Contra Costa Family Justice Center

Survivor Defined Success, Hope and Well-Being:
An Assessment of the Impact of Family Justice Centers

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Alameda County Family Justice Center

EXECUTIVE SUMMARY

The purpose of this report is to provide findings from a preliminary assessment of the Blue Shield of California Foundation Family Justice Center Initiative Project with a group of seven California Family Justice Centers.

Family Justice Centers are multi-agency, multi-disciplinary Centers that provide services to victims of inter-personal violence including intimate partner violence, sexual assault, child abuse, elder abuse, and human trafficking. The Family Justice Center movement began in San Diego in the mid-1990's through the vision and work of San Diego prosecutors Casey Gwinn and Gael Strack. They began co-locating police officers, prosecutors, community-based advocates, government-based advocates, civil legal service providers, and child trauma therapists in 1990 in the San Diego City Attorney's Office (Gwinn & Strack, 2006). In 2002, their multi-agency model evolved into the nationally recognized San Diego Family Justice Center, a coordinated, co-location of 120 professionals from 25 agencies in the City of San Diego (Gwinn, Strack, Adams, et al., 2007). Casey Gwinn provided oversight to the Center as the elected City Attorney and Gael Strack served as the first Family Justice Center Director in the country in her role as an Assistant City Attorney in San Diego.

In 2003, President George W. Bush created the President's Family Justice Center Initiative designed to open 15 federally funded Family Justice Centers, modeled after the San Diego Family Justice Center, through the U.S. Department of Justice, Office on Violence Against Women. Then-San Diego City Attorney Casey Gwinn was asked to provide national direction and leadership to this Initiative. In 2004, Alliance for HOPE International, through its Family Justice Center Alliance program, under the leadership of Casey Gwinn and Gael Strack, began serving as a training and technical assistance provider to Family Justice Centers and similar multi-agency Centers across the United States. In 2005, Congress added Family Justice Centers to the federal Violence Against Women Act as a specialized purpose area designed to promote collaborative models of service delivery for victims of intimate partner violence and sexual assault – further promoting the Family Justice Center model across the United States.

Between 2009-2017, Blue Shield of California Foundation worked with Alliance for HOPE International to develop a network of Family Justice Centers in California. The Family Justice Center Initiative provided technical assistance, training, and funding support for operating and developing Family Justice Centers. The Initiative helped open more than fifteen new Family Justice Centers in California. In 2011, the California Legislature authorized the first study of the Family Justice Center model in a "study bill" and asked Dr. Carrie Petrucci and ABT & Associates to conduct an independent evaluation funded by Blue Shield of California Foundation (Petrucci, 2013). In 2013, the California Legislature added Family Justice Centers to state law with the passage of Penal Code Section 13750, creating definitions and standards for Family Justice Centers and similar multi-agency Centers.

This assessment, requested and funded by Blue Shield of California Foundation in 2015, utilized a pretest posttest design to assess changes in hope and wellbeing among survivors of domestic violence and sexual assault receiving services at a diverse group of seven California-based Family Justice Centers. Further, this assessment examined the relationship of hope and wellbeing to survivor defined success operationalized by successful attainment of personal goals identified by the survivors.

318 survivors provided survey data at intake and/or at a 45-60 day follow up assessment. Ultimately, 125 surveys were matched to assess changes in Hope and wellbeing.

Gael Strack, Peter Long, Casey Gwinn

Change in Hope and Well-Being

- Survivors reported a statistically significant increase in hope.
- Well-Being Indicators significantly improved.
  - Statistically significant increase in satisfaction with life.
  - Statistically significant increase is positive emotional experience.
  - Statistically significant decrease in negative emotional experience.
  - Statistically significant increase in affect balance.
- Survivors reported a statistically significant increase in their capacity to flourish.

Increase in a survivor's Hope was associated with:

- Increased survivor defined success.
- Higher satisfaction with life.
- Improved positive emotional experience.
- Improved affect balance.
- Improved flourishing.

CONCLUSION

Victims of inter-personal violence and intimate partner violence are at an increased risk for anxiety, depression, social isolation, suicide, and substance use/abuse. The physical and psychological impact of inter-personal and intimate partner violence is a clear public health concern with a tremendous economic impact in the billions of dollars. Family Justice Centers offer a multi-disciplinary, single location for survivors and their children. The results of this assessment provide compelling evidence that Family Justice Centers are a source of hope and wellbeing for survivors of intimate personal violence and sexual assault.

Camp HOPE, Alameda Family Justice Center

INTRODUCTION

It is estimated there are 10 million victims of intimate partner violence (IPV) in the United States annually (Black et al., 2011). IPV is clearly a public health concern as 1 in 3 women in the U.S. will experience IPV including related sexual assault in their lifetime. While this crime is underreported, the data shows that young, low-income women of color are disproportionately affected. The negative consequences of IPV are significant for both adult survivors and their children (Black, Basile, et al., 2011; Hellman & Gwinn, 2015; Murray, Crowe & Akers, 2016; Simmons, Howell, Duke & Beck, 2016). Along with physical injuries, survivors of unmitigated trauma, including IPV, are at an increased risk for health, psychological, social, and financial difficulties (i.e., fear, anxiety, depression, dissociation, suicidal ideation, PTSD, stigma, isolation, housing, employment etc.). A large number of victims of IPV in high risk situations have experienced near-fatal strangulation or suffocation related assaults (Strack, McClane, Hawley, 2001; Murray, Lundgren, et al., 2016). The majority of high risk victims receiving services in Family Justice Centers have experienced life-threatening strangulation assaults (Strack & Morgan, 2017). Survivors of IPV-related strangulation and suffocation assaults suffer long-term health consequences including traumatic brain injuries, thyroid damage, permanent brain damage, and strokes (Strack, McClane, Hawley, 2001).

Intimate partner violence survivors, already experiencing profound trauma from violence and abuse, are then required to interact with multiple social service and criminal and civil justice system agencies in order to secure respite, safety, and legal protection from their abuser. These complex systems can be difficult and confusing, requiring the survivor to repeatedly tell the traumatic experiences to each service provider at many different locations. The Family Justice Center model seeks to alleviate the complex systems and end violence by providing a single location of co-located services for the survivor (Gwinn & Strack, 2010).

FAMILY JUSTICE CENTER MODEL

Family Justice Centers are multi-agency, multi-disciplinary Centers that provide services to victims of inter-personal violence including intimate partner violence, sexual assault, child abuse, elder abuse, and human trafficking (Gwinn & Strack, 2006). The Family Justice Center movement began in San Diego in the mid-1990's through the vision and work of San Diego prosecutors Casey Gwinn and Gael Strack. They began co-locating police officers, prosecutors, community-based advocates, government-based advocates, civil legal service providers, and child trauma therapists in 1990 in the San Diego City Attorney's Office (Gwinn & Strack, 2006). In 2002, their multi-agency model evolved into the nationally recognized San Diego Family Justice Center, a coordinated, co-location of 120 professionals from 25 agencies in the City of San Diego (Gwinn, Strack, Adams, & Lovelace, 2005). Casey Gwinn provided oversight to the Center as the elected City Attorney and Gael Strack served as the first Family Justice Center Director in the country in her role as an Assistant City Attorney in San Diego.

