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Women's Experiences of Domestic Violence and Mental Health: Findings from a European Empowerment Project

Objective: Research shows that women experiencing domestic violence and mental health problems often fall into gaps in services between support for domestic violence and support for mental health. This article reports on an action research project adopting a strengths-based approach to recovery funded by the European Commission. Multi-method research was carried out in five European countries examining how interconnections of domestic violence and mental health impact the lives of women, how their lives can be improved by empowering strategies, and how service providers' professional learning can be developed. Women survivors' strengths and post-traumatic growth in the context of domestic violence remains a considerably under-researched area and the study provides new insights into adopting a strengths-based framework. **Method:** Free training programs were designed, delivered and evaluated for two groups of participants (n=136) pertaining to women service users, and mental health service providers (men and women) working with abused women. **Results:** Program evaluation data gained through surveys and focus groups show that women participants reported growth in self-esteem and coping skills, while professionals felt better equipped to address the tandem issues of domestic violence and mental health. **Conclusions:** Findings extend current knowledge about the barriers and facilitators to empowerment and strengths-based recovery perspectives, professional learning, and offer a more nuanced understanding of women's agential ability for post-traumatic growth.

Keywords: domestic violence, mental health, strengths-based recovery, empowerment, professional learning

Introduction

There is much research indicating that domestic violence leads to mental health problems, and emerging evidence of the 'bidirectional causal relationship' (Khalifeh, Oram,

Trevillion, Johnson & Howard, 2015b, p. 211) between intimate partner violence (IPV) and mental health disorders. However, the connection of these problems is often lost when women come into contact with support services (Humphreys & Thiara, 2003; Flicker, Cerulli, Swogger & Talbot, 2012). Another concern is the deficit discourse evident in much work on domestic violence (Hamby, 2014) as well as in mental health, which tends to attribute failures to women victims. The purpose of this project is to examine how women's traumatic experiences of domestic violence and mental health problems can be addressed working from a strengths-based recovery perspective. In contrast to deficit-based approaches 'the strengths perspective is rooted in the belief that people can continue to grow and change' (Calder, 2008, p. 135) even after enduring traumatic experiences (Calhoun & Tedeschi, 2006). Regarding literature on women victim responses to abuse, Hamby (2014, p. 3) notes that 'survivor's strengths are greatly understudied', and the current project aims to contribute towards addressing the dearth of research in this area.

New meanings have been attached to mental health recovery, traditionally narrowly conceptualised as the cessation of clinical symptoms (South London & Maudsley NHS Foundation Trust & South West London & St George's Mental Health NHS Trust, 2010). In its extended meaning, mental health recovery entails individuals feeling more in control of their lives and having increased power to make decisions, sometimes through shared decision making with professionals (Ocloo & Matthews, 2016; author citation). Individuals are supported to better manage their mental well-being, including in cases where symptoms persist, with the aim of progressing towards personally-relevant rather than uniform outcomes. Strengths-based recovery starts with identifying existing strengths which can be applied to help manage current stressors and oppressions (Wise, 2008). In the context of domestic violence, there have been calls for a reframing of women's protective efforts which have often been perceived as evidence of passivity, such as not leaving an abusive partner.

Given that ‘women respond in complex ways to violence by their partner and that the situation is more complex than staying versus leaving’ (Hamby, 2014, p. 24), a strengths-based framework can offer a more nuanced understanding of women’s responses, coping strategies and recovery experiences (Anderson, Renner & Danis, 2012). With this in mind, the aim of this study was to provide a non-clinical strengths intervention to help enable women gain personal empowerment through enhanced self-confidence and self-worth (Wise, 2008). Since an integral part of recovery promotion among abused women is their interaction with service providers, the project examines how professional learning can effectively extend providers’ knowledge and confidence regarding strengths-based interventions with women.

The focus of this study is women rather than men as more women experience domestic violence in severe and repeated forms (Women’s Aid, 2009), and 9 out of 10 victims in the European Union (EU) are women (European Institute for Gender Equality, 2013). In addition, international research shows that domestic violence adversely affects the mental health of female victims more than male victims (Harne & Radford, 2008). The project’s research questions are: what is the impact of women’s participation in a therapeutic educational training program on their strengths-based recovery regarding domestic violence and mental health; and how can mental health service providers’ professional confidence and competence be developed through professional learning to better address the needs of this client group?

