruitment began, and the number increased to 41 (the maximum capacity of the program) during the recruitment period. We posted flyers on each apartment door and public bulletin boards, and attended program events to publicize the study. Trained research assistants and the first author conducted structured interviews with all

eligible and willing participants. In-person interviews were conducted in a location of the survivor's choice, and each survivor received $25 for their participation. The length of interviews ranged from 34 min to 160 min with an average of 72 min.

Thirty-three survivors (80% of the eligible sample of 41) completed an interview. Participant ages ranged from 19 to 63, with an average age of 33.3 (SD = 10.8). Eighty-eight percent of the sample identified as Black, African American, or African, and 12% identified as Latina or some other race/ethnicity. Five participants (15%) were not born in the United States. Fewer than a third of the sample (29%) were employed at least part time, almost one third were enrolled in school or in a training program (32%), and about one third were unemployed (29%). On average, survivors had been living in the program for a year at the time of the interview (M = 354.1, SD = 189.4). Thirty-two survivors gave permission to audio record the interview.

Phase 2 Measures

The final content of the interview guide was developed in collaboration with DASH staff. The codes from the core activities that DASH staff identified in phase one were turned into items on the DASH Model Practices Scale (described next). This allowed for the creation of items that were grounded in actual staff experiences. Seventy-six preliminary codes were presented by the first author to program staff. Staff then provided direct feedback about items that needed to be revised, and specific items that needed to be added to the discussion. The content of these items was checked with the original literature on survivor empowerment (Cattaneo and Chapman 2010; Sullivan 2017). The first author then piloted the DASH Model Practices Scale with a previous resident in the housing program. This scale was included in the structured interview and is described below.

DASH Model Practices Scale This multidimensional scale of DASH's core activities contained 33 items which detailed the behaviors that explicitly aligned with the organizational philosophy (DASH model; see Table 2 for specific items). *Sovereignty* assessed the extent to which survivors believed their own choices were valued and respected by advocates (4 items). Residents also reported the extent to which staff supported their voice and provided learning opportunities (*Empowerment*, 6 items). *Accountability* assessed the extent to which employees behaved in a way that was responsive to survivors' needs within professional boundaries (4 items). *Partnerships* assessed whether employees developed a mutually cooperative relationship with survivors (4 items). The *Compassion* subscale measured whether employees were engaging in empathetic care (6 items). On the *Integrity* subscale, items assessed the extent to which employees were consistent and ethical (3 items). *Recentering* (5 items) measured how staff supported survivors to find and integrate balance. Respondents answered on a five-point likert scale ranging from 0 (Not at all true) to 4 (Very true).

Survivor Empowerment This measure was derived from the empowerment model and assessed the extent to which survivors increased their self-efficacy, competencies and skills, and awareness of DV dynamics (Sullivan et al., 2013). It has three subscales with a total of 22 items. The *Confidence* sub-scale contained 9 items (M = 3.26, SD = 0.96, α =0.95). A sample item in this sub-scale was "I have a greater understanding that I have the ability to make changes in my own life." *Connections* (4 items; M = 3.07, SD = 1.06, α = 0.85) described the extent to which residents felt connected to the people and/or resources in the larger community. Items within this sub-scale included "I know more about the community resources that I need." The final sub-scale, *Consciousness*, assessed participants' knowledge of DV and its root causes (M = 3.11, SD = 0.96, α = 0.90). This eight-item scale included questions such as "I have a greater understanding that I have the right to be angry about what I've experienced." The response scale had 5 categories for all items ranging from 0 (Not at all true) to 4 (Very true).

Safety-Related Empowerment The Measure of Victim Empowerment Related to Safety (MOVERS) was used to measure survivors' empowerment as it relates to their ability to keep themselves and their families safe from abuse (Goodman et al. 2015). The measure included three subscales. *Internal Tools* (M = 4.30, SD = 0.70, α = 0.86) measured whether survivors believed they had the internal resources to support their safety. *Expectations of Support* (M = 3.95, SD = 0.97, α =0.79) assessed the extent to which survivors believed they had accessible and effective support networks. *Trade Offs* (M = 3.71, SD = 1.06, α = 0.57) measured whether survivors perceived the choices they made to keep safe would create new problems for them. The items in this subscale were reversed scored such that higher scores indicated fewer trade-offs for safety. The response scale ranged from 1 (Never true) to 5 (Always true). Previous studies reported acceptable alphas for these subscales ranging from 0.74–0.88 (Goodman et al. 2015).