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Between 2009-2017, Blue Shield of California Foundation worked with Alliance for HOPE International to develop a network of Family Justice Centers in California. The Family Justice Center Initiative provided technical assistance, training, and funding support for operating and developing Family Justice Centers. The Initiative helped open more than fifteen new Family Justice Centers in California. In 2011, the California Legislature authorized the first study of the Family Justice Center model in a "study bill" and asked Dr. Carrie Petrucci and EMT Associates to conduct an independent evaluation funded by Blue Shield of California Foundation (Petrucci, 2013). In 2013, the California Legislature added Family Justice Centers to state law with the passage of Penal Code Section 13750, creating definitions and standards for Family Justice Centers and similar multi-agency Centers.

The Family Justice Center Alliance (FJCA), a program of Alliance for HOPE International collaborated with the University of Oklahoma's Center of Applied Research for Non-Profit Organizations to design and implement this evaluation of seven California-based Family Justice Centers (including satellite locations). The seven Centers and their respective cities included the: Alameda County Family Justice Center (Oakland); Contra Costa Family Justice Center (Richmond,

Strength United Family Justice Center

Concord); Riverside County Family Justice Center (Riverside, Indio, Murrieta); Sacramento Family Justice Center (Sacramento); San Diego Family Justice Center (San Diego); Stanislaus Family Justice Center (Modesto); and Strength United Family Justice Center (Los Angeles).

The FJCA currently serves as the technical assistance provider for the U.S. Department of Justice, Office on Violence Against Women, for all federally funded Family Justice Centers. The FJCA also serves as the comprehensive technical assistance and training provider for the U.S. Department of Justice, Office for Victims of Crime, for the National Family Justice Center Polyvictimization Initiative entitled "Pathways to Hope, Healing, and Justice." The Initiative is focused on creating trauma-informed, Hope-centered approaches to meeting the needs of survivors of multiple forms of trauma seeking services in Family Justice Centers. Alliance for HOPE International seeks to measure Adverse Childhood Experiences (ACE), Hope, Resiliency, and other predictive outcome measurements in the lives of survivors and their children in all their programs.

Each Center in this report operates a centralized intake process where survivors come into a Center and go through a conversational interview with a "Navigator" or "Case Manager" that provides an orientation for the survivor on the available onsite services and seeks to determine what types of services the victim would like to access at the Center. While each Center has different types of partner agencies onsite, the most commonly requested services include civil legal services (including family law and immigration assistance), advocacy, counseling and mental health services, housing assistance, and criminal justice system consultations with detectives and prosecutors on pending cases. The intake and assessment process with the survivor also includes the use of a risk assessment tool to evaluate the current level of danger a victim is facing and the preparation of safety plan. The majority of victims receiving services in Family Justice Centers are found to be in "extreme" or "high" danger and the majority have experienced near-fatal strangulation or suffocation assaults at the hands of their abusers (Gwinn & Strack, 2010).

Survivors often return to Family Justice Centers multiple times for follow-up visits related to civil legal services, counseling for themselves or their children, and other opportunities for camping and mentoring programs, job training, court support services, spiritual care support, and other types of assistance. The key distinguishing characteristic of Family Justice Centers is the ability of survivors to go one place for many different services instead of going from agency to agency and re-telling their story over and over again and going through repeated intake, relationship building, risk assessment, and service delivery processes in many locations with both government and non-government agencies.

Purpose of Report

Hope represents an important psychological strength that can (1) buffer the effects of adversity and stress, (2) increase the potential for important outcomes (e.g., goal attainment), and (3) through targeted interventions be increased and sustained (Valle, Huebner & Suldo, 2004). Under guidance from the Alliance for HOPE International, Family Justice Centers are developing hope-centered services responding to the needs of intimate partner violence survivors and their children (Gwinn, 2015; Hellman & Gwinn, 2017; Simmons, et al., 2016).

The purpose of this report is to present findings from an evaluation of changes in hope and wellbeing among survivors with significant ACE Scores receiving services at seven Family Justice Centers located in California. Furthermore, this evaluation assessed the relationship of hope and wellbeing to survivor defined success in goal attainment. This evaluation was conducted by the University of Oklahoma Center of Applied Research for Nonprofit Organizations and is based upon a pretest posttest design using self-report measures of hope, wellbeing, and goal attainment.

HOPE THEORY

Hope is a future orientation that is focused on our ability to attain desirable goals.

-Synder (2002)

Snyder's (2002) Hope Theory has two fundamental cognitive processes termed "pathways" and "agency". Pathway thinking refers to the mental strategies or road maps we develop toward goal attainment. Hopeful survivors can identify multiple pathways to their goals and can articulate solutions to potential barriers. Agency refers to the mental energy or willpower the survivor can direct and sustain toward their goals. Hopeful survivors can self-regulate their energy toward the pathways even in the presence of adversity and stress. Alternatively, those who have experienced repeated failed attempts at goal pursuits often recognize their deficits in both pathways and agency thoughts.

The role of hope in an individual's capacity to thrive is well established. Hopeful individuals are able to identify productive paths towards reaching their identified goals, manage and overcome stress easier, and report lower levels of daily stress (Chang, 1998; Irving, Snyder, & Crowson, 1998; Ong, Edwards, & Bergeman, 2006; Snyder, 2002). Higher hope individuals have also been found to be less reactive to stressful situations (Chang & DeSimone, 2001; Snyder, 2002).

Overall, the experience of hope has a positive influence on individual health and well-being (Kwon, 2000; Shorey, Little, Snyder, Kluck, & Robitschek, 2007; Snyder et al., 1996). Those with higher hope tend to have lower levels of depression and higher positive affect and self-esteem (Geffken, Storch, Duke, Monaco, Lewin, & Goodman, 2006). Hopeful individuals are less likely to ruminate on their trauma experiences potentially alleviating the demands on their ability to exert willpower toward desirable outcomes (Tucker, Wingate, O'Keefe, Mills, Rasmussen, Davidson, & Grant, 2013).

Recently, research has begun to focus on hope as an outcome variable for interventions designed to assist survivors of intimate partner violence (Johnson & Zlotnick, 2009; Munoz, Hellman, & Brunk, in press). In this context, hope is considered an important psychological strength and protective factor to surviving intimate partner violence (Arian, 2013). The survivor's ability to identify meaningful goals along with the ability to develop both willpower and pathways to those goals is fundamental in their capacity to find meaning, purpose, and hope.

METHOD

Assessment Procedure

Three hundred and eighteen surveys were administered to survivors from seven Family Justice Centers in California as part of the Blue Shield project with the Alliance for Hope International. Representatives from each participating Family Justice Center attended a webinar-based training developed specifically for FJC covering ethical principles research. Recruitment, Consenting, data collection, and matching of pretest and posttest surveys were lead by each Family Justice Center. A pretest, posttest matched design was used for this evaluation. All completed surveys were provided to The Alliance for Hope International to ensure matching of pretest and posttest and de-identification of participating survivors. Ultimately, the University of Oklahoma Center of Applied Research role was to analyze and report on de-identified data. The University of Oklahoma Human Subject Review Board approved this data analysis process.

