

Features of Psychological Intervention for Women Survivors of Domestic Violence

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Abstract: This article discusses the psychological characteristics of women who have experienced domestic violence. The authors study the prescription of traumatic events in detail. As a result, the article outlines the key features of psychological intervention in the rehabilitation of this category of women.

1. Introduction

Over the past 20 years, many epidemiological studies have examined the prevalence of violence against women. In 2013, the London School of Hygiene and Tropical Medicine, the South African Council for Medical Research, and the World Health Organization (WHO) prepared a joint report [5], which globally reviewed 141 studies in 81 countries. In 2014, as part of the State of the World's Violence Prevention Report, the results were confirmed [6]. These studies confirmed the trend that one in three women in the world, about 35%, have experienced violence (physical, psychological, and/or sexual) from a partner with whom she was or is in a relationship at the time of the violence. Also, the report notes the global nature of this problem: up to 38% of murders of women occur at the hands of their intimate partners [5].

As a result of domestic violence, almost every aspect of the life of a woman victim of domestic violence is changing. Preventing abusive relationships involves moving from impotence to control. This change requires a lot of effort, as a woman who has experienced domestic violence moves from a survival mode to a new life [3]. Domestic violence often leads to severe physical and emotional consequences, it lasts for several years and persists after the end of the period of violence: post-traumatic stress disorder (PTSD), depression, and anxiety [1, 2].

The scientific and methodological literature is full of the described approaches and methods of providing support and assistance to women survivors of domestic violence. Still, there are so many of these approaches and directions that they need serious processing. In our opinion, psychological methods of helping women, most of all, lack systematization in terms of the prescription of receiving trauma. At the moment, such purely practical ways of working are prescribed only in some rehabilitation centers and contain basic recommendations for ascertaining women who came to the reception for the first time and are in acute traumatic experience [4]. At the same time, there is a wide category of women who survived traumatic events, about 2-3 months ago or more, who need psychological support, but the help of this category of clients is practically not considered, although most often it can be in demand.

2. Materials and Methods

The sample consisted of 90 women survivors of domestic violence who sought help from a crisis center for women, as well as seeking individual counseling from a psychologist. The average age of participants was 34.5 years. 70% of the respondents have at least one child, 30% of the respondents have no children; most of the respondents had completed higher education. In terms of income, the majority of the respondents were below average. About a third of female respondents had low earnings, less than 20,000 rubles a month. At the

time of the survey, 28.5% of the women surveyed were married to men who committed violent acts against them, 61.5% of the respondents were cohabiting, but not married, 10.4% of the respondents were divorced. At the same time, 9.7% of respondents, at the time of the study, lived together with their partners. The remaining women respondents lived separately. On average, abusive relationships between participants were 6.9 years, ranging from 3 months to 32 years. The duration of the violence was almost 5, from 7 days to 32 years. The survey participants were divided into three groups of 30 people: (1) the first group consisted of women remaining in a traumatic situation; (2) the second group consisted of women who were in a safe place after the injury was completed; (3) the third group consisted of women at the assimilation stage traumatic experience.

In the process of the study, the following methods were used: (1) Clinical questionnaire to identify and evaluate neurotic conditions (authors – K. K. Yakhin, D. M. Mendelevich); (2) Symptomatic Questionnaire SCL-90-R Derogatis Scale; (3) Q methodology; (4) TAT (thematic apperception test).

3. Results

According to the data obtained from the questionnaire by K. K. Yakhin and D. M. Mendelevich, with the help of which the characteristics of neurotic states in the 1st group were evaluated, such scales as the level of obsessive-phobic disorders (2.13) have normative indicators. Such scales as anxiety (-0.17), neurotic depression (0.4), hysterical type of response to the situation (0.72), and autonomic disorders (0.76) fell into the gray zone. Indicators of asthenia (-1.58) scored the most critical, which means high values. This group is remarkable that the results are almost no “normative” values on the scales. One can observe a significant predominance of obvious painful and pre-painful manifestations. In the second group, we observe asthenia (0.71), neurotic depression (1.08), anxiety (1.20), and a hysterical type of response (0.30) in the gray zone. Vegetative disorders (1.88) and obsessive-phobic disorders (1.56) have normatively healthy indicators; for this group in the critical painful zone, there are no pronounced values. In the third group, neurotic depression (0.90), a hysterical type of response (0.87) and asthenia (-1.04) are in the gray zone. In the health zone, vegetative disorders (1.77), anxiety (1.60), and obsessive-phobic disorders (1.76) were identified. It should be noted that this group had fewer indicators of the level of the disease than the first group, and some values were at the level of health. Comparing the results of the three groups according to the Fisher test (significance level $p = 0.05$), no significant differences were found. However, comparing the indicators of health and disease on such scales as anxiety $C^*emc = 2.765$, depression $C^*emc = 1.661$, asthenia $C^*emc = 3.862$, it was found that the obtained empirical values of C^*emc are in the significance zone. The scales of obsessive-phobic disorders $C^*emc = 0.467$, the hysterical response $C^*emc = 1.249$, and the scale of vegetative disturbances $C^*emc = 0.779$ are in the insignificance zone for all three groups. Thus, we can conclude that the highest level of neurotization is observed in group 1.

