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LESSONS FROM THE TRAINING PROGRAMME FOR WOMEN WITH DOMESTIC VIOLENCE EXPERIENCE

Abstract

It is well recognized that trauma of domestic violence has destructive impact on somatic and mental health – hence quality of life. In Poland today's assistance programs provide a quite wide range of services, including emergency shelter, crisis intervention, support groups and counselling services. While health care providers may be successful at treating the acute effects of domestic violence, these effects are not sufficiently linked to the restoration of victims' wellness and reestablishment of their connections with the community – hence social inclusion. The aim of this paper is to share with academics and mental health practitioners the experience of developing and piloting training programme for women with domestic violence experience. The objective of this descriptive study is to investigate participants' reaction to the intervention "Living better with the experience of domestic violence and mental health difficulties". The training was developed during the DAPHNE III Empowering W♀ project, and conducted in five countries: Greece, Italy, Slovenia, Poland, and United Kingdom. In Warsaw there were five hours workshops twice a month over sixteen weeks with six subsequent refresher sessions conducted once a month. The participants found it to be a very positive experience: effective and supportive. These results need replication and further work to identify what were the preconditions for making it such a worthwhile experience and how this could be replicated on a wider basis.

Introduction

> …*The [violence] victims want: the restoration of their honour and reestablishment of their own connections with the community…*(Herman, 2005, p. 585).

Domestic violence has been recognized as one of the most serious and widespread public health issues facing women that occurs in every culture and social group (Daoud et al., 2012; Garcia-Moreno et al., 2006; Gracia, 2004; Herman, 2005). In 2004, in Poland the survey was carried out as the International Violence Against Women Study (IVAWS). The national sample of 2009 randomly selected women between 18 and 69 years of age was interviewed by face-to-face contact. Over 1/3 of women have been subjected to physical, sexual or both types of violence during their life. The most frequent type of violence against women in Poland was physical violence. In many cases it was accompanied by sexual violence. The overall indicator of victimization in Polish survey of violence against women amounts to about 35% for lifetime, 17% in a five-year period and 6% for a 1-year period (Gruszczyńska, 2007, p. 3-4). The unsatisfactory police services interventions (as stated by responders) – contribute to the recurring victimization of women and is the serious barrier to overcome their trauma. According to The Public Opinion Research Centre (2010) – research and marketing information company in Poland –

the domestic violence victims in 61% are women. They are victims of sexual violence in 90%, physical violence in 63%, psychic violence in 64% and economic violence in 70%. More than half responders (60%) know in their surrounding at least one family in which there was a violence against women. The authors of the survey emphasize that the data is underestimated.

Abuse has devastating physical and psychological consequences for women – the "symptoms of abuse" (Humphreys & Thiara, 2003), the "battered woman syndrome" (Walker, 1991). The victims face post traumatic stress disorders (PTSD), depression, anxiety, phobias, current harmful alcohol consumption and psychoactive drug dependence (Coid et al., 2003; Fischbach & Herbert, 1997; Humphreys & Joseph, 2004; Roberts et al., 1998). They often report: low self esteem (Shields & Hanneke, 1983), low self efficacy often seen as learned helplessness (Walker, 1989), difficulties in dealing with negative emotions (Hajdo, 2007).

In Poland today's programs for victims provide a range of services, including emergency shelter, crisis intervention, support groups, counseling services. While health care providers may be successful at treating the acute effects of domestic violence, these effects are not sufficiently linked to the restoration of victims' wellness and reestablishment of their connections with the community – hence social inclusion. In this context the promising solution in assisting women with domestic violence experience seems to be training intervention based on lifelong learning, recovery and empowerment paradigm. Group work addresses all traumatic experiences levels – individual, organizational and social. It equips the individual with an instrument of self-determination, provides competency awareness and strengthens self-esteem. Sometimes it triggers the decision of disclosure which might be a starting point to abandon abusive relationship. Being a training group member one can learn from each other, give and gain support, exchange information and share experiences.