Table 1. **Participation by California Family Justice Center**

Family Justice Center	Count	Percent of Total
Alameda County	53	16.7
Riverside County	11	3.5
Stanislaus County	46	14.5
Sacramento County	24	7.5
San Diego (City)	98	30.8
Contra Costa County	31	9.7
Strength United (City of Los Angeles)	55	17.3
Total	**318**	

Ultimately, 318 survivors provided complete the pretest assessment (during the initial intake, screening interview) and 130 survivors completed the posttest assessment (after 1-5 visits and related FJC services). This process resulted in 125 (39.3%) matched surveys available for comparison. Pretest surveys were collected during the intake process at each Family Justice Center if the survivor was not in crisis. Posttest follow-up surveys were completed approximately 45-60 days after intake.

Sample Demographics

Participating survivors responded to several demographic survey items.

- **Gender**: 90.1% Female.
- **Average Age**: 36.39 years (SD = 11.29) ranging from a low of 15 years to a high of 79 years.
- **Marital Status**: 39.8% single, 31.3% married, 13.4% divorced, 11.9% separated.
- **Race/Ethnicity:** 48.5% Hispanic, 28.9% White, 10.8% Black, 2.9% Asian, 1.0% American Indian.
- **Education Level**: 26.4% less than 12th grade, 23.9% HS graduate, 23.9% some college, 21.9% college graduate.
- **Current Housing**: 53.4% in own home/apt., 31.9% in other's home/apt., 1.5% emergency shelter, 1.0% homeless.
- **FJC Services**: 20.4% had previously used FJC.

Stanislaus Family Justice Center

ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs) are known to be associated with negative consequences across the lifespan and represent a serious public health concern. Left untreated, those who have experienced child maltreatment are more likely to experience poor mental health, engage in health risk behaviors, and suffer physical diseases related to increased morbidity (Anda, Brown, Felitti, Bremner, Dube, & Giles, 2007; Bellis, Lowey, Leckenby, Hughes & Harrison, 2013; Dube, Andra, Felitti, Croft, Edwards & Giles, 2001; Dube, Anda, Felitti, Chapman, Wiliamson, & Giles, 2001; Hillis, Andra, Felitti & Marchbanks, 2001; Wilimansion, Thompson, Andra, Dietz & Felitti, 2002) and report more negative parenting experiences (Jaffe, Cranston & Shadlow, 2012). Moreover, these adults tend to experience lower educational, employment, and economic successes (Currie & Wisdom, 2010; Lanier, Kohl, Raghavan, & Auslander, 2015). Dramatically higher delinquency rates and criminal conduct levels have also been well documented in adults with ACE scores greater than zero (Reavis, Looman, Franco, & Rojas, 2013; Gwinn, 2015).

Table 2. **Prevalence of ACE Reported by FJC Survivors**

ACE Score	CDC Findings	Blue Shield FJC Study
0	36.1%	20.4%
1	26.0%	10.5%
2	15.9%	11.6%
3	9.5%	12.2%
4+	12.5%	**45.3%**

The average ACE score for the FJC survivors was 3.30 (SD = 2.62) with a median score of 3.0 and a mode of 0.0. Indeed, 45.3% of these survivors had an ACE score of 4 or higher. Comparatively, the Center for Disease Control Kaiser Permanente Adverse Childhood Study with over 17,000 participants report that 12.5% of the population have an ACE score of 4 or higher. Additionally, Ford, Merrick, Parks, Breiding, Gilbert, Edwards, et al. (2014) with a sample of 57,703 subjects found an average ACE score of 1.61. Results of a one sample t-test [$t(180) = 8.66$; $p < .01$] demonstrate that the average ACE score for our sample of FJC survivors was significantly higher than the national rate.

San Diego Family Justice Center

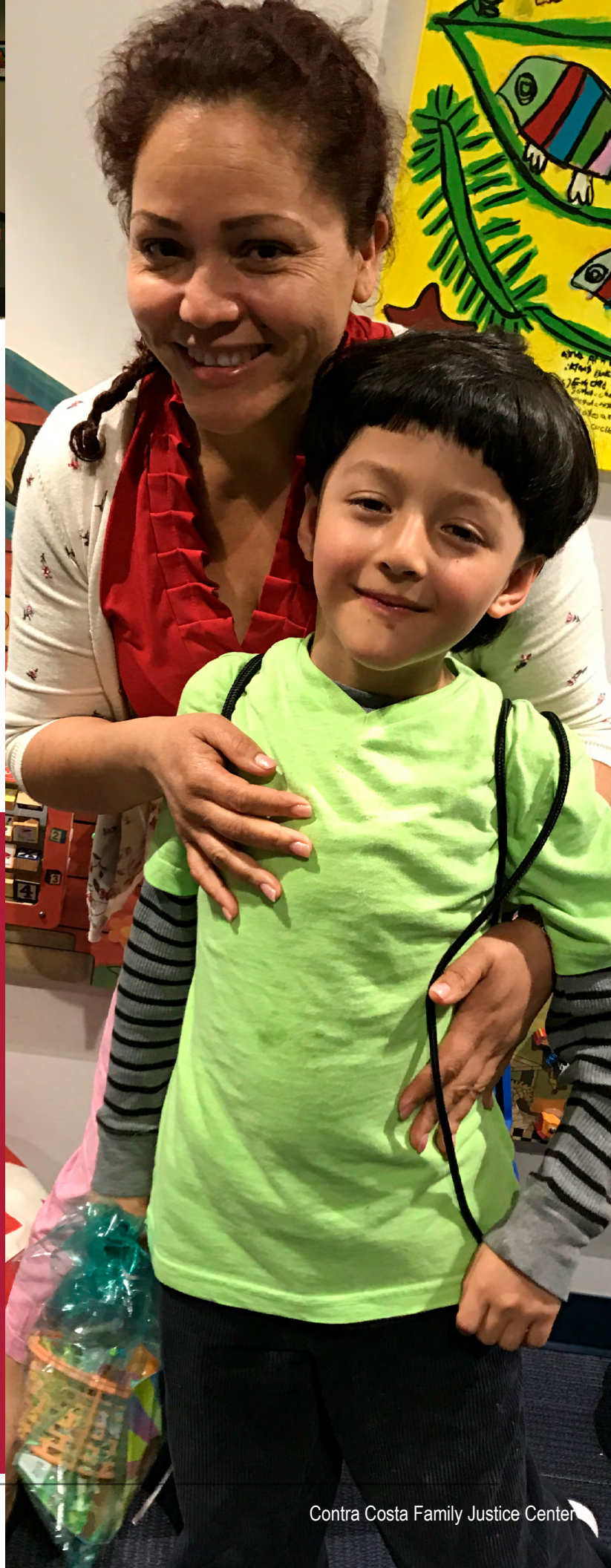
San Diego Family Justice Center

Table 3 below presents the percent of participating survivors reporting an experience with each ACE. The top ACEs for the survivors included parental divorce, verbal abuse, and substance use/abuse.

