provided by REVISTAS CIENTÍFICAS UNED. Servicio de Publicaciones

15 comunitania
INTERNATIONAL JOURNAL OF SOCIAL WORK AND SOCIAL SCIENCES
JULIO / 2018
ISSN: 2173-0512 / www.comunitania.com

YANIRA VALLE HERNÁNDEZ | CATALINA A. DENMAN CHAMPION | SANTIAGO CAMBERRO RIVERO | JUAN DAVID GÓMEZ-QUINTERO
ANTONIO EITO MATEO | JESÚS DOMÍNGUEZ SANZ | Mª CARMEN MARTÍNEZ MOLINA | TRINIDAD DONOSO-VÁZQUEZ
ANNA VELASCO MARTÍNEZ | EDUARDO LÓPEZ BERTOMEO | ÁNGEL LUIS GONZÁLEZ OLIVARES | MARTA ORTEGA GASPAR
MERCEDES FERNÁNDEZ ALONSO | MARÍA VIRGINIA MATULIČ DOMANDZIČ | IRENE DE VICENTE ZUERAS | JORDI CAÏS FONTANELLA
EMILIA IGLESIAS ORTUÑO | ENRIQUE PASTOR SELLER | LUIS MIGUEL RONDÓN GARCÍA

comunitania REVISTA INTERNACIONAL DE TRABAJO SOCIAL Y CIENCIAS SOCIALES
INTERNATIONAL JOURNAL OF SOCIAL WORK AND SOCIAL SCIENCES

Nº 16 / Julio 2018 / July 2018

Outcomes of a psychosocial treatment of women affected by intimate partner violence

Resultados del tratamiento psicosocial a mujeres afectadas por la violencia íntima de pareja

Trinidad Donoso-Vázquez*, Anna Velasco Martínez**

* Universitat de Barcelona. trinydonoso@ub.edu
** Consorci d'Educació de Barcelona. avelas2@xtec.cat

Abstract:

The objective of this paper is to present the outcomes of a group psychosocial intervention on women who had been victims of intimate partner violence (IPV). The sample was composed of 141 women from 19 centres in Spain. The evaluation of the outcomes includes: self-esteem, irrational beliefs, assertiveness, problem coping; gender ideology; evaluation of behavioural changes; and subjective well-being within three months of the completion of the intervention. The validity of the instruments used was tested. Significant changes were observed in all variables immediately after the intervention and three months after completion of the intervention. The discussion focuses on the impact of the variables affected by IPV, the potential for change in these variables, and treatment modality.

Keywords: psychosocial treatment, intimate partner violence, IPV intervention, self-esteem, irrational beliefs, assertiveness, problem coping, gender ideology.

Resumen:

El objetivo de este trabajo es presentar los resultados de una intervención psicosocial grupal en mujeres que habían sido víctimas de la violencia de pareja (IPV). La muestra estuvo compuesta por 141 mujeres de 19 centros en España. La evaluación de los resultados incluye: autoestima, creencias irracionales, asertividad, afrontamiento de problemas; ideología de género; evaluación de cambios de comportamiento; y bienestar subjetivo dentro de los tres meses posteriores a la finalización de la intervención. La validez de los instrumentos utilizados fue probada. Se observaron cambios significativos en todas las variables inmediatamente después de la intervención y tres meses después de la finalización de la intervención. La discusión se centra en el impacto de las variables afectadas por el maltrato, el potencial de cambio en estas variables y la modalidad de tratamiento.

Palabras clave: tratamiento psicosocial, violencia de pareja, autoestima, creencias irracionales, asertividad, afrontamiento de problemas, ideología de género.

Article info:

Received: 27/09/2017 / Received in revised form: 09/06/2018
Accepted: 15/06/2018 / Published online: 01/07/2018
DOI: http://dx.doi.org/10.5944/comunitania.16.4

1. Introducción

There has been an increased interest in recent years in evaluating the results of interventions carried out on women abused by their partners or former partners. Progress on proposals for efficient and effective interventions requires evaluative processes to prove whether the acquisition of strategies by women through treatment will allow them to overcome violence, initiate recovery processes in their personal, social and working life, and prevent any further abuse.

Parallel to the growth in interest in the evaluation of treatments has been an increase in the awareness of the difficulties faced in measuring change in female victims of intimate partner violence (IPV) after completing an intervention programme. Some of these difficulties are related to the variety of programmes and treatments, the differing methodologies used in measuring them, and the complexity of the interventions. To these difficulties can be added the characteristics of violence perpetrated on each woman, the social contexts and reality in which they are embedded, and the cultural patterns. The multiplicity of the effects of violence has implications for treatment and evaluation (Briere & Jordan, 2004).

The diversity of treatments has grown considerably. The macro-programmes of community intervention appear to have vast reach and effect, but these also present the greatest difficulties in evaluation (Gondolf, 2009). Evaluations for very specific interventions are increasingly found in the literature, such as transitions from their own home to sheltered accommodation (Wathen & MacMillan, 2003).

The instruments and ways of measuring these interventions on women affected by intimate partner violence also present great variability. All of the studies on psychosocial interventions reviewed by Abel (2000) use the self-esteem variable, followed by the variables relating to self-efficacy, locus of control, depression and indicators of intimate partner violence. Other variables used were anxiety, social support, perceived stress and problem coping (Bauman, Haaga & Dutton, 2008). The variables relating to attitudes towards family and marriage, and career maturity appear less frequently in studies.

To test the effectiveness of the treatment programme three months after the intervention in the study carried out by Tutty (as quoted in Abel 2004), measurements of self-esteem and perceived stress were used. Self-esteem clearly appeared as a key factor in evaluations, acting either as a triggering factor, or as an effect of abuse (Donoso-Vázquez, Luna & Velasco-Martínez, 2014).

In the study by Sullivan, Egan & Gooch (2004) of a combined care programme for mothers and children who were victims of violence, similar measures to those found in the review by Abel (2000) were used, in addition to parental efficacy and subjective well-being. Subjective well-being appears repeatedly due to the impact that violence situations have on it (Dutton, 1993; Golding, 1999).