Research Informing Current Study

Research into the relationship between domestic violence and mental health has found that patients with severe mental illness are substantially more likely to be the victims of domestic and sexual violence compared to the general population (Khalifeh, Moran, Borschmann, Dean, Hart, Hogg, Osborn, Johnson, & Howard, 2015a). Other studies suggest emotional abuse is often overshadowed by physical and sexual violence, and that the impact

of emotional harm may be greater than that of physical violence (Jewkes, 2010; Yoshihama, Horrocks, & Kamano, 2009). These findings underline the importance of practitioners enquiring about all forms of abuse encompassing emotional, sexual and physical. When practitioners engage in routine enquiry regarding domestic abuse, evidence indicates improved detection rates, though detection does not always inform patients' treatment plans (Howard, Trevillion, Khalifeh, Woodall, Agnew-Davies, & Feder, 2010). Despite abuse being manifested in emotional, physical, sexual and financial forms, physical domestic violence tends to receive more attention and budget allocation (Walby, 2004). Some progress is being made concerning raising awareness of the emotional harm of domestic violence, evidenced in the UK in the new offence of controlling or coercive behaviour in intimate or familial relationships which carries a maximum custodial sentence of five years, a fine or both (Home Office, 2015). In relation to the European context, findings from an EU-wide survey on violence against women by the EU Agency for Fundamental Rights (2014) showed that one-third of EU women have experienced physical and/or sexual violence since the age of 15, equating to 61 million women. Although violence and abuse are punishable by law, it is not uncommon for incidents to go unreported.

The privatized, stigmatized nature of domestically violent relationships and its ambivalent media coverage mean that many women view their abuse as a personal problem to be dealt with without accessing public services. Flicker et al. (2012) note that lack of motivation associated with depression, as well as coping strategies such as disengagement and denial, can hinder women victims from reaching out to potentially supportive services. Research has also found evidence of links between depression and anger suppression (Gilbert, Gilbert, & Irons, 2004; Goldman & Haaga, 1995) and it is possible that depression resulting from victimization may lead to anger inhibition with potential implications for women's help-seeking decisions. Another barrier to disclosure is self-blame which is

amplified among women with mental health difficulties as they may perceive themselves as provoking abuse (Rose, Trevillion, Woodall, Morgan, Feder, & Howard, 2011). Humphreys and Thiara (2003) discern that provision offered to some women by mental health services is inappropriate, such as recourse to medication over counseling, and perceiving the woman's mental health as unconnected to abuse, resulting in the abuser's actions evading scrutiny. The psychological consequences of abuse may impact on the ability of parents, primarily women, to care for and protect their children (Calder & Regan, 2008).

Research has identified how women's recovery from domestic violence can be facilitated by regular contact with trusted professionals such as social workers, positive support from friends and family, improved self-esteem and coping strategies (Song, 2012). Wise's (2008, p. 161) statement that 'the relationship between coping and empowerment is a tightly knit one, reciprocal in nature' informed our study design to include practical strategies for coping. Although women abused within the domestic sphere may encounter common experiences, their individual identities related to race, ethnicity, social class, sexual orientation, age, as well as other attributes, intersect in ways that differentiate their needs and responses to violence (Crenshaw, 1991; author citation). The issues of intersectionality and socio-political structure will impact on women's experiences of abuse. Furthermore, according to Kasturirangan (2008), empowerment processes must be flexible and adaptable to women's individual needs and values. When designing the training programs we were accordingly attentive of recovery being non-linear and recursive, and carrying diverse meanings and goals associated with the diverse realities of women's lives. The potential for post-traumatic growth (Calhoun & Tedeschi, 2006) and the strengths-based, empowering approach to recovery provided the conceptual framework for the empirical layers of the study described next.

Current Study

Funded through the European Commission Daphne III framework the current project was entitled ‘Empowering Women and Providers: Domestic Violence and Mental Health’. In a previous European project on mental health and social inclusion (author citation), when participating mental health providers were asked to identify areas in which they required further professional learning, the most commonly cited response was dealing with domestic violence. This current study was led by (author University and project code) (2011-2013) with eight partners in universities and practice organizations in the UK, Greece, Italy, Poland and Slovenia. These European states were chosen as representing contrasting socio-cultural environments with different levels of gender equality. According to the Gender Equality Index published by the European Institute for Gender Equality (EIGE, 2013), of the 27 EU member states Greece and Italy are ranked third and fourth lowest, respectively, for gender equality, while the UK is ranked fifth highest. Slovenia and Poland, both former communist countries, are contrastingly ranked eighth and seventeenth, respectively.

The study examined how women and mental health service providers working with abused women can be supported to engage in recovery promotion. We designed, delivered and evaluated free, interactive programs for the following three groups: women who experienced domestic violence and mental health difficulties; mental health providers (men and women); and women peers wishing to become co-facilitators of support groups. The first two training programs will be discussed here and referred to as Study 1 and Study 2 respectively; the latter will be discussed in another publication. As indicated by the project’s title, the emphasis was on empowering women as well as providers, namely promoting both the strengths of women participants and the professional capacity of service providers (Guo & Tsui, 2010). Study 1 was a therapeutic educational program for women, designed to increase their wellness, coping capacity, and control over their environment, by applying evidence-based interventions including self-help and mutual support strategies. Study 2 was

designed to enhance the professional confidence and competence of mental health providers through improving ways of identifying and safely managing abuse cases, increasing awareness of the impact of domestic violence and abuse on women and children, and gaining understanding of perpetrator behaviour.