Phase 2 Data Analysis

The first analytic step was to use Bayesian confirmatory factor analysis to examine the psychometric properties of the DASH Model Practices scale and Survivor Empowerment scale. Bayesian analysis is particularly useful for small sample sizes and for non-normally distributed data (Song and Lee 2012). This approach was ideal given the significant negative skew of these data,

Table 2 Final items for DASH model practices scale

DASH model component	Practice item
Sovereignty	Encourage me to be who I am
	Respect the choices that I make
	Treat me with dignity
	Understand that I know what's best for me
Compassion	Believe me when I share things about my life
	Listen to me
	Care about me
	Work to understand my situation
	Care about my children
	Accept me for who I am
Accountability	Respond to my needs promptly
	Are flexible
	Follow up with me when I make a request
	Clearly explains how this program works
Partnership	Work with me to help me make my goals a reality
	Make me feel like we are working as a team
	Provide opportunity for us to learn from one another
	Are on my side
Integrity	Are honest with me about what they can and cannot do
	Are consistent with me
	Are trustworthy
Empowerment	Help me reach out to organizations outside of DASH in order to get the resources I need
	Provide me with the tools I need to accomplish my goals
	Work with me step by step to accomplish my goals
	Provide me with the information that I need to make my own choices
	Help me to define successes on my own terms
	Help me to find resources I need
(Re)centering	Help me move forward when I feel stuck
	Notice when things are out of the ordinary for me
	Provide me time to learn at my own pace
	Help me find ways to manage stress
	Help me learn different ways of dealing with feeling overwhelmed

which are typical of samples from DV shelters. We used a non-informative prior given the exploratory nature of the study, and conducted three sensitivity analysis checks (first and third, trace plots, and autocorrelation) which revealed that the non-informative prior did not bias the results (Song and Lee 2012). Results from the Bayesian confirmatory factor analytic models suggested that the DASH Model Practices subscales and Survivor Empowerment scales had significant factor loadings. Model fit was assessed using the DIC (deviance information criterion) and the posterior predictive *p* value (PP p value). Both measures indicated acceptable fit. Reliability was also acceptable across all models.

Next, we reviewed the frequencies and distributional properties of the main constructs. We conducted correlational analyses to examine the seven DASH model practices, three survivor empowerment subscales, and three safety-related empowerment subscales. Results from the preliminary analysis suggested that the DASH Model Practices subscales were significantly related, and the scale items did not sufficiently differentiate from each other. However, given the exploratory, theoretical study aims and participatory approach to the study, we decided to keep the subscales separate and explore descriptively how each subscale might relate differently to each empowerment component. This was done to provide insight into further measurement development for future studies.

Phase 2 Results

The model practices most highly endorsed by survivors were sovereignty practices ($M = 2.49$, $SD = 0.71$) followed closely by compassion practices ($M = 2.47$, $SD = 0.77$). Survivors believed that staff were highly engaged in practices that supported their personal autonomy and trusted them and their decisions. A majority of participants reported that staff encouraged them to do what was best for themselves. Many survivors felt that staff believed what they had to say, helped them to work through difficult choices, and accepted the decisions they made for their lives. The third highest practice was accountability ($M = 2.25$, $SD = 0.88$) followed by partnership practices ($M = 2.17$, $SD = 0.99$), and integrity practices ($M = 2.16$, $SD = 1.05$). These three practices were procedural in nature and varied by the skills and capacity of the staff member. Whether staff were flexible, provided clear directions, followed-up in a timely manner, were consistent, and engaged in strategies that strengthened the partnership were endorsed slightly less often, on average, relative to compassion practices and sovereignty practices. Empowerment practices ($M = 2.04$, $SD = 0.93$) and (re)centering practices ($M = 1.96$, $SD = 0.87$) were the least endorsed in the DASH model practices scale (averaging 'somewhat' on all responses). Fewer survivors endorsed getting the tools, information, and resources they needed to accomplish their goals, compared to other practices. More than half of the survivors reported that staff helped them gain skills to manage stress and learn other strategies to maintain their emotional wellness.