Another group of variables widely used to measure changes are those related to indicators of intimate partner violence and how these indicators vary before and after the intervention (Nelson, Nygren, McInerney & Klein, 2004; Hfjar & Valdez-Santiago; Wathen & MacMillan, 2003). In these studies measures of the intimate partner violence index and the severity of the violence were collected. Suárez González et al. (as quoted in Híjar & Valdez-Santiago, 2008) incorporated the measurement of the knowledge about the causes of violence and, in turn, Wathen and MacMillan (2003) measured social support and quality of life, as well as the incidence of intimate partner violence and the degree of violence. Intervention programmes in the healthcare environment used indicators of this type, such as personal and physical safety, physical and emotional health, and unhealthy behaviour (taking harmful substances, such as smoking or taking pills, etc.) (Hathaway, Zimmer, Willis, Silverman, 2008).

The purpose of this study is to evaluate the outcomes of a psychosocial support programme for women. We want to check the level of achievement of the intervention objectives, and to what extent they were maintained in the mid term.

1.1. The structure of the intervention

Our intervention adopts a feminist model of interpretation of IPV. This approach places inequality between men and women, gender roles, the patriarchal structure of societies and, ultimately, gendered roles, at the basis of violence against women (Dobash & Dobash, 1977; Lenton, 1995; Yllo, 1988). These socially defined roles lead to social vulnerability of women and places them in a subordinate position, while granting men a position of power (Walker, 1984). For some authors violence of any kind perpetrated by men against women is an exercise in power and control over them (Pence & Paymar, 2006). Empirical support for this model comes from studies that examine relationships between male patriarchal values and violence committed against their partners (Ferrer & Bosch 2003; Leonard & Senchak, 1996; Smith, 1990; Yllo, 1988). In the last two decades a feminist model has arisen as both a critique and restructuring of this model, which interlinks gender-based oppression

with other vulnerability factors, such as race, class, ethnicity, language and nationalism. According to this latter approach, the feminist model of gender violence needs to be expanded to intersect with other socially constructed identities that are also elements of marginalisation (for a detailed review of IPV interpretative models, see Bella & Naugleb, 2008; Kelly, 2011). Although we agree that in transforming power relations between women and men, the other multiple identities should be taken into account, we cannot forget that patriarchal norms are deeply rooted in each of these identity locations.

According to these premises, an intervention by way of a psychosocial support programme delves into the very foundations of inequality and counteracts the effects produced by violence against women. The aim of the programme is to assist in the recovery process of female victims of IPV by working with: a) Gendered roles and stereotypes; b) Self-value and personal autonomy; c) Decision making and problem-coping strategies; d) Abusive control and communication; e) Isolation and loneliness; and f) Strategies for the development of a personal and professional project (Donoso-Vazquez & Palacios, 2009; Donoso-Vázquez, 2013).

The intervention adopted a group format of 13 sessions lasting approximately 2 hours and 30 minutes each. A psychosocial group approach addresses especially the social learning inculcated in women, which places them in a subordinate position. This approach is based on learning new strategies and tools to replace existing behaviour, motivations and beliefs.

Two social intervention specialists managed the sessions. The previous year they had received technical training on the programme and the evaluation procedures. Monitoring of the sessions was undertaken in order to provide support to the specialists during the process.

2. Methodology

2.1. Objectives

1. To check the starting point of women victims of IPV regarding i) self-esteem ii) assertiveness; iii) irrational beliefs; iv) gender ideology; and v) problem coping. Variables associated with the ability for personal agency.
2. To analyse the reliability of the instruments used.
3. To check the changes that occur in the women after treatment in each of the variables measured.
4. To analyse the differences in outcomes after treatment depending on age, place of birth, employment status, education level and characteristics of IPV suffered: type and duration of exposure to violence.

2.2. Sample

A total of 19 women's groups from 11 of the 17 autonomous communities (regions) in Spain were used. The number of participants in the groups ranged between 8 and 12. In total, the sample consisted of 141 women. The intervention was held in women's care centres of associations and NGOs. The selection process of the sample was intentional, the women decided to access the workshop motivated by the technical staff and for the desire to overcome the consequences of violence. All women were or had been victims of IPV.

TABLE I. Socio-demographic characteristics of the sample

Age	%
18 to 35 years old	36.4%
36 to 49 years old	48.6%
50 to 65 years old	15%
Place of birth	
Spain	64.5%
Outside Spain	35.5%
Latin-American	18.7%
North Africa	7.5%
Eastern Europe	6.5%
Sub-Sahara	2.8%
Period of stay in Spain	
1 to 2 years	15.4%
3 to 5 years	23.1%
More than 5 years	61.5%
Employment status	
Unemployed	59.8%
Occasional employment	13.1%
Housewife	12.1%
Stable employment	12.1%

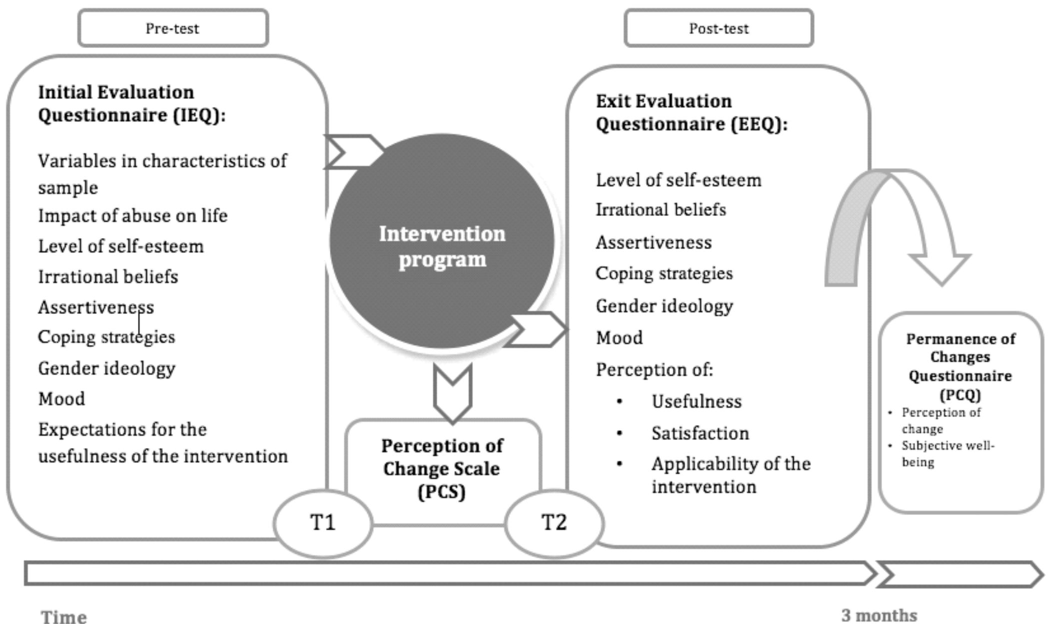
2.3. IPV Characteristics

All the participating women had been victims of IPV (13.9% of them continued to be harassed during the programme). The type of IPV varied according to the length of time of exposure to it and the different ways of perpetuation. 92% of women had been or were victims of psychological violence, 68% of physical violence, 37% of economic violence and 16% of sexual violence. As for the duration of IPV, 30.2% reported having been abused for over 10 years, 30.2% for between 2 and 5 years, 20.8% for between 5 and 10 years, and 18.8% for between 1 and 2 years.