While Table 2 demonstrated that the prevalence of ACE for FJC survivors is significantly higher than the general population in the US, the results in Table 3 show the specific type of adversity prevalent across the three dimensions of the ACE. Taken as a whole, these findings warrant attention to the Polyvictimization needs for survivors of domestic violence.

Table 3. **Prevalence of Adverse Childhood Experience by Type**

	Percent
ABUSE:	
Verbal	48.5
Physical	36.5
Sexual	31.7
SEXUAL NEGLECT:	
Emotional	35.5
Physical	19.5
DYSFUNCTIONAL FAMILY:	
Witness Domestic Violence	24.9
Parent Divorce	52.7
Substance Abuse	40.1
Mental Illness	26.2
Parent Incarceration	16.9



Contra Costa Family Justice Center

MEASUREMENT

Survivor Hope

The Dispositional Hope Scale (Snyder et al., 1991) is an 8-item survey that measures the extent to which the respondent feels motivated to obtain goals and if they see viable ways in which to attain those goals. Item responses are on an 8-point Likert scale, ranging from 1 (definitely false) to 8 (definitely true). The Dispositional Hope Scale is divided into two subscales: 1) agency, which captures motivation to obtain said goals, and 2) pathways, which captures ones thinking in regards to goal attainment. Together, the two subscales derive a total hope score with a potential range of 8 (low) to 64 (high). In the current study, Cronbach's alpha for the intake was .88 and .88 for the follow up. This was consistent with reliability estimates reported in other studies (Hellman, et al., 2014).

Satisfaction with Life

The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) is a five-item survey that measures general perceptions about satisfaction with one's life. Respondents indicate on a seven-point Likert scale, from strongly disagree to strongly agree, their satisfaction with general aspects of their life. Scoring is achieved by adding up the total of all the responses with higher scores reflecting higher satisfaction with life. In the current study, Cronbach's alpha for the intake was .86 and .85 for the follow up.

Riverside Family Justice Center

Emotional Well-Being

The Scale of Positive and Negative Experience (SPANE; Diener et al., 2010) is a 12-item scale that measures positive and negative feelings. The respondent indicates on a five-point Likert scale (1 = very rarely or never, 5 = very often or always) how much they have been experiencing various positive and negative feelings within the past four weeks. Positive and negative feeling subscale scores are derived by adding up the responses from each of the six items included in the respective subscale, and can vary from 6 (lowest possible score) to 30 (highest possible positive or negative feelings score). A total affect balance score is derived by subtracting the negative feelings score form the positive feelings score, with a possible range of -24 (unhappiest balance) to 24 (highest affect balance). In the current study, reliability coefficients for the positive feeling scale (intake α = .92; follow up α = .90) and negative feeling scale (intake α = .87; follow up α = .82) were acceptable.

Flourishing

The Flourishing Scale (Diener et al., 2010) is an 8-item measure describing aspects of human functioning in the areas of engagement, relationships, goal attainment, as well as meaning and purpose. Items are presented with a seven-point Likert response (1 = Strong disagreement; 7 = Strong agreement). All items are phrased positively and scores are summed such that higher scores reflect higher functioning. Internal consistency for this study was high (α = .87 and α = .86).

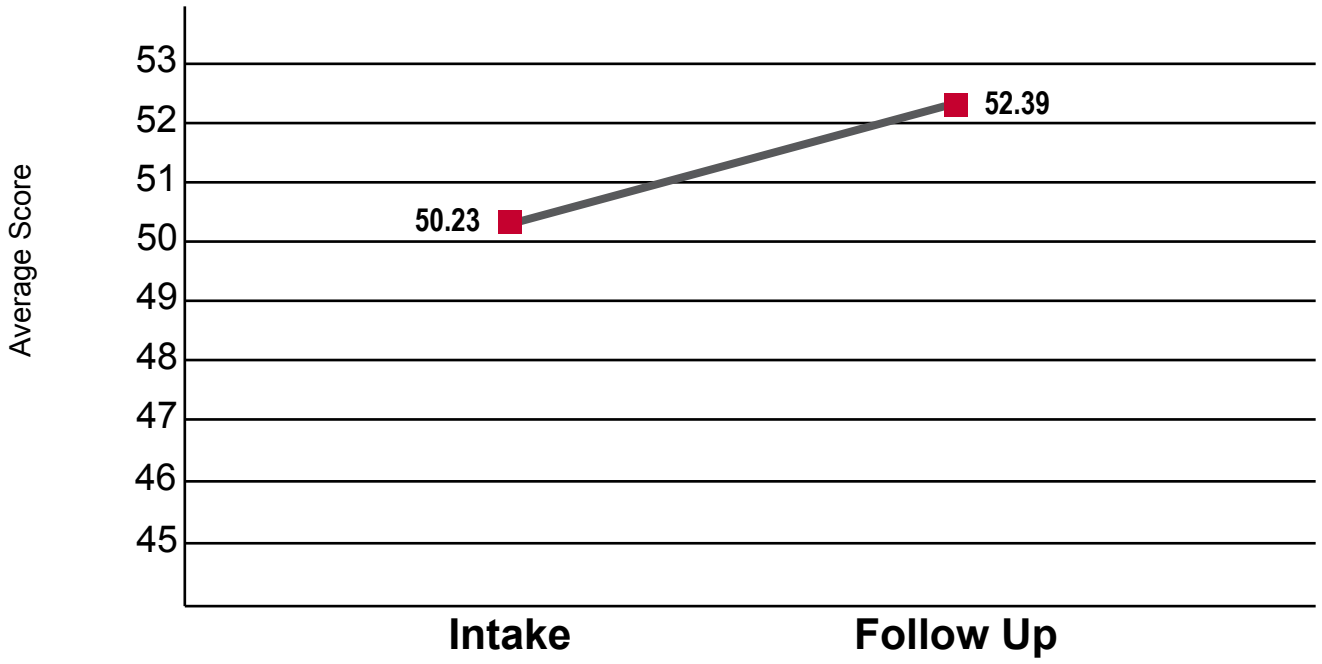
Survivor Defined Goal Success

Survivors were asked to write down up to three goals they had set for themselves while working with the Family Justice Center. On the posttest assessment, the survivor was asked to indicate the overall success they have had in pursuing each goal with a six-point Likert response scale (1 = not at all successful; 6 = very successful). Scores were then summed for the three goals and ranged from a low of 3 to a high of 18 (α = .77).