Recruiting women through refuges and practice organizations reassured us that the women were in a position of safety to part take in the study. Where required, refuges and practice organizations provided childcare to enable women to attend the training. Individual countries gained ethical approval from their respective research ethics bodies and an international advisory group was convened to help inform the project.

Method

Participants

The overall recruitment target for Studies 1 and 2 was 150 comprised of 100 women service users and 50 providers. In practice 136 participants were recruited comprised of 62 women and 74 providers. Recruitment of Black and Minority Ethnic (BME) women was low in all partner sites, discussed further below.

In Study 1 women who had contact with primary care, welfare services or refuges were recruited. Women living in a refuge, or those in acute admission mental health facilities were excluded. The 62 women recruited comprised 6 in the UK, 19 in Greece, 6 in Italy, 23 in Poland and 8 in Slovenia. For the purpose of inclusion, women with any mental health condition or symptom of abuse were eligible and such symptoms included depression, anxiety, emotional distress, trauma symptoms, self-harm and attempted suicide. In the six months prior to starting the program, over a third of women (38.7%) had been on psychiatric medication, nearly a fifth (19.4%) had self-harmed, and over half (53.2%) had used police services, the purposes of which included being taken to hospital and protection when

attending court. Most women (87%) had children. The age range of women participants was 25 to 62 and their average age was 40.63 (SD = 9.728).

Just under a fifth of women (19.4%) had left school aged 16 or younger. Those who had attended university totalled 29%, illustrative of domestic violence cutting across education levels. In terms of work, 30.6% of women were employed full-time or self-employed, and 9.7% worked part-time. A minority undertook voluntary work whilst the largest proportion, 45.2%, were not currently in paid employment.

The length of time women participants experienced domestic violence ranged from 5 months to 40 years, with the average being 8.943 years (SD = 8.887). The length of time they had experienced mental health distress for which they had consulted their doctor or mental health provider ranged from 2 months to 17 years, averaging at 4.071 years (SD = 4.520). While most women had experienced domestic violence for longer than mental health problems, the reverse was true for 6 women (9.7%), and co-occurrence emerged in the cases of 7 women (11.3%).

In Study 2 mental health providers were recruited through practice organizations encompassing specialist mental health services, welfare services and charities. The 74 recruited providers comprised 9 in the UK, 13 in Greece, 15 in Italy, 12 in Poland and 25 in Slovenia. 90% were women and 10% men and included social workers, nurses, psychologists, occupational therapists, educators, counselors and refuge workers.

Procedures

Program and evaluation material was developed jointly by all teams in English and translated by project partners; participant responses were likewise translated into English by partners. The programs were delivered on university campuses or at practice organizations by experienced facilitators including professionals from women's refuges. In Study 1 the program for women was designed to be of 8 weeks' duration, with participants meeting once

a week for half a day. This was followed by 5 refresher sessions enabling us to have contact with participants for the generation of follow-up data, and ensuring our methodology was not one of parachuting in, collecting data and leaving. In Study 2 the program entailed 4-8 one-day sessions depending on work load commitments of participating professionals. Partner sites were afforded scope for tailoring programs according to local requirements.

Study 1 training sessions with women covered strategies for assertiveness, asking for help, safeguarding, relaxation; identifying and sharing strengths; discussing labels concerning domestic violence and mental ill health; reforming relationships with children; managing anger, and managing depression. Women were given a treasure folder on the first day to keep empowering thoughts in one place and to add coping strategies each week. Participants were invited to locate their experiences on the Duluth Power and Control Wheel and Equality Wheel where applicable. During training sessions they were supported to develop their Wellness Recovery Action Plan (WRAP) devised by Copeland (1997), discussed below.

Study 2 training provided examples of enquiring questions professionals could use with clients, facilitated by role-play. Intervention models with families, couples, and individuals were examined along with referral pathways. Disclosure was defined as often requiring time rather than being a one-off question and answer event. Training also promoted awareness of abuse experienced by women in mental health services without disclosure, and awareness of the provider's attitudinal response. It addressed the sense of helplessness and hopelessness providers sometimes experience, leading them to ignore the domestic violence experience and to avoid disclosure, often referring women to other services only for them to come back to mental health services as their mental health needs were left unmet. The program aimed to increase providers' knowledge, confidence and skills for strengths-based, empowering interventions with these women.

Evaluations eliciting quantitative and qualitative data were administered at pre-program (T1), immediate post-program (T2) and 6-month follow-up (T3) stages to establish whether the training was effective and to observe possible longer term effects. In Study 1, at the T1 and T3 data collection stages, women participants were invited to respond to sections of the WRAP (Copeland, 1997). In Study 3, T3 data were collected from mental health providers through self-completion surveys sent via email. There was, however, attrition between data intervals: T1 comprised 62 women and 74 providers; T2 comprised 38 women and 57 providers; T3 comprised 33 women and 25 providers. The implications of attrition rates are discussed further in the limitations section.