2.4. Instruments

A battery of instruments were developed and selected based on the variables affected by a situation of IPV on which the programme aimed to work. A pre-post questionnaire was used, together with a behavioural observation scale and a scale three months after the intervention had ended. The figure below shows the instruments and measurements used and their progression over time.

FIGURE I. Instruments and time-scale of the psychosocial support program



A. **Initial Evaluation Questionnaire (IEQ).** In addition to the variables used to characterise the sample, the questionnaire contained the following scales:

A.1. Impact of intimate partner violence on the lives of women, Based on Echeburúa and Corral's Maladjustment Scale (1998). It is self-reporting and consists of six items, and it assesses the extent to which the IPV situation affects everyday life. The original scale introduced the area of relationship to their partner, but we changed it to relationship with their children (it must be remembered that one of the criteria for the selection of participants was that they had ceased cohabiting with the aggressor). Our scale covered the following areas: work, family relationships, relationships with children, social relationships (friendships), health and degree of overall impact on everyday life. The response range was from 1-5, from lowest to highest impact on each area. The cut-off point of the item is 3. For scores on the cut-off point of 3 and above, this area of life can be considered to be considerably affected.

A.2. Self-esteem, Measured according to Rosenberg's scale (1965) (Spanish version by Fernández-Montalvo and Echeburúa, 1997). This scale has been validated in 53 countries, and has been translated into more than 28 languages. It has good reliability and validity indicators, with Cronbach alpha coefficients of between 0.80 and 0.89 (Martín, Núñez, Navarro and Grijalvo, 2007; Schmitt & Allik, 2005; Vázquez, Jiménez & Vázquez, 2004; Vázquez Morejón, Jiménez García-Bóveda & Vázquez-Morejón, 2004). Self-esteem is undoubtedly one of the variables with the most significant changes in women suffering IPV, due to feelings of failure, inefficiency and self-contempt resulting from the abuse. Therefore it is important to check how the intervention may have an impact on this variable. It has been used not only to measure the effectiveness of treatment (Abel, 2000) but also the impact of abuse on this variable (Kim & Kahng, 2011) in populations of women affected by IPV. It consists of 10 items and a scale range of 1 to 4. The cut-off point in the adult population is 29. In this research, in order to standardise the measurement range of all of the scales, we established a response range of 1-5 (range: 10-50), the cut-off point of the scale being 40 and Item 4. Two items were added to measure the variability of self-esteem: 'My opinion of myself is very variable'; 'Some days I have a very good opinion of myself and other days, a very bad one.'

A.3. Irrational Beliefs, Experiencing IPV makes women engage in a series of performances of 'how to be and behave', influenced by the demands of the abuser. Such thoughts have a powerful influence on the individuals, as they are not fully aware of them (Bargh &Tota, 1988). Among these beliefs, guilt takes a strong hold because the abuser demands that the woman internally take responsibility for what is happening. These interpretations made with respect to an event and oneself negatively affect emotional well-being and decision-making (Vocate, 1994). An ad hoc scale was developed based on Ellis & Grieger's model (1990). It consisted of seven items (range: 7-35) with a Likert-type response on a five-point scale where beliefs such as 'I should be perfect' and 'Whatever I do will go wrong"' were assessed. The cut-off point for

the scale is 21 and Item 3. The scale should be interpreted to the effect that scores of over 21 points show that irrational beliefs have a strong impact on the cognition processes of the women involved.

A.4. Assertiveness, Assertiveness is considered to be one of the most important social behaviours linked to self-affirmation. It involves placing oneself on an equal footing in interpersonal relationships, with knowledge of rights and duties, both one's own and those of others (Michelson, Sugai, Wood & Kazdin, 1987). Other aspects are also relevant, such as the ability to have a healthy, realistic self-perception and self-value that allows one to feel confident (Galassi & Galassi, 1977). Intimate partner violence involves being in an uncontrollable, threatening situation that has a broad range of symptoms (Briere & Jordan, 2004), including the inability to defend one's rights, which may even lead the individual to question whether they deserve those rights in the first place. Altarriba (1992) described a number of features found in his research into women affected by intimate partner violence, associated with inhibited and unassertive behaviour patterns. These include the tendency to place themselves in a position secondary to the male role and the inclination to guide their behaviour depending on the male's demands, suppressing their own perception of situations and reducing implicit and explicit communication of their own positions. The scale used our study was extracted from the García Pérez & Magaz Lago assertiveness scale (1994). The reliability of the original scale is 0.87. 10 items were chosen (range: 10-50) from the total 35 of the original scale and six were reformulated in collaboration with the technical staff. A Likert –type scale was used for the responses, with five choices. The cut-off point of the scale was 30 and Item 3. The score should be interpreted inversely to the variable: the higher the score, the lower the individual's assertiveness.

A.5. Problem coping, There are a number of cognitive and behavioural strategies that the individual uses to minimise, control or tolerate internal and external demands from the environment that are perceived as dangerous or risky. Two widely-used categories of problem coping are problem-focused coping and emotion-focused coping (Lazarus & Folkman, 1984). These two categories can also be defined as active or passive coping and may be generalised to a wide variety of situations. Women who have been victims of IPV often adopt a passive response in problem coping. Follingstad, Neckerman & Vormbrock (1988) argued that women affected by IPV try to avoid thinking or feeling emotions that cause them to re-experience what happened, thus protecting themselves from chaos, confusion and danger. Avoidance strategies help women, at first, not to confront the emotional impact of the incident to its full extent. However, the use of such strategies has negative consequences in the long term, such as presenting with stronger psychological symptoms and / or emotional distress, and increased difficulty in leaving the abusive relationship; although women suffering IPV may develop specific strategies to deal with the situation being experienced (Bauman, et al., 2008). We opted to design a scale that did not include items specifically related to situations of IPV, but rather

to general strategies for coping with problems, according to two categories: problem-focused coping (active coping) and emotion-focused coping (passive coping) (Lazarus & Folkman, 1984). The ad hoc scale developed consisted of 17 items—12 for passive coping and 5 for active coping—with five Likert-type scale responses. The range was 5-25 for active coping and 12-60 for passive coping. The cut-off point on the scale for the active-coping subscale was 15 and Item 3, and 36 and Item 3 for the passive-coping scale. The passive-coping scale is interpreted inversely: the higher the score, the more emotion-focused strategies. Examples of active-coping items are, 'I analyse the circumstances to know what to do', 'I reflect on strategies to use'. Examples of passive-coping items are: 'I accept the situation, since it is inevitable', 'I pretend that there is no danger'.