RESULTS

Family Justice Center Survivor Hope

Graph 1



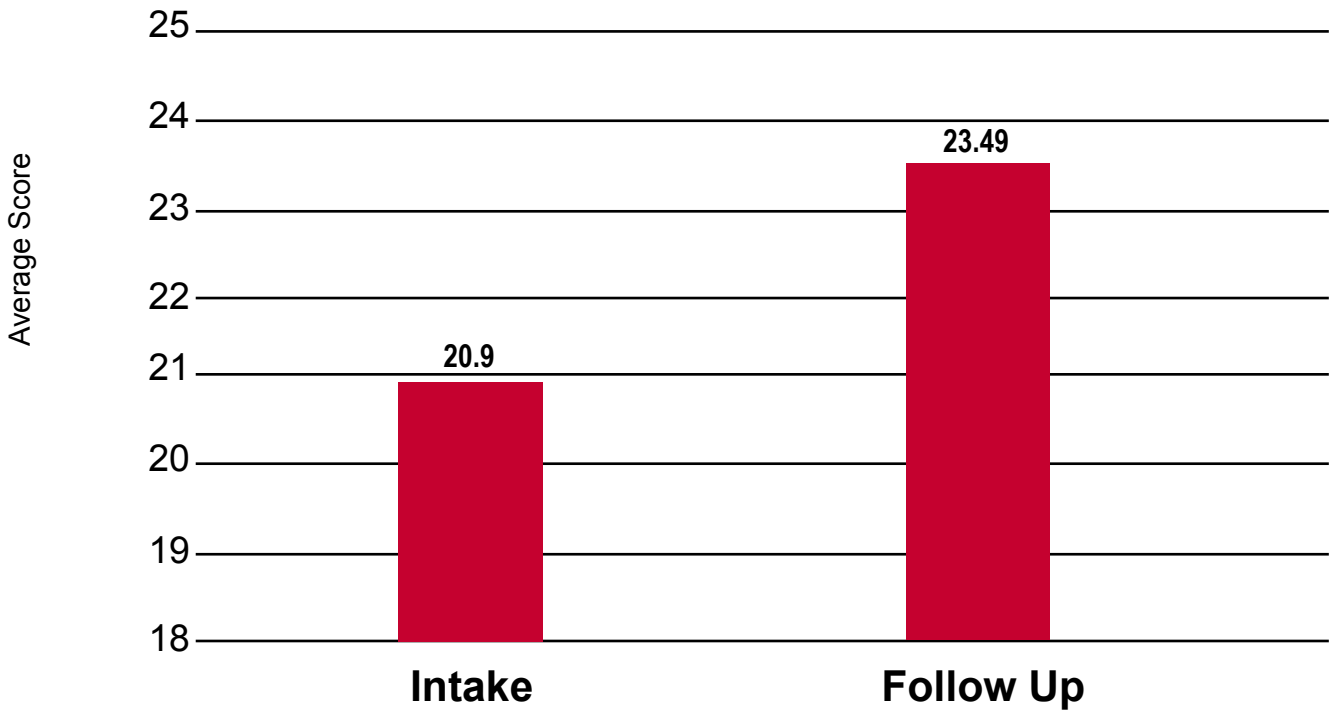
Hope reflects the individual's capacity to develop pathways and dedicate mental energy (agency) toward desirable goals.

Graph 1 presents the average hope scores for the survivors. As seen in the graph, survivor hope scores increased from intake to follow-up. A paired samples t-test showed that this increase in hope was statistically significant [t (113) -3.11; $p < .01$; d= -0.26].

Subjective Well-Being

Graph 2

Family Justice Center Survivor Satisfaction with Life



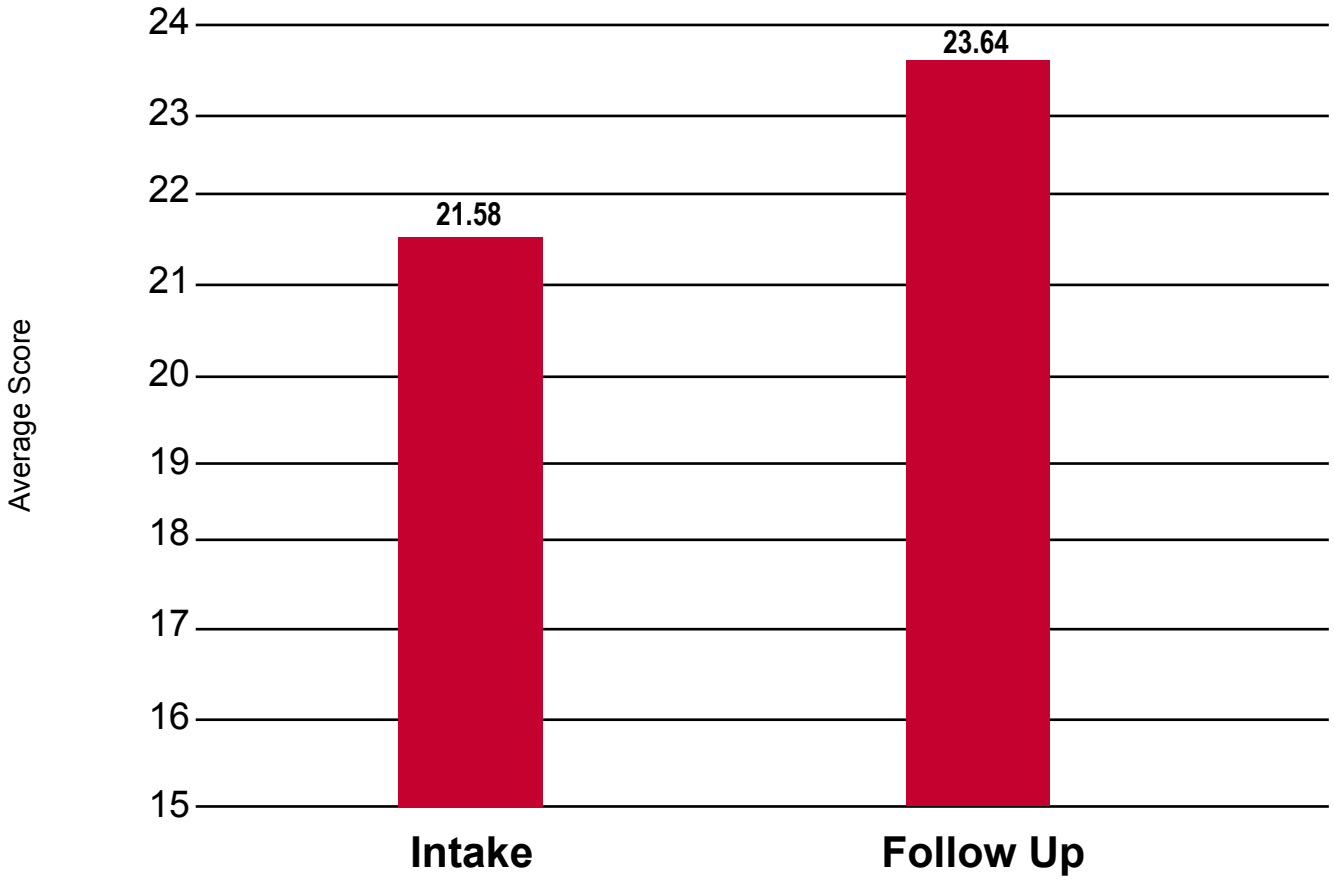
Satisfaction with life is the subjective assessment that one has had a meaningful life.