Lifelong leaning, recovery and empowerment

> *Lifelong learning is the development of human potential through a supportive process which stimulates and empowers individuals to acquire all the knowledge, skills, values and understanding they will need throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments* (Longworth, 1999, p. 2).

Recovery can be defined in many different ways but one approach is to see it as a process of individual discovery, encouraging hope and formulating realistic goals. According to Farcas (2007) recovery is a non-linear, multidimensional, individualized process that reach beyond symptom reduction. In recovery narratives people describe the following experiences: it is the reawakening of hope after despair, it is breaking through denial and achieving understanding and acceptance; it is moving from withdrawal to engagement and active participation in life; it is active coping rather than passive adjustment; it is moving from alienation to a sense of meaning and purpose, it is not accomplished alone – the journey involves support and partnership (Ridgway, 2001). The fundamental goals of the recovery movement are: the re-establishment of normal roles in the community, the developments of a

personal support network and an increased quality of life. The idea of learning and empowerment facilitate the process.

The idea of Personal Recovery Plan originated as well as from the increased attention paid to the assessment of clients' personal construct systems and meanings (Lyddon et al., 2006; Van Geel & De Mey, 2004) as well as from Personal Development Plan (PDP) – the tool derived from management and education to help people to clarify what and when to change. Working on personal recovery plan is hopeful, meaningful, self-determined and empowering exercise. It supports the recognition that recovery is about moving forwards rather than returning to a place before the crisis occurred (Anczewska et al., 2009).

The Wellness Recovery Action Plan – WRAP (Copeland, 1997) is an evidence-based system that is used world-wide by people who are dealing with mental health and other kinds of health challenges and by people who want to attain the highest possible level of wellness. It was developed by a group of people who have a lived experience of mental health difficulties and wanted to work on their own recovery; people who were searching for ways to resolve issues that had been troubling them for a long time. WRAP involves listing personal resources, Wellness Tools and then using those resources to develop Action Plans to use in specific situations which are individually determined. Using WRAP as a framework people can develop an effective approach to overcoming distressing symptoms and dysfunctional behavior patterns.

Empowerment is a term broadly used across the disciplines of sociology, psychology, politics, education, service administration and health promotion. It encompasses a number of phenomena which might be related to: changing the social perception of domestic violence victims, reforming the operations and rationale of their care and social welfare, changing the intra-psychic and behavioural dimensions of women themselves.

The training process and structure

The training was developed during the DAPHNE III Empowering W♀ project and conducted in five countries: Greece, Italy, Slovenia, Poland, and United Kingdom.

In Warsaw (Poland), women with domestic violence experiences were contacted through emergency shelter "DOM". The decision to participate in the training was strictly voluntary, based upon the information provided by the shelter team. The only exclusion criteria were as follow: acute crisis and work place violence experience.

The training "Living better with the experience of domestic violence and mental health difficulties" prioritise a "three-fold concept": sensitivity and awareness, knowledge and understanding, individual practice. The training process took place over sixteen weeks with six subsequent refresher sessions once a month. There was an emphasis on developing personal strengths and coping skills. A Personal Recovery Plan as well as Wellness Recovery Action Plan was part of the *curriculum*.

Each teaching session lasted about five hours with short breaks. The teaching sessions were organised on two Saturdays monthly in order to not interfere with participants occupational and family duties. The module was designed to be

delivered in eight sequences with the exercises: *In what kind of the group I would like to be? In what kind of the group I would dislike to be? Emotions' dealing, Big Wind Blows in specific: focus on strengths, My Personal Recovery Plan, Finish the sentence: I admire other people, because they..., The Way to My Goal, What helps me in my recovery? Wellness Recovery Action Plan, Breathing and Imaginary Technique, Autogenic Training, Progressive Muscles Relaxation, Making the Thought-Mood Connection, Two Column Technique – good and bad sides of anger, Managing Anger, Using Imagery in Working with Anger, Responsibility Pie, Power and Control Wheel, Safety Planning, How assertive am I? What are the benefits of assertiveness? My rights and boundaries.*

Participants

23 women were recruited to participate in the training.