A.6. Gender ideology, The gender ideology construct refers to the maintenance of sexist attitudes and traditional gendered stereotypes. In general, being guided by rules related to gender appears to have more negative than positive consequences in terms of emotional relationships, both for men and for women. The empirical results show that traditional attitudes towards gender roles increase the vulnerability of women to gender violence (Foa, Cascardi, Zoellner, Kasturirangan, Krishnan & Riger, 2000; Garcia-Moreno, Jansen, Ellsberg, Heise & Watts 2006), and constitute a risk factor for suffering IPV. The intervention in gender equality has reduced the levels of men-perpetrated violence (Decker, et al., 2008). This variable was measured by choosing 11 items from the Moya, Exposito & Padilla scale (2006). Its reliability indices range from 0.71 to 0.90. The 5-point Likert-type scale indicates the degree of agreement with traditional roles being assigned to women in the area of family, social life, sex, work and politics. The cut-off point on the scale is 33 and Item 3 (range: 11-55). The higher the score, the greater the gender ideology.

A.7. State of mind, A state of mind scale was also included, composed of an item with 5 schematic faces representing 5 states of mind—from the most negative to the most positive—with which women had to identify themselves. Given the variety of symptoms associated with IPV, state of mind is one of the variables that will be affected (Echeburúa & Corral, 1998).

B. Exit Evaluation Questionnaire (EEQ). Once the intervention had been completed, a final questionnaire was administered in the last session, with the same variables of the initial questionnaire in order to measure the impact of the workshop on the participating women. This new instrument, apart from containing all of the variables included in the initial evaluation questionnaire (IEQ), had three more items so as to find out a) the degree of usefulness of the intervention in their personal growth, b) the applicability to aspects of their life and c) the satisfaction level with the type of assistance that the programme had provided.

C. Perception of Change Scale (PCS). The perception of change scale is a scale that assesses the behaviour of the women during their passage through the programme.

The technical staff completed one per female participant at two different points in time: after the second session and after the completion of the intervention. The scale items emerged from focus groups with the social intervention specialists who managed the sessions of the programme, which had been previously carried out in order to validate the design. The transcripts of these focus groups revealed a number of expressions generally used by the specialists to refer to their perceptions of the changes taking place in the women as the programme progressed. From these expressions, eleven items were created and grouped into two categories: a) expressive behaviour and personal development behaviour; and, b) the ability to interact, connect and be part of a group in a constructive way.

Each item had two poles: from lower to higher occurrence of the observed behaviours, the item range being from 1-10. (Annexe 1).

D. Mid-term Evaluation: Permanence of Change Questionnaire (PCQ). Three months after having carried out the intervention, each of the female participants was contacted and invited to express—on an individual basis—examples of modified behaviour, ideas that had changed, and any fears that they had overcome as result of having participated in the programme. They also answered a question about their *overall satisfaction with the programme*: "How do you feel overall after finishing the workshop, as a result of having done it?" This had a response range of 1 (much worse) to 5 (much better). And finally, they completed the subjective well-being scale.

D.1. Subjective well-being, is the emotional and cognitive self-perception of an individual. It includes self-affection, projection over time and overall satisfaction with life (Diener, 1984; Diener, Oishi & Lucas, 2003; Shmotkin, 2005). According to Veenhoven (1984, p.22-24) is the 'the degree in which an individual judges the overall quality of life-as-a-whole favourably.' Due to the psychological, personal and social deterioration resulting from having been a victim of IPV, a low level of subjective well-being is a characteristic shared by the vast majority of abused women. Studies confirm the close relationship that women affected by IPV have with suffering from depressive symptoms associated with unhappiness, anguish, fear of the future, distrust of one's own achievements, etc. Having been or currently being a victim of IPV inversely affects the degree of subjective well-being (Walker, 1984). This has also been a variable used in the assessment of treatment in situations of IPV (Peled, Davidson-Arad & Perel, 2010). The scale used was developed by the authors taking into account Ryff & Keyes' model (1995), and the more global model by Diener, Emmons, Larsen & Griffin (1985). The ad hoc scale developed consisted of 10 items (range: 10-50) with five Likert-type response choices. These contained the main elements related to personal growth, self-acceptance and overall life satisfaction compared with the past. Some examples of items are: 'I feel better about myself', 'I think more pleasant things will happen to me', 'I have more desire to live', 'I feel that everything is going well now.' The scale cut-off point was 30 and Item 3.

2.5. Procedure

Women were asked for their consent to participation and the confidentiality of their information was ensured.

A specialist delivered the initial evaluation questionnaire (IEQ) individually to each woman before the start of the programme. There were various reasons for this decision:

a) It allowed contact to be established and the necessary relationship and synergy between the specialist and each of the group members to be initiated.

b) It was preferable for participants to be alone with the specialist when completing the initial questionnaire so that they can feel comfortable, ask any questions they deem appropriate, take their time without being subject to the requirements of the group, or making comparisons with how the others answer the questions or the time they take to do so.

c) When dealing with women with high social vulnerability or language problems, the technical staff may need to read the items of the scales to them. If this is the case, it is advisable to introduce each of the scales with explanations of what they are intended to measure to ensure that each individual understands them.

d) It avoids the awkwardness involved in starting group sessions with self-reporting scales where the woman feels explored and analysed, as this does not contribute to the group cohesion needed.

The procedure was the same used with the final evaluation questionnaire (FEQ) at the end of the programme. Each woman responded individually, with the assistance of the specialist. The perception of change scale (PCS) was completed by the specialist on two separate occasions, after the second and after the last session. The perception of change questionnaire (PCQ) was also completed individually three months after the completion of the programme.

2.6. Data analysis

Data analysis (means, standard deviation, frequency, percentages, mean comparisons and ANOVA) was carried out using the SPSS statistical package (version 20).