Prior to written evaluation questionnaires being administered, site researchers checked with refuges and practice organizations whether women participants had literacy needs and, if so, questions were asked verbally of women and their responses written down. It was emphasised to all women participants that there were no right or wrong answers to questions posed on the evaluation forms, and that it was the support services they had been provided with which were being evaluated rather than their individual behaviour.

To gain a more holistic picture of participants' program experiences in Study 1 and Study 2, training facilitators provided a written post-session overview in narrative form. These anonymised accounts enabled us to learn about individual and group engagement with the content and process of the sessions. Additionally, in Study 2 focus group discussions were led by site researchers on the last training session for mental health providers, though not on the women's program in Study 1 as group-based data generation was not deemed appropriate in this context. At the end of the study overall group findings were sent to program participants who expressed an interest in receiving feedback.

Codes for analysing data emerged inductively during the process of analysing participant responses, and also deductively through being theoretically informed by existing

literature (Saldaña, 2016). Qualitative data were analysed for themes, and content analysis was undertaken where recurring language patterns emerged. Quantitative data were analysed using SPSS (Statistical Package for the Social Sciences) version 23. One of the UK women participants was interviewed about her training experiences, the video of which can be accessed through YouTube (<http://youtu.be/N2yxGqQRqaQ>).

Measures

In Study 1 women participants completed scales at T1 and T3 to examine evidence of change. The rationale for scale selection was based on domestic violence victimization having psychological consequences for self-esteem, depression and anger, and suitable measures were deemed to be: Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965), Center for Epidemiological Studies Depression (CES-D) Scale 10 Items, (Irwin, Artin, & Oxman, 1999), and Novaco Anger Scale-Provocation Inventory (NAS-PI) (Novaco, 1994). Research has shown the RSE Scale to have high ratings in reliability and construct validity (Robins, Hendin, & Trzesniewski, 2001). The CES-D Scale has high internal consistency and repeatability (Radloff, 1977), as well as reliability and validity across countries (Van de Velde, Huijts, Bracke, & Bambra, 2013). The NAS-PI demonstrates excellent internal consistency, and good test-retest reliability and validity (Hornsveld, Muris, & Kraaimaat, 2011). In study 2, at T1 and T3, mental health providers completed the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) (Short, Alpert, Harris, & Surprenant, 2006). PREMIS has good internal consistency, is a reliable tool for measuring physician preparedness for managing cases of IPV, and can be used to assess the effectiveness of IPV educational programs (Short et al., 2006).

This article presents evaluation data based on key findings from Studies 1 and 2, with the women's therapeutic educational program forming the main focus as it was their oft-silenced voices which we predominantly wished to listen to and learn from.

Results

Findings from Study 1

Themes of self-esteem and survival

When analysing data from Study 1, dominant themes of reconstruction and looking to the future were identified at T1. On the question of what they hoped to learn from the program women's responses included aims for recovery and self-esteem: 'To gain a better sense of self-worth; to understand my feelings; to lessen my mood swings' (woman, Italy, T1). The cumulative effects of gradual undermining of confidence and instilling of fear resulted in some women participants navigating complex emotions: 'How to avoid subordination. How to lose the fear. Learn my personality' (woman, Slovenia, T1). To 'learn my personality' appears to be suggestive of how a victim's personality and sense of self can become lost to abuse, discussed in more detail below. The psychology of domestic violence often leads to fear and anger becoming closely associated and the intertwined nature of emotions came through in women's data: 'To be assertive, to cope with anger, to know my strength' (woman, Poland, T1).

Evaluation data revealed some of the ways women can be supported on their own paths towards personal recovery, underlining the variance in coping choices. This emerged at T1 in response to whether there were any areas they would rather the therapeutic educational program did not focus on; 11 out of 62 women (17.7%), cross-nationally, stated they did not wish to talk about personal matters or specific incidents that had happened to them which aligned with the program's ethos of foregrounding women's strengths. However, these findings highlight the careful balance needed between focusing on recovery and dealing with past events which should not be conceptualized as mutually exclusive; for some, though not all, recovery will entail revisiting past experiences, in a constructive way, in order to move forward.

At T2, alongside themes of renewal were those of survival and protecting children. Being unable to provide protection can affect women's sense of personal failure which may be amplified by mental health problems. Erosion of self-worth is a common effect of abuse, and reduction in life purpose a depressive symptom. So low was their self-esteem that some women reflected on how they had found the training (re)affirmative of self-worth and purpose: 'To keep in mind that I am worthy as a human being' (woman, Greece, T2), 'Life has more meaning than I used to believe' (woman, Greece, T2). Although the psychologically harmful effects of abuse can be heard within the women's responses, they articulated a language of strength and recovery rather than victimhood. A dialectical relationship appears to exist between increased mental well-being and decreased self-blame.