Graph 2 above demonstrates the increase in satisfaction with life from intake to follow up. A paired samples t-test suggests the change in satisfaction scores was statistically significant [t (123) -5.16; $p < .01$; d= -.51].

Emotional Well-Being

Graph 3

Family Justice Center Survivor Positive Emotional Experience



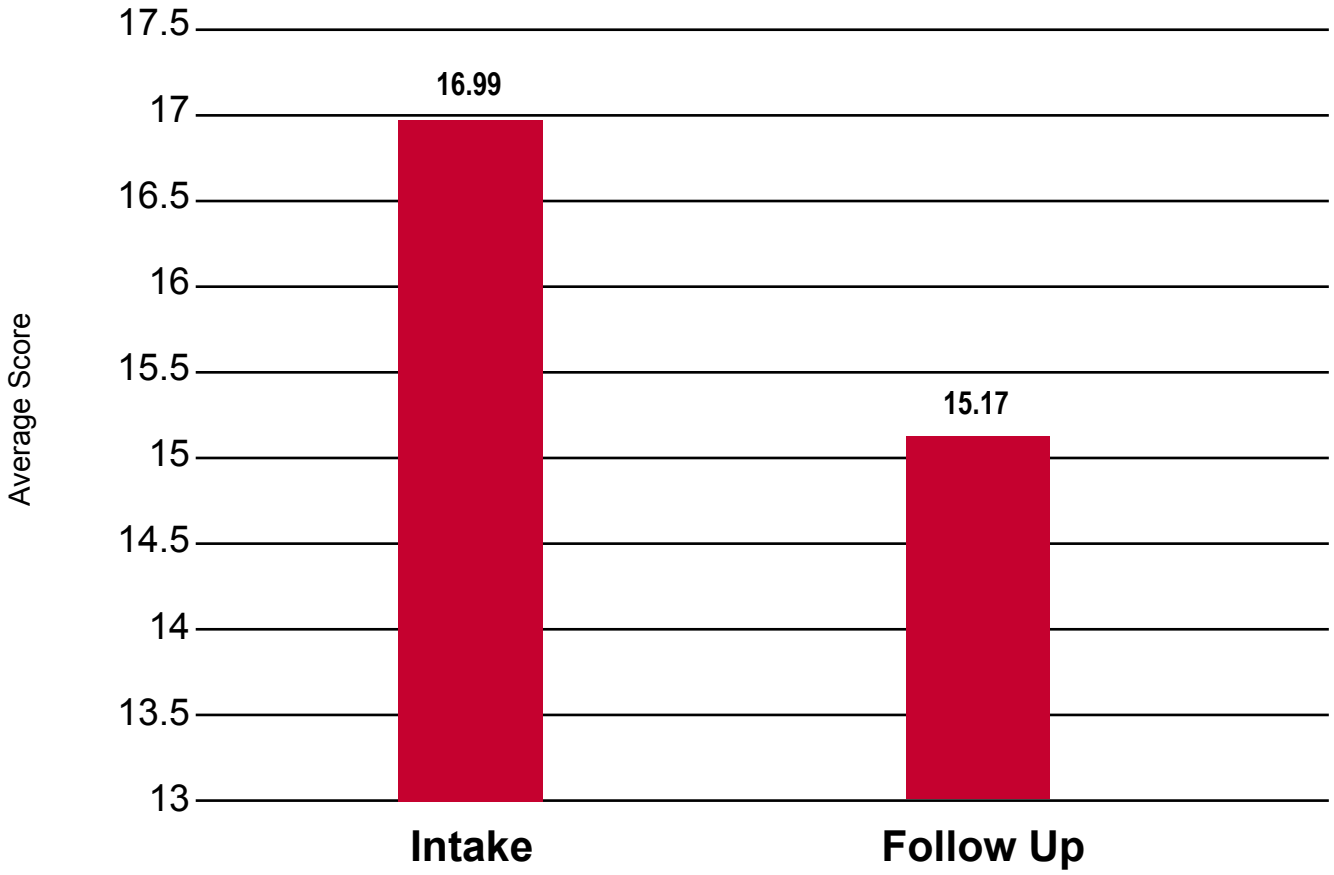
Positive emotional experiences reflect both the general feeling of happiness and the experience of positive moods.

Graph 3 above demonstrates the increase in positive emotional experience among participating Family Justice Center survivors. A paired samples t-test suggests the increase in mean scores for this item was statistically significant [t (124) -5.76; $p < .01$; d= -0.45].

Emotional Well-Being

Graph 4

Family Justice Center Survivor Negative Emotional Experience



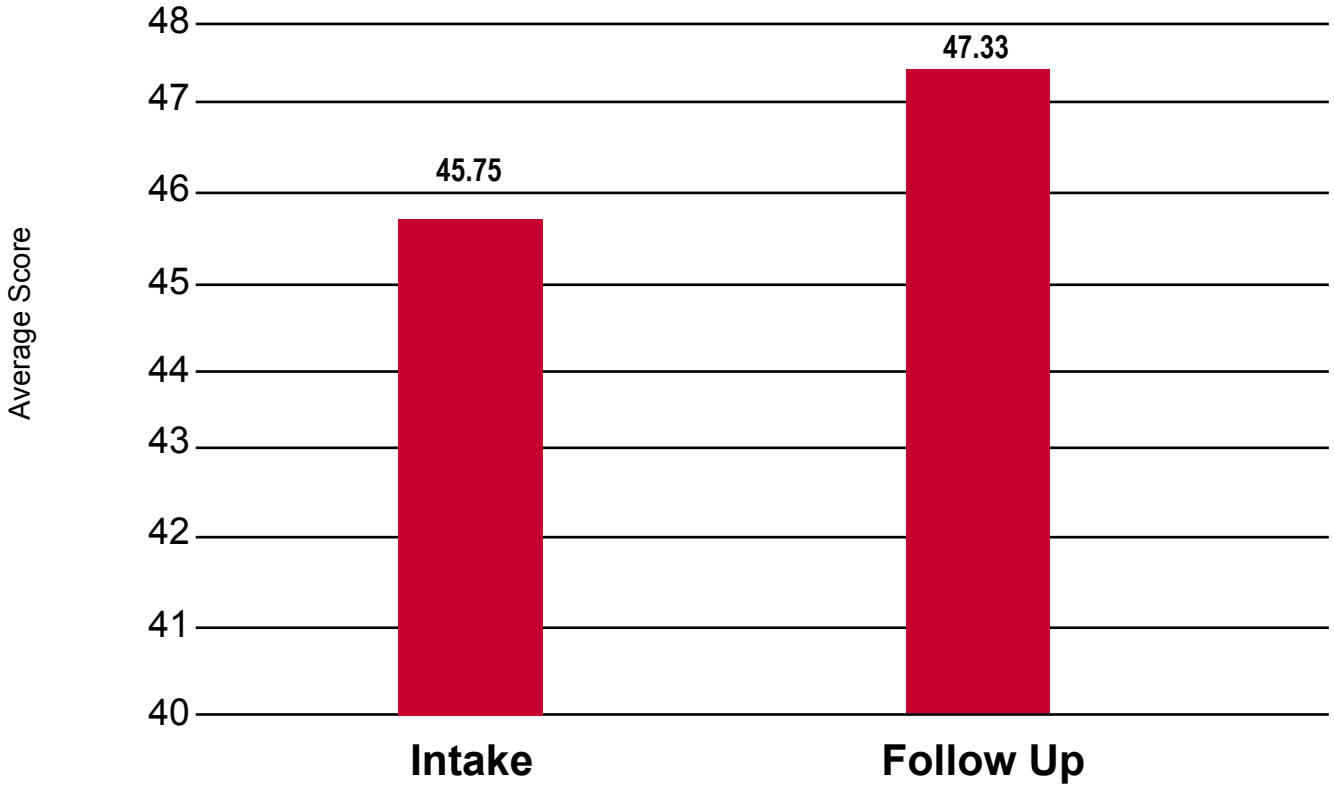
Negative emotional experiences reflect both the general feeling of sadness and the experience of negative moods.