Results

TABLE II. Pre– and post-intervention reliability index of scales

α pre-intervention	α post- intervention
.864	.648
.829	.819
.656	.720
.873	.875
.736	.747
.643	.597

3.1. Differences in treatment outcomes according to sample characteristics

No significant differences were found in the ANOVA analyses with repeated measures taken for each of the socio-demographic variables and intimate partner violence, and the variables measured. Age, place of origin, employment status, education level and type of IPV suffered did not yield different outcomes either pre-intervention or post-intervention.

3.2. Results of the impact of IPV on the participants' lives

The following table shows the outcomes of the impact of IPV on the participants' lives with the means and standard deviations for each of the areas assessed.

Table III. Mean and standard deviation for the impact of violence on the women's lives

AREAS	$\bar{X}$	σ
Work	3.27	1.46
Family relationships	3.61	1.28
Relationships with children	3.37	1.47
Social Relationships (friendships)	3.43	1.30
Health	3.89	1.19
Overall impact	4.05	.97

All scores were above the cut-off point for each item, which is 3. The area receiving the greatest impact was health, followed by family relationships and social relations. The degree of overall impact on everyday living was very high (4.05).

3.3. Pre– and post-intervention results

Table IV. Pre– and Post– results

	N	$\bar{X}$ pre-intervention	$\bar{X}$ post-intervention	Difference in *t* means (absolute values)	sig
Self-esteem	126	33.166	35.29	2.738	.007*
Assertiveness	110	32.14	28.44	4.792	.000**
Beliefs	104	21.81	18.49	7.941	.000**
Ideology	107	25.20	20.57	6.326	.000**
Active coping	134	21.73	23.50	4.198	.000**
Passive coping	134	33.09	32.59	.880	.381
Variability in self-esteem	111	6.97	6.45	2.31	.022*
Mood	108	3.24	3.86	7.390	.000**

In the *pre-intervention* scores the scores indicate that: the women had a level of self-esteem below the scale cut-off point; a low level of assertiveness; a high level of irrational beliefs; low gender ideology; high levels of active-coping and high levels of passive-coping strategies; self-esteem variability was high; and state of mind was above the midpoint of the scale, equivalent to a neutral state of mind.

All the mean differences between pre– and post-intervention outcomes are statistically significant, except in the passive-coping scale. The largest mean differences were found in beliefs, ideology, assertiveness and active coping, in that order. Self-esteem was more stable and there was a change on the state of mind to a more positive one.

3.4. Perception of change scale results

TABLE V. Difference in means of behaviours observed on the perception of change scale

Perception of Change Scale	$\bar{X}$ 2nd session	$\bar{X}$ Post-Inter-vention	σ	Difference in *t* means	df	Sig. (bilateral)
Non-verbal Language	5.33	7.72	1.741	-12.808	86	.000
Verbal expression	5.82	7.7 5	1.751	-10.288	86	.000
Group communication	5.83	8.09	1.833	-11.523	86	.000
Humor	5.59	7.80	1.833	-11.290	86	.000
Contribution to conversations	5.85	8.01	1.656	-12.174	86	.000
Engagement in activities	6.14	8.20	1.602	-11.979	86	.000
Interest	6.57	8.41	1.430	-12.000	86	.000
Group cohesion	5.54	7.91	1.746	-12.648	86	.000
Ability to be outgoing	5.71	7.82	1.855	-10.574	86	.000

The initial scores of the scale show that the means of all the items were above the mean scale cut-off point, five points. The lowest scores, according to the technical staff, were related to group cohesion, the ability to step outside of oneself, capacity for humour and non-verbal language. The most affected behaviours were within the category of personal development. The highest averages were identified in the interest shown in the activities and processes carried out at the end of the group session. There is a statistically significant difference (P.001) in all of the behaviours scored by the specialist staff between the second and the last session. The greatest changes occurred in non-verbal language, communication with the rest of the group, humour, group cohesion and contribution to discussions.

3.5. Perception of the relative success of the intervention

The relative success index was found on the basis of the three items related to usefulness, applicability, and satisfaction with the help received. Considering that the response range went from 3 to 15 and that, having reached scores equal to or higher than 9, the intervention can be considered to be a success. The score obtained (N = 110 and = 13.25) falls within the expression 'very much' in terms of satisfaction, usefulness and applicability.

The comparison of means were analysed, using independent samples, between high and low relative success and the variables related to the programme. It was established that 'low relative success' was understood to correspond to a score of less than 6, and 'high relative success', to a score between 6 and 15. The only significant relationship found was with active coping. The greater the level of relative success, the greater the level of active coping (T= 4.051; df 99; P .000).

3.6 Mid-term impact results

The outcomes of the questionnaire administered three months after completing the programme indicate that the women had a very high overall level of satisfaction. The item on 'overall satisfaction with the programme' received a score of 4.21 out of 5.

The subjective well-being scale scored an average of 37.76 with an alpha of .914. The scale's internal consistency was high. The cut-off point of the scale had been set at 30, and it can therefore be considered that the women who obtained scores above 30 perceived that they were generally satisfied with their life. The average obtained by the women placed their subjective well-being between 'I quite often feel that way' and 'I very often feel that way.'

4. Discussion and conclusion

The pre-intervention scores obtained by women are at, or very close to, the cut-off point established for the scales, except for gender ideology and active coping. The scores were placed within risk levels for the women to be able to achieve an ability for personal agency. This is the ability that allows them to gain control over their own lives, recognise cultural and social patterns that underlie violence, confront those beliefs and normative standards, and develop strategies for overcoming them. The initial scores were also within risk levels in terms of their engagement in violent partner relationships in the future. These data are to be assessed together with those obtained on the impact that IPV has on the women's lives. All of the areas were affected above the cut-off point. Although there were some more affected areas than others, such as health, and social and family relationships, we cannot fail to note that the overall index of the impact of IPV on daily life is 4.05 out of 5. These initial results are also indicative of the need for an intervention.

As regards coping styles, the women used active coping strategies but at the same time, had high scores in passive coping. This 'coexistence' of the two types of coping could be explained by the characteristics of the sample: women entered the programme when they had left the abuser. This could be a factor that might have driven active coping, since, according Haggerty & Goodman (quoted in Kasturirangan, Krishnan, & Riger, 2004), when women turn to institutional or formal support it is a sign that there has been a change of strategies in addressing violence. However, passive-coping strategies may continue to exist. The results of Goodman, Dutton, Weinfurt & Cook (quoted in Kasturirangan et al., 2004) were not verified in our study; according to these authors, the greater the exposure to violence, the greater the use of active-coping strategies. We did not find significant differences between the length of exposure to intimate partner violence and problem coping. Also in relation to problem coping, it should be noted that at the end of the programme, those women who increased their active-coping strategies, had a greater perception of relative success and vice versa. It may be the case that, since coping is considered a very specific strategy for the ability to deal with problems, the women had a greater sense of acquiring tools with which to face life.