Best and least satisfactory aspects of women's program

One of the best aspects was being able to talk about experiences with other women as well as with program facilitators. The recurring subject of self-blame was mentioned but referred to with positivity in terms of women making progress towards overcoming it: 'To understand that I'm not the only woman in this situation and that I'm not guilty' (woman, Italy, T2). Having feelings affirmed and legitimated by the program also proved an integral part of women's capacity for post-traumatic growth as did the security of the setting itself: 'The best thing was being able to understand my feelings and them to be ok. Also to feel secure with the people around me and comfortable to talk about anything' (woman, UK, T2). Personal reflections of 'I'm proud of myself' (woman, UK, T2) and 'To see how I have changed' (woman, Poland, T2) denote women's pride on completing the training.

When asked about the least satisfactory aspect of the program the most commonly identified theme cited across all partner sites was that of not having enough time to cover matters in sufficient depth. There were, however, some positive spin-offs from the program's brevity in the form of precipitating women's individual agency: 'The program needs to be

longer to explore different feelings and experiences. Things were cut short due to time keeping. As a result things were left and I needed to deal with feelings on my own but this did show me I can!' (woman, UK, T2).

Study 1 – Self-esteem, depression and anger scores

Mean scores from the RSE Scale, CES-D Scale, and NAS-PI are given in Table 1. Due to small sample sizes, overall findings are given in preference to cross-country comparisons.

Table 1 here

For the RSE Scale, scores below 15 indicate low self-esteem while those between 15 and 25 suggest normal range. Women's baseline score of 13.3 rose to 18.6 at T3 thus demonstrating increased self-esteem. On the CES-D Scale, lower scores indicate fewer symptoms, with a cut-off score of 11 differentiating between significant or mild depressive symptoms. Although women's T1 depression score of 13.7 decreased to 13.0 at T3, they remained in the range of significant symptoms. NAS-PI scores range from 0 (no anger) to 100 (frequent, intense anger). There was reduction in women's anger score of 66.6 at T1 to 64.4 at T3, but both scores came within the average anger range of 56-75.

Findings from the scales were triangulated with women's qualitative responses. Increases in responses to the RSE Scale corroborate aforementioned findings gained through open-ended evaluation questions. The picture to emerge from the other scales was less pronounced. While there was modest reduction in women's depression and anger overall, there were increases in depression and anger among some participants, suggesting potentially confounding findings in need of further explanation. To this end, it is perhaps useful to refer to the link between depression and anger suppression, described above, where depression can lead to inhibition of anger. Hence, a consequence of decreased depression could be an increase in anger. This may help explain the convergence of quantitative data for depression

and anger amongst some women since their responses show decreased depression but increased anger. Furthermore, in the context of domestic violence, the issue of righteous anger appears to represent part of the explanation. Again, cross-checking with qualitative findings shows that women spoke about their feelings of anger and guilt and their realization, through the program, that the abuse was not their fault. It is possible for there to be positive by-products to experiencing and harnessing anger exemplified in the words of one participant who had experienced domestic violence for 18 years: 'I have discovered my anger! Thank you' (woman, Poland, T2). The patterns of data from the validated scales, complemented by qualitative data, could be interpreted as evidence of women's individual and collective conscious raising during their training.

Study 1 – Wellness Recovery Action Plan responses

Women's responses to the WRAP (Copeland, 1997) on the T1 and T3 evaluation forms were compared. Self-identified aspects that supported women's wellness at T1 were first and foremost contact with children, family, friends and welfare services. Additional responses were: going out socially, travelling, focusing on job, helping others, television, reading, painting, sleeping, music, relaxing, eating, shopping, alcohol, smoking, and anti-depressants. Physical activities such as dancing, horse riding, cycling, walking and being with nature were cited too. Cleaning the house was mentioned - indicative maybe of women wresting back some control over their environment. A minority expressed a preference for being alone and silence. 'Nobody has [the] right to humiliate me' were the sentiments on one woman's recovery plan (Poland, T1). Through writing their WRAP some women engaged in constructive critique of themselves as well as those around them: 'I learnt that my threshold of tolerance for domestic violence is too high. I learnt that I am not responsible for other's action' (Slovenia, T1). Women in Poland, Greece and Italy were more likely to refer to

praying, faith, God and church in comparison to those in the UK and Slovenia who made no religious references on the WRAP at either the T1 or T3 stages.

Contact with children, family, friends and welfare services also topped women's T3 WRAP responses followed by recreational activities and religion, although alcohol, smoking, and anti-depressants did not appear. New T3 responses included keeping a diary and taking care of appearance along with recognition of recovery signifying improved ability to live with continuing symptoms: 'I thought moving away would make everything go away but I know that certain things will always be there, but I can manage them' (woman, UK, T3). The recurring issue of self-worth having been undermined by abuse was also evident on the WRAPs at T3: 'I repeat [to] myself that I am a valuable person, truthful, that I can realize my aims' (woman, Poland, T3), 'I learnt that my life is as important as the others' (woman, Italy, T3).