Survivors reported high levels of generalized empowerment and safety-related empowerment. They reported feeling able to complete their goals (confidence; $M = 3.26$, $SD = 0.96$), being connected to the community (connections; $M = 3.07$, $SD = 1.06$), and having increased domestic violence awareness (consciousness; $M = 3.12$, $SD = 0.96$). Residents also reported that they had internal resources necessary to stay safe (internal tools; $M = 4.30$, $SD = 0.70$) and knowledge about formal supports (expectations for support; $M = 3.94$, $SD = 0.97$). On average, they did not believe that keeping safe would bring more difficulties (trade-offs; $M = 3.71$, $SD = 1.33$). See Table 3.

The Relationship between DASH Practices and Survivor Empowerment

DASH model practices and survivor empowerment were significantly positively associated with one another (see Table 4). Confidence was positively related to sovereignty practices ($r = 0.47$, $p < 0.01$), compassion practices ($r = 0.35$, $p < 0.05$), and re-centering practices ($r = 0.41$; $p < 0.05$). In other words, practices that promoted survivors' autonomy, were empathetic, and provided skills to manage stress were related to an increase in the survivors' ability to do more things on their own. Each DASH model practices subscale was positively and significantly related to building social support networks and community connections. Sovereignty practices ($r = 0.82$, $p < 0.01$) and partnership practices ($r = 0.79$, $p < 0.01$) had the strongest relationships with the connection subscale. As expected, greater use of DASH model practices was positively associated with survivors being able to find the external resources necessary to meet their needs. Consciousness was related to sovereignty practices ($r = 0.45$, $p < 0.01$), partnership practices, ($r = 0.37$, $p < 0.05$), and compassion practices ($r = 0.39$, $p < 0.05$).

Table 3 Descriptives of DASH model practices, survivor empowerment, and empowerment-related safety scales

Measure	# of items	M (SD)	α	95% CI
DASH model practices				
Sovereignty	4	2.49 (0.71)	0.89	[0.80,0.94]
Empowerment	6	2.04 (0.93)	0.94	[0.90,0.97]
Accountability	4	2.25 (0.88)	0.89	[0.80,0.94]
Partnerships	4	2.17 (0.99)	0.91	[0.85,0.95]
Compassion	6	2.47 (0.77)	0.92	[0.87,0.96]
Integrity	3	2.16 (1.05)	0.91	[0.83,0.95]
Re-centering	5	1.96 (0.87)	0.88	[0.79,0.93]
Survivor empowerment				
Confidence	9	3.26 (0.96)	0.95	[0.92,0.97]
Consciousness	8	3.11 (0.96)	0.90	[0.83,0.94]
Connections	4	3.07 (1.06)	0.85	[0.74,0.92]
Empowerment-related safety				
Internal tools	6	4.30 (0.70)	0.86	[0.75,0.92]
Expectations for support	4	3.95 (0.97)	0.79	[0.65,0.89]
Trade offs	3	2.28 (1.06)	0.57	[0.24,0.78]

The Relationship between DASH Practices and Safety-Related Empowerment

Correlational analysis suggested that DASH model practices and safety-related empowerment scales were significantly associated (see Table 4). Each DASH model practice had a significant and positive relationship to each safety-related empowerment subscale. Sovereignty practices ($r = 0.58$, $p < 0.01$), partnership practices ($r = 0.58$, $p < 0.01$), and empowerment practices ($r = 0.56$, $p < 0.05$) had the strongest relationships to internal tools—the extent to which survivors believed that they the tools they needed to keep safe. The practices that were the most highly associated with expectations of support were sovereignty practices ($r = 0.62$, $p < 0.01$) and compassion practices ($r = 0.50$, $p < 0.01$). Survivors perceived having to make fewer trade-offs for safety when staff used any of the DASH model practices scales, but it was the strongest among sovereignty practices ($r = 0.51$, $p < 0.05$) and partnership practices ($r = 0.50$, $p < 0.05$).