Despite the fact that the above-referred authors emphasise that the length of time of exposure to violence and characteristics of IPV cause more extreme psychological effects (Briere & Jordan, 2004) and, therefore, one would expect to find differences in variables based on these characteristics, we found no differences in the ANOVA tests for any of the groups, whether for the length of time of exposure to violence, abuse type, or socio-demographic characteristics.

The pre-intervention and post-intervention analysis of mean differences is significant at .01 and .05. This indicates, on the one hand, that the instruments are sensitive to change and on the other, that the treatment has an effect on the measured

variables. This effect has an impact on the ability of women to gain control over their own lives, recognise cultural and social patterns that underlie violence, confront those normative beliefs and standards and have strategies available for overcoming them. However, with regard to self-esteem, although there was a significant increase, the score failed to reach the established cut-off point. Self-esteem is a variable that is strongly affected in female victims of IPV and recovery certainly requires longer, combined treatments (Donoso-Vázquez, Luna, Velasco-Martínez, 2014-; Loke, Wan & Hayter, 2012; Nicoladis, Wahan, Trimble, Mejia, Mitchell, Raymaker, Thomas, Timmons & Walters, 2012).

The results related to gender stereotypes were lower than expected. Although the cut-off points of previous studies placed the gender ideology average score at 33 points, our participants started the intervention with a lower level of gender ideology (25 points). The score could be understood contextually because of the prevailing insistence on equality in Spanish society, both in advertising campaigns and legislative measures; yet the score did not move away from the risk scores.

There is much evidence that suggests that acceptance of a gender ideology based on stereotyped roles for men and women is a risk factor in IPV (Decker, et al., 2008). We believe that the most common, stereotypical beliefs in terms of gender and gender ideology should be the core elements in interventions against gender violence. While on the ideology scale the women deviated slightly from the cut-off point of the scale (low level of gender ideology), considerably different pre– and post-intervention scores were subsequently obtained, indicating that the programme triggered this change in perception.

On the perception of change scale (PCS) which assesses the changes perceived by the experts in every woman during the intervention, significant results were obtained in all items at .001. The qualitative comments by the specialists on this scale gave it a very high value. This scale was developed on the basis of the specialists' comments on the changes observed in the women. In the view of the specialists, the Likert-type scale moved from 10 to 5 points. This scale appears in the annex, since we do not know of any other similar one in the literature (Annex I).

Finally, the permanence of change questionnaire (PCQ) that was implemented three months after the intervention provided high reliability indicators on the subjective well-being scale. This indicates that, when some time had elapsed after the intervention, the women had an overall satisfaction with their lives (an indirect measurement of them having overcome the traumatic process of IPV). This measurement remains as a long-term indicator, although it is recommended that the questionnaire be applied within six months and not within three months of programme completion, to avoid contamination from the immediate effects of the experience of having gone through the programme.

Our contribution to the literature has focused on the outcomes of an intervention with a psychosocial focus and a group approach that achieved satisfactory changes in the measurements taken. However, there remains a lack of clarity as to which treatment modality is superior or more effective in IPV interventions, or the appropriate number of sessions required (Mairuo & Eberler, 2008). There is still a lack of empirical evidence to support a particular treatment (Babcock et al., 2004).

A limitation of this study is the absence of more measurements of the process with different data collection techniques, which would have enabled a more detailed monitoring. Another limitation is the lack of clarity on the causal relationships between variables, which could not be established.

7. References

Abel, E. M. 2000. Psychosocial Treatments for Battered Women: A Review of Empirical Research. *Research on Social Work Practice, 10*(1), 55-77.

Altarriba Mercader, F. X. 1992. *Vivències silenciades: entrevistes a dones victimitzades*. Barcelona: Institut Català de la Dona.

Bargh, J. A. & Tota, M. E. 1988. Context-dependent automatic processing in depression: Accessibility of negative constructs with regard to self but not others. *Journal of Personality and Social Psychology, 54*, 925-939.

Babcock, J., Green, C., & Robie, C. 2004. Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23*(8), 1023–1053.

Bauman, E. M., Haaga, D. A. F. & Dutton, M. A. 2008. Coping with Intimate Partner Violence: Battered Women's Use and Perceived Helpfulness of Emotion-Focused Coping Strategies. *Journal of Aggression, Maltreatment & Trauma, 17*(1), 23 – 41. doi: 10.1080/10926770802250942.

Bella, K. M. & Naugleb, A. 2008. Intimate partner violence theoretical considerations: Moving towards a contextual framework. *Clinical Psychology Review, 28*(7), 1096–1107. doi: http://dx.doi.org/10.1016/j.cpr.2008.03.003

Briere, J. & Jordan, C. E. 2004. Violence Against Women: Outcome Complexity and Implications for Assessment and Treatment. *Journal of Interpersonal Violence, 19*, 1252-1276. doi: 10.1177/0886260504269682

Decker, M. R., Miller E., Kapur, N. A., Gupta, J., Raj A. & Silverman, J. G. 2008. Intimate partner violence and sexually transmitted disease symptoms in a national sample of married Bangladeshi women. *International Journal of Gynecology and Obstetrics, 100*, 18–23.

Diener, E. 1984. Subjective Well-Being. *Psychological Bulletin, 95*(3), 542-575.

Diener, E., Oishi, S. & Lucas, R. E. 2003. Personality, culture, and subjective well-being: Emotional and cognitive evaluations of life. *Annual Review of Psychology, 54*, 403-425.

Diener, E. D., Emmons, R. A., Larsen, R. J. & Griffin, S. 1985. The Satisfaction With Life Scale. *Journal of Personality Assessment, 49*, 71-75.

Dobash, R. E. & Dobash, R. P. 1977. Wives: The appropriate victims of marital violence. *Victimology, 2,* 426–442.

Donoso-Vázquez, T. y Palacios, J. 2009. La intervención con mujeres que han sufrido maltrato. *Revista de Educaçao, Ciencia e Cultura, 14*(1), 85– 102.