Study 1 impact of training

In response to the request to describe their experiences of attempting to put into practice aspects covered in the program, women at T3 reported that relationships with their children had improved: 'I learned to take care of myself and protect my children from violence' (woman, Greece, T3). Others reflected on their increased self-awareness: 'Realizing I'm stronger than I think by speaking up' (woman, UK, T3).

Based on the narrative accounts of the women's program from the session co-facilitators, we learnt that many women had contact with each other socially in between sessions, thus augmenting their social support network often beneficial in increasing self-esteem: 'I made new friends that I can trust' (woman, Greece, T3). In response to which aspects of the training should continue in future programs, one participant noted 'The understanding it's not our fault' (woman, UK, T3). Here the use of the collective pronoun 'our' could symbolize group solidarity and collective consciousness raising.

‘I found ways to manage my anger’ (woman, Greece, T3) and ‘I managed to stop drinking alcohol when being in a bad mood’ (woman, Greece, T3) convey women’s ability for agentically implementing their learning. One participant from Slovenia explained she was now able to stay calm when she visited different institutions who wished to simply send her away. Relaxation skills and breathing techniques practiced during training sessions were regarded as easily translated into practice and effective. When asked to comment on the best aspects of the program women’s continuing development was in evidence: ‘Helping me to understand where I am in my recovery at this moment in time’ (woman, UK, T3). The therapeutic opportunity to deal with the emotional after-effects of abuse had a positive impact on women’s coping ability: ‘[The program] has made me a stronger person already and [I] would love to help other people who are in or out of the same situation. I feel no shame for what I have been through anymore’ (woman, UK, T3). In reference to how the program might help in the future, potential benefits straddled personal and public domains: ‘In all fields. From the work to the private life’ (woman, Slovenia, T3).

Women’s sense of self

While the program positively impacted both the personal and public spheres of women’s lives, it was in relation to women’s sense of self that affirmative effects and aspirational aims were primarily expressed. The psychological harm of domestic violence, exacerbated by its inherently private nature, can lead to the rupturing of women’s sense of self and to feeling anonymous, unknown. This was encapsulated by one woman whose therapist had told her ‘nobody has a right to say you are no one’ (Poland, T1). Study 1 data across the three data collection intervals highlight the recurring theme of *self*. The participant-generated language cited below demonstrates the importance of women’s psychological autonomy and self-concept. The two most commonly stated themes concerning ‘self’ were self-esteem (cited 44 times) and self-confidence (cited 22 times). The

many affective and aspirational responses in the list below were articulated by multiple women (order of responses is not indicative of weighting):

self-esteem, self-confidence, self-belief, self-awareness, self-worth, self-efficacy, self-evaluation, self-defence, express myself, respect myself, take care of myself, talk about myself, know myself better, feel better about myself, help myself, self-help groups, doing things for myself, learn more about myself, reflect upon myself, accept myself, change myself, be more kind to myself, invest in myself, develop myself, not pity myself, support myself, train myself, strengthen myself, not isolate myself, understand myself, stand up for myself, look after myself, protect myself, I like myself as I am, learn how to love myself

Findings from Study 2

The mental health providers' program aimed to develop professional confidence and competence. When asked what they would like to achieve as a result of the training participants wished, firstly, to be better equipped to identify and manage cases of domestic violence; to learn how to talk with potential victims and how to react upon seeing evident violence; to improve skills in accessing and signposting professional help and knowledge of legal issues. They were keen to pre-empt and avoid aspects of poor practice as one participant noted: 'what kind of mistakes I shouldn't make dealing with domestic violence victim' (provider, Poland, T2). Secondly, providers wished to have increased awareness of the links between domestic violence and mental health and the extent to which links were causal. Their professional practice entailed working simultaneously with vulnerable and potentially aggressive clients, including involuntary clients, which brought risks resulting in one participant wishing to learn 'how to defend myself from others' aggression' (provider, Poland, T1).

The desire among professionals for the training program to provide ‘concrete examples’, ‘concrete knowledge’, ‘concrete actions’ and ‘concrete exercises’ could signify a lack of confidence for working in this sensitive area, and/or a wish to gain tried and tested practices. Alongside having tangible strategies some providers wanted to be able to tune into cases where abuse was less perceptible: ‘Learn to read the signals and the silent pleas for help’ (provider, Italy, T1). From the descriptions of the providers’ training program provided by the session facilitators it emerged that a minority of participants felt ‘overwhelmed’, ‘surprised’, even ‘shocked’, at the scale and statistics relating to domestic violence, but were keen to be given training materials and resources to develop their professional learning still further.