Table 4 Correlations of DASH model practices, survivor empowerment, & empowerment-related safety

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Sovereignty	–	.55*	.52**	.80**	.79**	.68**	.67**	.47**	.82**	.45**	.58**	.51**	.62**
2. Empowerment		–	.91**	.80**	.73**	.66**	.79**	*ns*	.61**	*ns*	.56**	.46**	.40*
3. Accountability			–	.79**	.69**	.66**	.78**	*ns*	.61**	*ns*	.43*	.38*	.34*
4. Partnerships				–	.88**	.84**	.85**	*ns*	.79**	.37*	.58**	.50**	.48**
5. Compassion					–	.83*	.87**	.35*	.75**	.39*	.53**	.42*	.50**
6. Integrity						–	.72**	*ns*	.73**	*ns*	.51**	.38*	.46**
7. (Re)Centering							–	.41*	.74**	*ns*	.45*	.38*	.38*
8. Confidence								–	.65**	.80**	.43*	*ns*	*ns*
9. Connections									–	.54**	.65**	*ns*	.58**
10. Consciousness										–	.67**	*ns*	.48**
11. Internal tools											–	*ns*	.79**
12. Trade offs												–	*ns*
13. Expectations of support													–

The trade offs subscale was reversed scored. Higher scores indicated fewer perceived tradeoffs

**p < 0.01; * p < 0.05

Phase 2 Summary

DASH model practices were positively related to all empowerment and safety-related empowerment outcomes. When survivors perceived staff to be engaging in DASH model practices, they also reported higher levels of empowerment. Survivors were more likely to: believe in their ability to accomplish their goals, feel more connected to the community, have greater awareness about DV and its dynamics, believe they had a greater their sense of internal resources, understand how to access formal supports, and perceive fewer tradeoffs when making decisions about safety.

Discussion

Settings that promote the empowerment of its members are grounded in collective, strength-based, justice-orientated, and sustainable individual and institutional practices. This was the first study that applied empowering settings theory to a DV crisis housing organization. All empowering setting characteristics were present at DASH, which provides preliminary evidence for using empowering setting theory to understand the extent to which empowering practice is occurring in DV settings.

Study results revealed that staff believed their role was to increase access to safe housing, and provide services led by survivors needs (*group-based beliefs)*. DASH's culture held basic assumptions that survivors had the right to power. Members in the setting also valued trust, responsiveness, and innovation *(empowering culture)*. Advocates enacted this mission by using empowering practice (*core activities)* and cultivating relationships that were core to the organizational functioning *(relational environment)*. Staff members had a voice in decision making, and new roles were created to accommodate personal interests and broaden organizational impact *(opportunity role structure)*. Setting leaders fostered an environment where members were deeply trusted, encouraged to learn, could make mistakes, and practice their skills *(leadership)*. The TA team provided on-going technical and emotional support to advocates while they implemented core activities, and leadership did not apply for funding that did not align with the DASH mission *(mechanisms for setting maintenance and change)*. The policies, and implementation of those policies, were flexible and more reliant on survivors' personal needs than following procedures. Leadership also ensured that resources were spent on providing advocate support *(empowering structure)*. Consistent with empowering settings theory, these setting characteristics potentially contributed to employees enacting practices associated with the DASH model through core activities. Practices associated with the DASH model were significantly and positively associated with survivor empowerment and safety-related empowerment.

The collective investment in the organizational mission – the DASH model – was a prominent theme and vital to implementation of core activities. Staff could identify, define, and explicate practices related to each component of the model. Previous research has found that employees who have a deep understanding of, and commitment to, the organizational mission and know how to implement it, are more likely to contribute to desired setting outcomes (Boswell 2006). Other setting characteristics, such as the importance of building deep relationships, being survivor-centered, and supporting survivors' autonomy, mutually reinforce staff investment in the DASH model.

The relational culture at DASH also provided employees with emotional, as well as technical, support to engage in and refine core activities. Collaborative, team-orientated cultures—sometimes called clan cultures which emphasize human relationships, teamwork, flexibility, and trust—support the ability for employees to gain competencies and garner emotional support from their colleagues (Agbenyiga 2011). Given the crisis-orientated nature of the work, an emphasis on fostering relationships could help mitigate the negative impact of burnout and compassion fatigue. Skills were also built through meaningful interactions with the staff. Future research efforts that examine how relational culture contributes to knowledge and skill acquisition could provide another pathway, outside of direct trainings, to promote empowering practice.