Donoso-Vázquez, T.; Luna-González, E. y Velasco-Martínez, A. 2017. Relación entre autoestima y violencia de género. Un estudio con mujeres autóctonas y migradas en territorio español. *Trabajo Social Global-Global Social Work*, (79), 12: 93-119. (http://revistaseug.ugr.es/index.php/tsg/issue/view/434/showToc)

Donoso-Vázquez, T. 2013. Proceso colectivo de elaboración y evaluación de un programa de prevención en violencia de género. Efectos en el empoderamiento de las mujeres. *Asparkía, 24,* 69-86.

Dutton, M.A. (1993). Understanding women´s responses to domestic violence: A redefinition of battered woman syndrome. *Hofstra Law Review, 21*(4), 1191-1242.

Echeburúa, E. & Corral, P. (1998). *Manual de violencia familiar*. Madrid: Siglo XXI.

Ellis, A. & Grieger, R. 1990. *Handbook of rational-emotive therapy*. New York: Springer Publishing Company.

Ferrer, V. A. & Bosch, E. 2003. Maltrato de mujeres y misoginia: estudio empírico sobre un posible factor explicativo. *Anuario de Psicología, 34*(2), 215-233.

Foa, E. B., Cascardi, M., Zoellner, L. A. & Feeny, N. C. 2000. Psychological and environmental factors associated with partner violence. *Trauma Violence Abuse, 1*, 67-91.

Follingstad, D. R., Neckerman, A. P. & Vormbrock, J. 1988. Reactions to victimization and coping strategies of battered women: the ties that bind. *Clinical Psychological Review*, *8*, 373-390.

Galassi, M. D. & Galassi, J. P. 1977. *AssertYourself – HowTo Be YourOwnPerson*. New York: Human SciencesPress.

García Pérez, M. & Magaz Lago, A. 1994. *ADCA-1: Escala de evaluación de la asertividad*. Madrid: CEPE.

Garcia-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L. & Watts, C. H. 2006. Prevalence of intimate partner violence: Findings from the WHO multicountry study on women's health and domestic violence. *Lancet, 368*, 1260-1269.

Golding, J. M. 1999. Intimate Partner Violence a risk factor for mental disorders. A meta-analysis. *Journal of Family Violence, 14*, 99-132.

Gondolf, E. W. 2009. Implementing mental health treatment for batterer program participants: Interagency breakdowns and underlying issues. *Violence Against Women, 15*(6), 638-655.

Hathaway, J. E., Zimmer, B., Willis, G. & Silverman, J. G. 2008. Perceived changes in health and safety following participation in a health care-based domestic violence program. *Journal of Midwifery & Women's Health, 53*(6), 547-555.

Híjar M. M. & Valdez-Santiago, R. 2008. *Programas de intervención con mujeres víctimas de violencia de pareja y con agresores: experiencia internacional y mexicana*. Cuencava: Instituto Nacional de Salud Pública.

Kasturirangan, A., Krishnan, S. & Riger, S. 2004. The impact of culture and minority status on women's experience of domestic violence. *Trauma Violence Abuse, 5*, 318-332.

Kelly, U. A. 2011. Theories of Intimate Partner Violence: From Blaming the Victim to Acting Against Injustice Intersectionality as an Analytic Framework. *Advances in Nursing Science, 34*(3), 29–51. doi: 10.1097/ANS.0b013e3182272388

Kim, H. & Kahng, S. K. 2011. Examining the Relationship between Domestic Violence and Depression among Koreans: The Role of Self-esteem and Social Support as Mediators. *Asian Social Work and Policy Review, 5*, 181–197.

Lazarus, R. S. & Folkman, S. 1984. *Stress, appraisal and coping*. New York: Springer.

Lenton, R. L. 1995. Power versus feminist theories of wife abuse. *Canadian Journal of Criminology Special Issue: Focus on the Violence Against Women Survey, 37*, 305–330.

Leonard, K. E. & Senchak, M. 199). Prospective prediction of husband marital aggression within newlywed couples. *Journal of Abnormal Psychology, 105*, 369–380.

Loke, A. Y., Wan, M. L., Hayter, M. 2012. The lived experience of women victims of intimate partner violence. *Journal of Clinical Nursing, 21*(15-16), 2336-2346.

Maiuro, R. D. & Eberle, J. A. 2008. State Standards for Domestic Violence Perpetrator Treatment: Current Status, Trends, and Recommendations. *Violence and Victims, 23*(2), 133-155. doi: 10.1891/0886-6708.23.2.133

Martín A. J., Núñez, J. L., Navarro, J. G. & Grijalvo, F. 2007. The Rosenberg Self-Esteem Scale: Translation and validation in university students. *The Spanish Journal of Psychology, 10*(2), 58-67.

Michelson, L., Sugai, D.P., Wood, R. P. & Kazdin, A. E. 1987. *Las habilidades sociales en la infancia*. Barcelona: Martínez Roca.

Moya, M., Expósito, F. & Padilla, J. L. 2006. Revisión de las propiedades psicométricas de las versiones larga y reducida de la escala sobre ideología de género. *International Journal of Clinical and Health Psychology*, *6*(3), 709-727.

Nelson, H. D., Nygren, P., McInerney, Y. & Klein, J. 2004. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, *140,* 387–396.

Nicolaidis, C., Wahab, S., Trimble, J., Mejia, A., Mitchell, S. R., Raymaker, D., Thomas, M. J., Timmons, V., & Star Waters, A. 2012, November 13. The interconnections project: Development and evaluation of a community-based depression program for African American violence survivors. *Journal of General Internal Medicine*. Advance online publication. doi:10.1007/s11606-012- 2270-7

Peled, E., Davidson-Arad, B. & Perel, G. 2010. The Mothering of Women Abused by Their Partner: An Outcome Evaluation of a Group Intervention. *Research on Social Work Practice, 20*, 391-402.

Pence, E. & Paymar, M. 2006. *Education groups for men who batter.* New York: Springer.

Rosenberg, M. 1965. *Society and the adolescent self-image*. Princenton: Princenton University Press.

Ryff, C. & Keyes, C. 1995. The Structure of Psychological Well-Being Revisited. *Journal of Personality and Social Psychology, 69*(4), 719-727.

Schmitt, D. P. & Allik, J. 2005. Simultaneous Administration of the Rosenberg Self-Esteem Scale in 53 Nations: Exploring the Universal and Culture-Specific Features of Global Self-Esteem. *Journal of Personality and Social Psychology , 89*(4), 623–642.

Shmotkin, D. 2005. Happiness in the face of adversity: Reformulating the dynamic and modular bases of subjective well-being. *Review of General Psychology, 9,* 291-325.