Study 2 – Practitioners’ readiness for IPV work

Mental health providers’ completed the PREMIS tool at T1 and T3 regarding their readiness to manage cases of IPV by indicating their strength of feeling towards listed statements on a scale from ‘Strongly Disagree’ (1) to ‘Strongly Agree’ (7). Due to space limitations items most salient to this paper are included in Table 2.

Table 2 here

The difference between the means at T1 and T3 is statistically significant ($p < 0.05$) for one item related to being capable of identifying victims of IPV. Analysis by percentages shows that less than half of providers (44.6%) at T1 agreed they were capable of identifying victims which rose to 56% at T3. Providers’ responses at T1 and T3 show that 66.3% and 68%, respectively, agreed that victims of abuse often have valid reasons for remaining in the abusive relationship. More than three-quarters (77%) at T1 disagreed that victims of abuse must accept responsibility for continuing abuse if they remain, yet this figure declined to 60% at T3. Just under half (49.3%) agreed they did not have the necessary skills to discuss abuse with a victim at T1 which decreased to one third (33.4%) at T3. Whereas nearly half (47.9%)

felt unable or neutral concerning gathering the necessary information to identify IPV as the underlying cause of patient illnesses at T1, this proportion halved to 24% at T3. Overall, responses suggest that both identification and discussion of victimization were more problematical for service providers at T1, hence their pre-programme appeal for the training to provide ‘concrete’ working strategies. Findings at T3 indicate improvement in providers’ skills and readiness for IPV work.

Study 2 impact of training

Consistent with quantitative data, in focus groups at the end of the training providers reported increased knowledge and skills for working with this client group: ‘From a professional point of view now I feel like I have more tools’ (focus group, Italy), ‘New knowledge helps me to broaden my view and contributes to my thinking how can I work with the people and how to start the conversation with service users’ (focus group, Slovenia). Having new knowledge and tools enhanced their belief in their own abilities regarding domestic violence: ‘I feel more confident about looking out for it and dealing with it’ (focus group, UK).

Just as women in Study 1 had found the safety of the setting conducive to sharing experiences, so too did providers in Study 2 discern the environment played a role in making them feel safe enough to disclose their thoughts and experiences. Providers welcomed the fact that training facilitators and invited speakers were practitioners working in various fields connected with domestic violence, such as midwifery, and their ‘passion’ for their professions was transmitted. As much as mental health providers valued the passion and expertise of training facilitators and invited speakers, they would welcome hearing first-hand accounts from survivors too, especially positive ones of how barriers were overcome and which services worked well. In relation to the training in Study 2, an appropriate balance between theory and practice, including ‘practical examples’, had been achieved, though the

training was commonly seen as too short. Some providers discerned a gap between their training needs and the training opportunities open to them. This, they perceived, was contradictory to the declared objectives of having well trained practitioners, and also counterproductive since they viewed investment in them as workers would be cost effective in the long term through improved management of cases.

Although providers found it beneficial attending the training with a range of professionals, some suggested practitioners from different areas of service provision also undertake the training, citing general practitioner doctors, hospital doctors, paramedics, psychiatrists, therapists and the police, in order for multi-agency training to facilitate multi-agency working. Indeed, following the training providers reported evidence among some professional colleagues of continued pockets of resistance to work in this area, and a lack of inter-agency working including with the police.

Discussion

In this project, a focus on empowering both women and mental health providers underpinned a strengths-based perspective regarding the interconnections of domestic violence and mental health. Women spoke of their increased self-esteem and sense of empowerment, and providers of their increased confidence and competence, with both parties aware that their respective areas of development were ongoing.

Recognizing they were not responsible for their own abuse was an essential part of women's recovery since self-blame is exacerbated among those with mental health problems (Rose, et al., 2011). Findings in this project signal a fresh resonance with Kelly's (1988) research which found evidence of women expressing anger at the years they had blamed themselves for abuse. We saw earlier how the issue of righteous anger, often borne of victim-survivors discharging themselves of guilt, was experienced by some women participants. Women's WRAP comments at T3 told of a resurfacing of self-worth suggestive

of progress in their strengths-based recovery and concur with Wise's (2008, p. 153) discernment that 'One indication that a person is living from a position of personal empowerment is the refusal to accept or tolerate devaluation of themselves or of others'.

The impact of domestic violence can evidently lead to a reversal of responsibility thereby reinforcing notions of an individualized problem rather than a societal public health issue (Carlyle, Slater & Chakroff, 2008). Women's responses refer to blame, guilt, shame and humiliation. Our related research into media representations of domestic violence found evidence of victim-blaming and sexualising violence against women (author citation). There is evidence, then, of a paradox regarding, on the one hand, women participants' individual and collective strengths-based recovery documented above, and, on the other, continuing wider media representations of a victim-blaming narrative.