Graph 4 above demonstrates the decrease in negative emotional experience among participating Family Justice Center survivors. A paired samples t-test suggests the decrease in scores for this item was statistically significant [t (117) 4.72; $p < .01$; $d = 0.39$].

Social-Psychological Functioning

Graph 5

Family Justice Center Survivor Flourishing



Flourishing represents believing that life has meaning and purpose, being engaged in activities, feeling competent, and having positive relationships.

Graph 5 above demonstrates the increase in flourishing among participating Family Justice Center survivors. A paired samples t-test suggests the increase in scores for this item was statistically significant [t (124) -3.13; $p < .01$; d= -0.25].

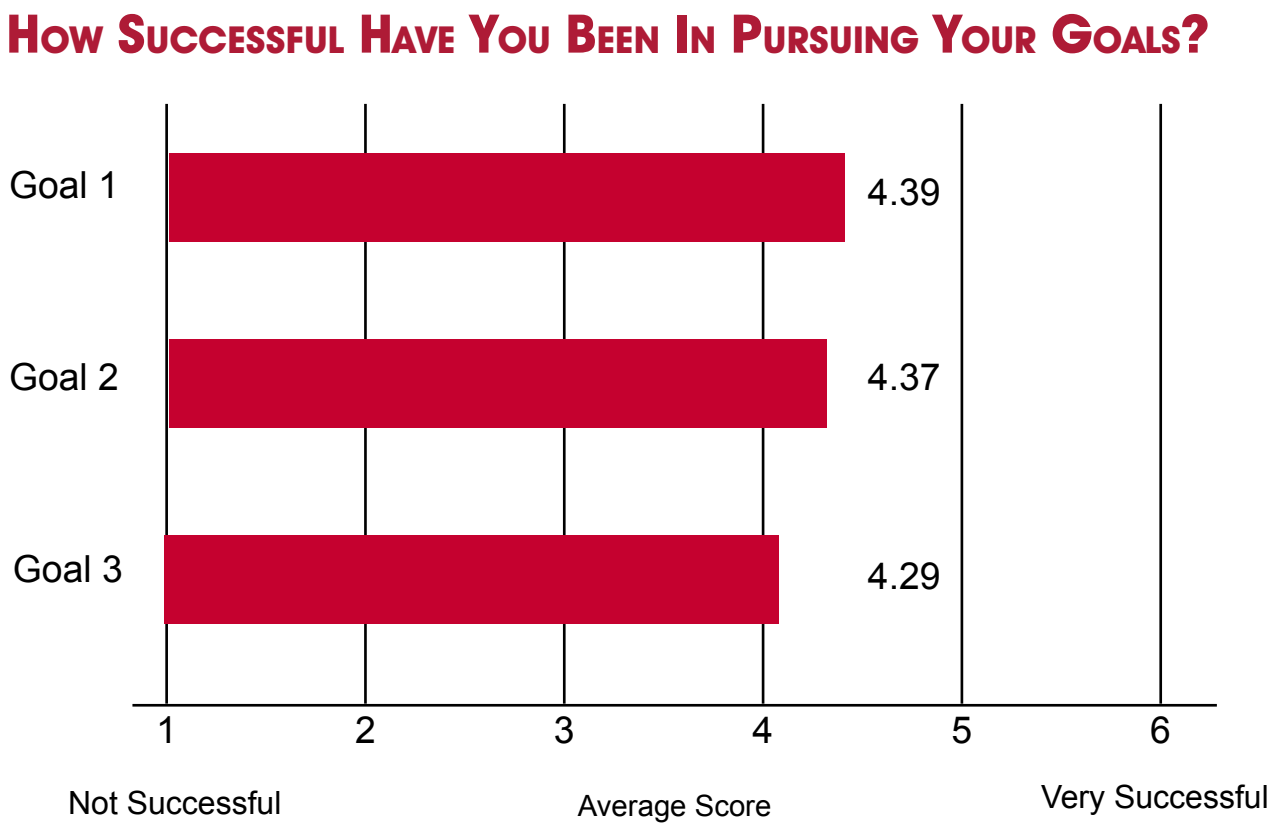
Survivor Defined Success

The prevalence of domestic violence and impact to individuals, families, and communities continues to be the topic of prevention and intervention efforts. Recently, the Full Frame Initiative (FFI; 2014) in California began to consider how survivors define success and how these perspectives align with service provider views. Findings from the FFI indicate survivor definitions of success transcend the service provider focus on program outcomes such as safety (e.g., social connections, accomplishment). One of the recommendations from the FFI was the creation of success measures based upon survivor definitions.

This program evaluation from the California Family Justice Center Blue Shield Project operationalized survivor defined success by asking participants to identify the goals they set for themselves.

Participants listed 280 goals that focused on topics such as education (e.g., attend classes, finish GED), parenting (e.g., be present for my daughters, become a good supportive parent), housing (e.g., find permanent housing for my kids), and social relationships (e.g., have fulfilling friendships). Consistent with the Full Frame Initiative, safety outcomes were mentioned with less frequency (less than 10 stated goals). While survivors identified personal goals on the survey, the intent of this study was not to conduct a phenomenological study on survivor goals. Rather, this evaluation attempted to build on the findings from the Full Frame Initiative and quantify successful attainment of goals identified as meaningful to survivors.

Graph 6



Next, these participants reported on how successful they had been pursuing their goals with responses ranging from a 1 (not successful at all) to a 6 (very successful). As illustrated in Graph 6 above, survivors reported being moderately to mostly successful in pursuing their goals. Furthermore, the median score for each of the three goals was a 5.0 (mostly successful).

Correlations among the Measures

Table 2.0 below provides the correlation matrix for all the scales described in this study. A correlation represents the level of relationship between two variables. The interpretation is based upon the strength of the relationship as well as the direction. Strength of a correlation is based upon Cohen's (1992) effect size heuristic. More specifically, a correlation (+ or -) of .10 or higher is considered small; a correlation (+ or -) of .30 is considered moderate, and a correlation (+ or -) of .50 is considered strong. With regards to direction, a positive correlation indicates that higher scores on one variable are associated with higher scores on the other variable. A negative correlation indicates that higher scores on one variable are associated with lower scores on the other variable. Using a correlation matrix is a parsimonious way to present several correlations among multiple variables. Identifying a specific correlation is based upon matching a row to a particular column.