Smith, M. D. 1990. Patriarchal ideology and wife beating: A test of a feminist hypothesis. *Violence & Victims, 5*, 257–273.

Sullivan, M., Egan, M. & Gooch, M. 2004. Conjoint Interventions for adult victims and children of domestic violence: A program evaluation. *Research on Social Work Practice, 14* (3), 163-170.

Vázquez Morejón, A. J., Jiménez García-Bóveda, R. & Vázquez-Morejón Jiménez, R. 2004. Escala de autoestima de Rosenberg: fiabilidad y validez en población clínica española. *Apuntes de Psicología, 22*(2), 247-255.

Veenhoven, R. 1984. *Databook of Happiness.* Boston: Dordrecht-Reidel.

Vocate, D. R. 1994. *Intrapersonal communication. Different voices, different minds.* Hillsdale: N. J. Erlbaum.

Walker, L. E. 1984. *The battered woman syndrome.* New York: Springer

Wathen, C. N. & MacMillan, H. L. 2003. Interventions for violence against women scientific review. *JAMA: The Journal of the American Medical Association, 289*(5), 589-600.

Yllo, K. 1988. Political and methodological debates in wife abuse research. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 28–50). Thousand Oaks, CA: Sage Publications, Inc.

Annex I

PERCEPTION OF CHANGE SCALE

The social worker assesses **each woman** in the group at two points in the course : after the **2nd session** and after the **last session**.

Alias:

Mark with an 'x' the number which best reflects the behavio r and attitude perceived on:	**2ND SESSION**						LAST SESSION				
Non-verbal la nguage (from anxious and not making contact; to relaxed and making contact. E.g. from frowning, stiff posture, hunched posture, bowed head, constant hand gestures or relying on repeated non-verbal gestures, clenched hands, tightly-closed mouth; to relaxed, at-ease posture,.	1	2	3	4	5		1	2	3	4	5
Verbal expression (from incoherent, rambling speech; to confident speech during the session, addresses the social worker and others directly, clear and coherent self-expression).	1	2	3	4	5		1	2	3	4	5
Communication with rest of group (from hardly communicates unless directly spoke n to; to communicates openly with the group).	1	2	3	4	5		1	2	3	4	5
Laughs, makes jokes (from never makes jokes and hardly partic ipates in others' jokes; to laughs openly at others' jokes and/or participates with her own).	1	2	3	4	5		1	2	3	4	5
Contribution to conversations (from makes contribution s only when directly asked, and then only short ones; to contributes throughout, firstly without referring to her own experience, and later referring to her own life and experience).	1	2	3	4	5		1	2	3	4	5
Engagement and interest in activities (from does not engage , lets herself be led in activities rather or completely mechanically, shows no interest; to engages fully, commits herself to the success of the activity, shows great interest in everything that is said and done).	1	2	3	4	5		1	2	3	4	5
Cohesion with the group (from speaks always from the "I" position; to includes "we" in her speech and contributes throughout to helping the group grow and develop).	1	2	3	4	5		1	2	3	4	5
Ability to be outgoing (from never s hows an attitude of wanting to help and engage in others' problems, passive and indifferent attitude or solely self-centered; to contributes to helping others when they speak about their problems and/or offers ideas, self-expression and jokes to help others, speaks and lets others speak).	1	2	3	4	5		1	2	3	4	5
At the close of sessions (from does not say goodbye to anyone and quickly leaves the room; to takes time to say goodbye and make comments with others. From tense situation of leave -taking; to relaxed situation).	1	2	3	4	5		1	2	3	4	5

comunitania REVISTA INTERNACIONAL DE TRABAJO SOCIAL Y CIENCIAS SOCIALES
INTERNATIONAL JOURNAL OF SOCIAL WORK AND SOCIAL SCIENCES

ARTICULOS/ARTICLES

Universidades Promotoras de la Salud en México: el caso de la Universidad de Sonora / Health Promoting Universities in México: the case of University of Sonora
Yanira Valle Hernández y Catalina A. Denman Champion .... Págs 9-30

Gestión de la edad en las ENL en Extremadura: la "huella generacional" / Age management within the NPOs in Extremadura: the "generational footprint"
Santiago Camberro Rivero .... Págs 31-57

El trabajo social comunitario ante la vulnerabilidad urbana: un estudio documental de regeneración de barrios / Community social work before urban vulnerability: documentary study socio-urbanistic regeneration
Juan David Gómez-Quintero, Antonio Eito Mateo, Jesús Domínguez Sanz y Mª Carmen Martínez Molina .... Págs 59-79

Outcomes of a psychosocial treatment of women affected by intimate partner violence / Resultados del tratamiento psicosocial a mujeres afectadas por la violencia íntima de pareja
Trinidad Donoso-Vázquez y Anna Velasco Martínez .... Págs 81-101

Metodología didáctica y modelos pedagógicos en la enseñanza preuniversitaria de la Comunidad de Madrid / Didactic methodology and pedagogical models in pre-university education of Community of Madrid
Eduardo López Bertomeo y Ángel Luis González Olivares .... Págs 103-124

Las transferencias intergeneracionales en España y Andalucía. Una primera aproximación al estudio de los factores explicativos en el cuidado de los nietos / Intergenerational transfers in Spain and Andalusia. A first approach to the study of explanatory factors in the care of grandchildren
Marta Ortega Gaspar y Mercedes Fernández Alonso .... Págs 125-140

Relatos de vida de personas sin hogar en la ciudad de Barcelona: desafiliación social y salud / Life stories of homeless people in the city of Barcelona: social disaffiliation and health
María Virginia Matulič Domandzič, Irene De Vicente Zueras y Jordi Caïs Fontanella .... Págs 141-157

La comunicación en mediación social y su oportunidad para el desarrollo comunitario / Communication in social mediation and its opportunity for Comunity Development
Emilia Iglesias Ortuño, Enrique Pastor Seller y Luis Miguel Rondón García .... Págs 159-184

RESEÑAS/REVIEWS

Amaya Ituarte Tellaeche (coord.). (2017). Prácticas del Trabajo Social Clínico / Clinical Social Work Practices (por Arantxa Hernández Echegaray) .... Págs 185-188

Enrique Pastor Seller (ed.). (2017). Sistemas y políticas de bienestar, una perspectiva internacional / Welfare systems and policies, an international perspective
(por Jesús Manuel Martínez Serrano) .... Págs 189-193

editorial UNIVERSITAS

UNED | FACULTAD DE DERECHO | Departamento Trabajo Social

ISSN: 2173-0512
00016
9 772173 051202