Procedural flexibility and autonomy are also important to consider when implementing empowering practice. Staff members understood the policies, and applied them in ways that fit their personal strengths and capacities. Staff also did not have to enforce procedures that restrict survivors' choices. Instead, they focused primarily on helping survivors meet their needs, which has been shown to increase survivor empowerment (Sullivan and Virden 2017). In addition, job autonomy and procedural flexibility has numerous benefits for staff, such as job satisfaction and the feelings of being trusted (Kim and Stoner 2008).

The second phase of this study demonstrated that core activities (practices aligned with the DASH model) were positively associated with empowerment and safety-related empowerment. These core empowerment-based activities had a statistically significant relationship with survivor empowerment. Survivors, on average, highly endorsed that staff engaged in practices promoting sovereignty and demonstrating compassion, and these practices were significantly related to all aspects of empowerment and safety-related empowerment.

Practices that were more related to staff skills and capacities rather than the DASH culture were endorsed less consistently (e.g., "Provide me with the tools I need to accomplish my goals"). Staff practices that involve more highly developed skills were the least endorsed (e.g., "Help me learn different ways of dealing with feeling overwhelmed"). Some of these practices may also differ based on other pressing needs in survivors' lives, survivors' desire and availability to engage with staff, and the strength of the relationship between staff and survivor.

Beyond individual behaviors of staff members, empowering setting characteristics may also independently contribute to survivor empowerment. For example, empowering structures, specifically policies and procedures that are low barrier and flexible, could contribute to survivors' feeling a greater sense of personal power (Nnawulezi et al. 2018). While this is the first study to examine the relationship between setting structure and survivor empowerment, prior research has found an association between shelter structures and survivor *dis*empowerment. Specifically, restrictive policies that created barriers to accessing social support networks and mandated survivors to engage in services removed survivors' ability to choose what they needed and contributed to negative psychological well-being (D'Enbeau and Kunkel 2013; Gregory et al. 2017). A great deal more research is needed to examine these relationships, and empowering setting theory provides guidance about ways to identify the direct, and indirect, pathways to survivor empowerment.

Survivors who have limited access to material resources tend to seek services from formal DV settings to get their safety and resource needs met. Many survivors in the current study were low-income women of color. They described disempowering experiences with formal systems across the city that made it difficult for them to achieve safety and well-being. In an empowering setting, members understand the relationship between power and social identities, and create conditions where people who occupy multiply marginalized social identities can gain more power and resources. Evidence suggests that DV housing settings are often hierarchal and operated by white ciswomen who hold power related to their individual identity status and institutional status (Donnelly et al. 2005). Empowering settings theory provides a framework for these agencies to help structure efforts to equalize power dynamics.

Findings should be considered along with methodological limitations. First, DASH was selected based on its reputation for having a strong program theory. Future research is needed that samples multiple, diverse organizations to determine how outcomes might vary in less aligned organizations. Second, the samples for both the qualitative and quantitative phases were small, which limits the extent to which the results can generalize to other organizations. Third, it is difficult to ascertain directionality between the contextual variables using qualitative, cross-sectional data. Additional studies taken with multiple waves of DV survivors entering or leaving organizations should be conducted to further substantiate findings. Fourth, the DASH Model Practices subscales were found to be highly related, which suggests that it might be a unidimensional scale. Continued scale development is needed. Fifth, the use of self-report data to assess both practices and outcomes is another limitation, given that any number of variables may bias the findings. Finally, it would have been ideal to assess outcomes at pre and post time points. This study was exploratory in nature and raises many new questions that require systematic investigation.

As researchers and practitioners continue to try to understand the complicated pathways that contribute to survivor empowerment and well-being, setting context must be considered. Conceptualizing domestic violence crisis housing organizations as either empowering or disempowering settings

allows for future intervention efforts to go beyond simply changing individual behaviors as a pathway to improve services. Efforts are needed that consider how mission and values shape the policies that are created, how organizational policies shape advocate behavior, and how cultural norms shape what is appropriate to say and do within a work setting. Understanding how advocates are impacted by their work settings can lead to positive changes in those settings, which will then influence practice as well as outcomes for survivors. These linkages are rarely studied within DV shelters, but are critical for the promotion of survivor empowerment.

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