Examples from Table 2.0

On the left side of the table the column marked "item" identifies the order of the correlations. The first item "hope" is also the next column labeled 1. The first correlation (r = .64*) under the hope column represents the relationship between hope and life satisfaction (variable 2). We interpret this correlation as follows: "Participating survivor who scored higher on Hope had higher scores on life satisfaction reflecting a strong positive correlation." Notice the correlation (r = .64*) has an asterisk indicating the finding was statistically significant ($p < .05$) meaning that the observed relationship between these two variables was likely not due to chance. As another example, higher scores on survivor Hope (column 1) was associated with higher scores survivor defined success (row labeled 6; r = .27*) and the strength was small. One more example will look at the correlation between negative emotion and survivor-defined success. Here we look at column 4 (Negative Emotion) and row 6 (Survivor Defined Success) and find the correlation is a negative value (r = -.34*). Thus, higher scores on negative emotion are associated with lower scores on survivor-defined success and the strength is moderate.

Table 2.0 **Correlations Among the Measures**

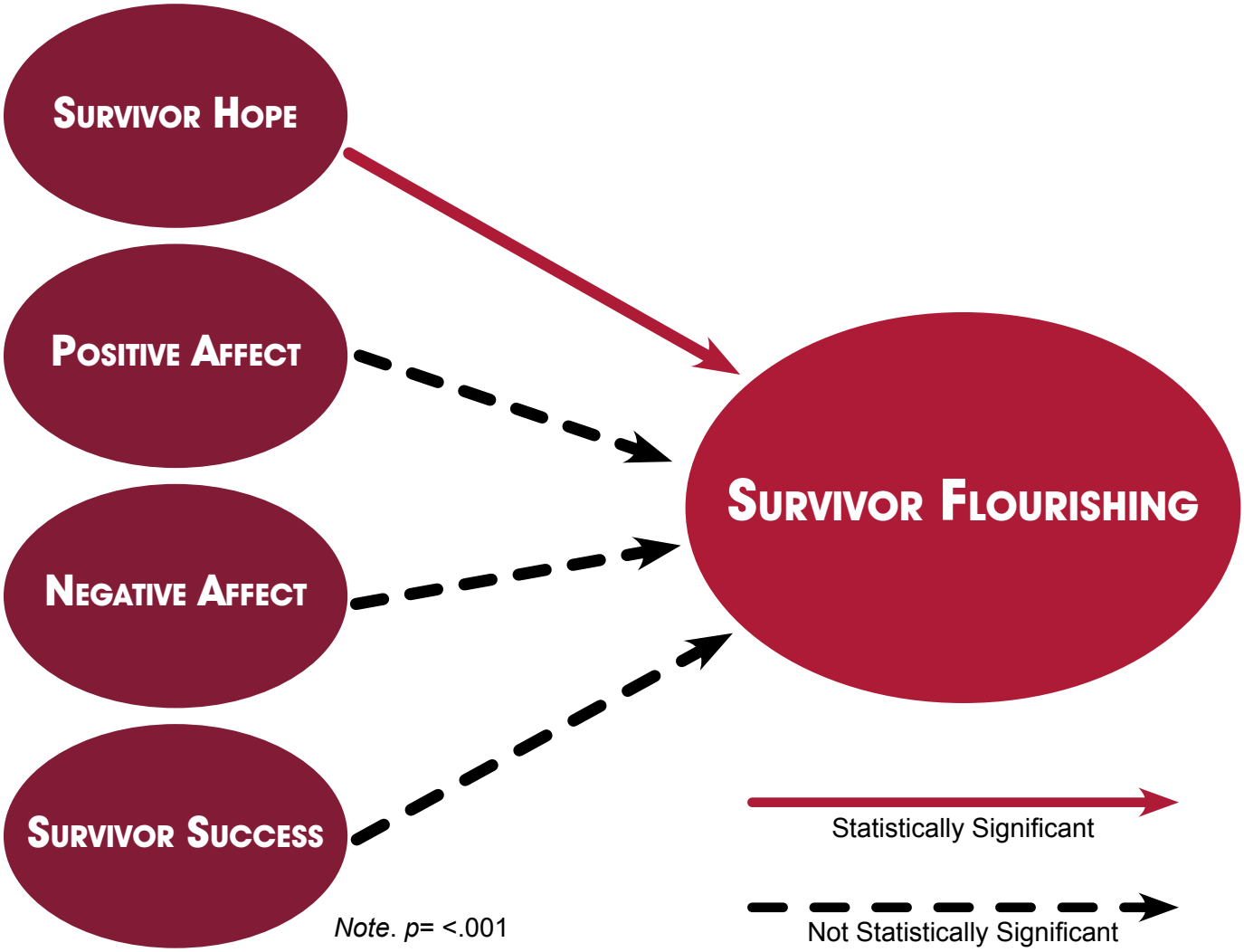
Item:	*M*	*SD*	1.	2.	3.	4.	5.	6.	7.
1. Hope	51.60	8.49	--						
2. Life Satisfaction	23.50	6.61	.64*	--					
3. Positive Emotion	23.50	4.70	.62*	.59*	--				
4. Negative Emotion	15.09	4.33	-.46*	-.52*	-.69*	--			
5. Flourishing	47.48	6.16	.71*	.53*	.52*	-.48*	--		
6. Survivor Success	13.07	3.65	.27*	.22*	.30*	-.34*	.34*	--	
7. ACE	3.30	2.62	-.06	-.10	.04	.06	.02	-.08	--

*Note: All Scores obtained at Follow Up except ACE (Intake). N = 126. *p < .05*

Correlational analysis demonstrated that an increase in survivor hope was associated with increases in the life satisfaction, positive emotion, and flourishing. Additionally, survivor defined success was positively associated with hope, positive emotion and flourishing.

Predicting Survivor Capacity to Flourish

Given the significant correlations among the variables, a multivariate linear regression model was tested to determine the significant predictors of survivor capacity to flourish. The full model accounted for 50% of the variance in survivor capacity to flourish [R2 = 49.9; F (4,64) = 14.94; p < .001]. While the correlations between flourishing and independent variables of hope, emotional well-being, and survivor defined success were statistically significant, only hope independently predicted great flourishing capacity of survivors. The findings from this analysis are consistent with a growing body of evidence suggesting the potential of hope-centered interventions on the wellbeing for survivors of IPV (Munoz, Hellman & Brunk, in press).



Note. *p*= <.001

CONCLUSION

Victims of inter-personal violence and intimate partner violence are at an increased risk for anxiety, depression, social isolation, suicide and substance use/abuse. The physical and psychological impact of inter-personal and intimate partner violence is a clear public health concern with a tremendous economic impact in the billions of dollars. Family Justice Centers offer a multi-disciplinary, single location for survivors and their children. The results of this assessment provide compelling evidence that Family Justice Centers are a source of hope and wellbeing for survivors of intimate personal violence and sexual assault.

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