The mean age of the participants was 47 years. 15 women had higher education but only 8 were in full time employment. 11 women were married, 3 were divorced, 3 – separated and 1 was widowed. The mean number of children was 2. Women had been experiencing violence for 16 years on average.

Nearly 50% (11 out of 23 women) reported that good and satisfying relationships with friends and family are their major resources which help to support their wellness. 4 women mentioned physical activity to be of great use. More than 50% (13 women) were not able to list things they would like to try to support their wellness which may indicate that there is a call for guidance in this respect. For 5 participants faith in God was a source of sense of meaning or significance and inspiration, followed by children and family.

Participants' reactions to the training

Participants' expectations towards the training focused on new knowledge and skills. Examples included: to learn to be assertive, to cope with anger, to know my strength; to learn how to accept the situation and accept it; to learn self-confidence and sense of womanhood; to cope with my anxiety, to be assertive, to improve my self-esteem; to cope with stress, to improve self-esteem, to put aims and realize them, to take care of my needs; to be assertive and know how to put boundaries, to improve self-esteem, how to get rid of fear (people, shouts).

11 participants were interviewed during post training assessments. Only 1 person stated that she had gained little information, other women were satisfied with the amount of knowledge they learnt.

All of the participants, who took part in the sessions showed full engagement with the training. Women which during the first two sessions were laud, even hostile became calmer. Anxious and fearful women became more open. They underlined that talking of their strengths was helpful and made them feel good. The most problematic issue was identifying personal goals – participants were wondering why but no definite conclusion was made. Very diversified feelings and reactions were observed during relaxation training – new experience and doubts regarding this technique effectiveness. During the fourth, and the following sessions women shared: friendliness, thankfulness, gratitude and admiration to each other and facilitators. Majority of them demonstrated satisfaction, pride regarding

achievements and hope for the future. They stated they have lived in isolation and participating in the training let them build new relationships and rebuild the old ones. They discovered many similarities with others participants life situation and learn from each other. Majority of them noticed they needed to practice acquired knowledge and skills in everyday life.

Some examples of participants' views:

the most useful was to see how I have changed, self-evaluation regarding what I have done and what is in front of me; training on coping skills in crisis, relaxation – it helped me a lot, however I doubt it; I liked that we have "opened" ourselves; I have discover my anger! Thank you.

Some comments on refresher sessions:

they helped to work on several issues which we have been trained; occasions to have more contacts with so experienced and skillful professionals; they helped to recall me the training material; more supportive than I have expected; I didn't realise that this training will last so long, sometimes it was hard to organize the day to be present, but these "extra" sessions were very useful in regards farther development.

The least satisfactory aspects of the programme included deviations from the topic actually discussed and too long introductory session.

There seems little doubt that all the participants found this learning experience to be very positive – in most cases useful and inspiring. These results obviously need replication on the wider basis.

Considering that the programme is still in its very developmental phase, participants' opinions and suggestions regarding training's design and content were especially valuable. Two themes seem to be of great importance for the participants: to learn how to manage anger and how to help children who experience violence. As far as training's design is considered participants recommended that it should be longer and include not more than 10 trainees.

Conclusions

Domestic violence has been recognized as one of the most serious and widespread public health issues facing women that occurs in every culture and social group. Such an experience has destructive impact on somatic and mental health as well as on quality of life. In Poland today's assistance programs are mainly provided on the medical care basis. The positive effects of these interventions are not sufficiently linked to the restoration of victims' wellness and reestablishment of their connections with the community – hence social inclusion. The idea of empowering training intervention directed at vulnerable and socially excluded domestic violence survivors is ideal as it might help women to gain control of their lives and instil in them motivation to reclaim their position in the community.

Acknowledgements

The paper is sponsored by EU project: Empowering W♀ – Empowering women and providers: DV and MH – JUST/2009/DAP3/AG/1082 – 30-CE-0393020/00-57 (DAPHNE III)

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