Professional work concerning domestic violence requires advanced levels of skill (Flegg & Bell, 2008). Yet results from the PREMIS tool in Study 2 showed that at the beginning of their training more than half the mental health providers perceived they lacked the necessary skills to identify IPV cases. This is especially significant in light of research demonstrating that victims with pre-existing mental problems are more likely to disclose IPV to service providers than to informal social networks, thereby emphasizing the pivotal part played by providers in uncovering IPV and supporting victims (Khalifeh et al., 2015b). Despite having a key role in disclosure, research has found that primary care and mental health professionals cite their insufficient knowledge and readiness to manage IPV cases as contributing to their continued under-detection of IPV (Rose et al., 2011). There is congruence here with mental health providers in this study who identified disparity between their training needs and availability of training opportunities.

Methodological lessons have been learnt too. In the UK, when the two co-facilitators of the women's program started the training sessions at (author University), the importance of

having rooms with windows came to light due to the sensitive nature of the sessions. This led to university rooms needing to be re-booked for the remaining sessions to ensure women's needs were met. Furthermore, training certificates were awarded to all participants at the end of training. Significantly, several women asked if it was possible to be given two certificates, one in their former name and one in their new name since they had assumed new identities for protection purposes. These women appear to have retained, maybe regained, elements of their core self-identity and wished this to be so reflected in their named training certificates.

Limitations

One of the limitations of this study relates to the recruitment of women participants in general and those of BME heritage in particular. In line with previous research, women of BME heritage may find it more difficult to seek help due to cultural pressures and family honour, and due to fear of institutional and societal racism (Harne & Radford, 2008). Furthermore, despite being able to enter the training through the self-referral route (subject to their family doctor's agreement), very few women did so. The requisite confidence and opportunity to embark unilaterally on training without the intermediary of an existing contact at a women's refuge, practice organization or social worker was underestimated in the preparation of the project. This has, however, highlighted the importance of further nurturing community-university engagement, and developing partnerships between practice organizations and informal contacts, such as community leaders (Ocloo & Matthews, 2016), religious and social networks, employment, education and disability networks, in order that diverse populations may be more fully represented in future research projects.

Further limitations are the project's small sample size and attrition rates between data collection stages. Although sample size raises questions about the generalizability of findings, we hope quantitative findings will at least provide an indication of overall patterns among participants, enriched by more in-depth qualitative data.

Research Implications

This study raises questions about the extent to which welfare services are available to, and being accessed by, different cultural groups across Europe, particularly pertinent in the current context of increased refugees to the continent. Future research projects should consider Europe's changing demographic contours and help ensure participants are recruited from more ethnically diverse populations.

Clinical and Policy Implications

The non-clinical, empowering interventions offered in Study 1 and 2, including the value of group solidarity, the reduction of guilt and the increase in self-esteem for the women, and the increase in awareness of undisclosed domestic violence and the acquisition of new skills for the providers, highlight the value of a strengths-based, empowering approach. Sharing strategies for self-help has fed into women's agential ability for ongoing empowerment and growth in self-worth, and enhanced their capacity to support and protect their children. The wish for training programs in Study 1 and 2 to be of longer duration and to cover multi-layered issues in greater depth suggests continuing need for such provision.

The feedback from mental health providers to hear first-hand accounts from survivors of how they have been supported has been taken on board. Where appropriate, subsequent training and well-being events have included victim-survivor speakers, exemplifying our commitment to research-informed teaching and practice, as well as enabling survivors to play an impactful role in awareness raising.

While personal learning and professional learning have been advanced as a result of the programs in this project, addressing the training gap among mental health providers is essential in facilitating optimal response to those in need. Encouragingly, knowledge of domestic violence is progressing in several fields and examining the under-researched area of

domestic violence and mental health from a strengths perspective is testimony to how far we have come, but also how far we still have to go.

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Table 1

Study 1 Mean Scores at Baseline (T1) and 6-Months Follow-Up (T3)

Scale	Score range	Mean Scores All Countries	
		T1 (n=62)	T3 (n=38)
Rosenberg Self-Esteem	0-30	13.3	18.6
CES Depression (10 items)	0-30	13.7	13.0
Novaco Anger	0-100	66.6	64.4

Table 2

Study 2 PREMIS Scores at Baseline (T1) and 6-Months Follow-Up (T3) showing Mean, Std. Deviation and T-Tests between T1 and T3

Statement	All Countries T1 (n=74) T3 (n=25)				
	Mean		Std. Deviation		P-value
	T1	T3	T1	T3	
I am capable of identifying victims of intimate partner violence.	4.07	4.72	1.427	1.370	.049
If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.	2.53	2.68	1.769	1.676	.699
I don't have the necessary skills to discuss abuse with a victim.	4.01	3.38	1.822	1.663	.132
Victims of abuse often have valid reasons for remaining in the abusive relationship.	4.64	4.56	1.540	1.227	.825
I am able to gather the necessary information to identify intimate partner violence as the underlying cause of patient illnesses (e.g., depression, migraines).	4.32	4.96	1.589	1.369	.073