The SCL-90-R questionnaire was used to diagnose the degree of development of the traumatic condition and its effect on women's health and quality of life. All respondents on the scale of the questionnaire have values above the norm in the direction of pronounced negative symptoms. Women from the first group, in comparison with women of the second group, have higher results on the scales of depression, psychotism, somatization, and obsessiveness/compulsiveness. In the third group, only on the somatization scale there is a similarity with the first group; these indicators are the only ones among the two groups that are directed towards health indicators.

Compared with women from the third group, the results of the second group were higher on the scales psychotism, depression, hostility, and interpersonal sensitivity. Thus, it can be noted that women from the first group have clear psychological distress, compared with the other two groups. Such characteristics presumably have some acquired characteristics, and they are intermediate between normative states and mental disorders. One can assume the presence of a connection with a long psycho-traumatic situation. According to the results of a comparative analysis of the SCL 90 R questionnaire, we can talk about the influence of the stage of development of the psycho-traumatic situation on the psychological state of women. The respondents of the second and third groups increase the possibility of developing constant, irresistible, and alien thoughts and actions, they can have pronounced obsessive-compulsive features ($p < 0.01$). In the first group, depressive symptoms are expressed, which cannot be said about the second and third groups, where these indicators, although not normal, are significantly lower ($p < 0.01$). So, it is shown that women in a traumatic situation have a high level of anxiety, while women of the third group are fixed on somatic health problems ($p < 0.01$).

When analyzing the Q-methodology indicators, it was found that women from the first group (5.3), second (7.0), and third (5.3) groups have a tendency to addiction. Women from the first group (6.6), the second group (8.3) and the third group (8.6) show a tendency to avoid critical and conflict situations, i.e. avoidance of struggle (these indicators are two times less than the norm). Based on the data obtained, one can assume that there are difficulties in interacting with others and low social adaptation. The female respondents of all three groups have a reduced desire for independence, almost twice as compared with the normative values. On this basis, it can be assumed that women have a desire to get away from communicating with others, a desire to maintain a neutral position and to avoid leadership responsibility. In the stories of the first and second groups, topics of dominance, interaction with others, are presented most widely. At the same time, in the stories of the third group, the topic of relations with men turned out to be the most relevant ($p < 0.01$). For women from the first group, the most relevant topic was related to relationships with others, developing in interpretations of the interactions of characters in the stories described. It is interesting that the theme of "attitude to oneself" was extremely not clearly expressed in three groups.

4. Discussion

Thus, women who remain in traumatic situations are characterized by painful and pre-painful manifestations of mental states. Women have a high level of asthenia and anxiety. Women are characterized by pathological mental disadaptation and a probable painful state; they show depressive symptoms: a loss of interest in life, lack of motivation, reduction of general activity. Women tend to avoid struggles, which is twice the normative indicators. This observation suggests that there are problems in communication and poor social adaptation. Women who find themselves in a safe place after the end of the trauma are characterized by a high level of asthenia and a hysterical response. Women have a high level of nervous and mental adaptation, and the probability of developing continuous, insurmountable, and alien thoughts, impulses, and actions increases. Women who are at the stage of assimilation of a traumatic experience are characterized by a high level of asthenia and neurotic depression.

According to the results, the authors of this article developed a system of psychological interventions depending on the age of experienced domestic violence.

Trauma deprives the victim of a sense of power and control, the main task of working with women in the post-trauma stage: restoring control over their own lives. This task takes precedence over all others since psychological work cannot be successful if security is not adequately ensured. In the process, when a woman returns to her rudimentary sense of security or at least predictability, she discovers that she can count on herself and others. Group work at the first stage should be highly informative and educational, but not profoundly transforming. The group should be structured in such a way as to promote the development of strengths.

While studying traumatic experiences in a group can be very disconcerting in the first stage of recovery, the same work can be extremely productive in the second stage. A well-organized group provides a powerful stimulant for reconstructing the story and can be a source of emotional support. As each member of the group shares their unique story, the group gives a deep experience of versatility. At the post-traumatic stage, reconstruction of the traumatic memory is necessary in order to integrate into the life story. A woman and a psychologist slowly collect the fragmented components of frozen images and sensations in an organized, detailed, time-oriented, oral report. In this case, the history of trauma serves a purpose that goes beyond mere catharsis or living trauma, and it is a means to gain control of the situation actively. In addition, social methods, such as intensive group therapy or psychodrama, can be used. Whatever the method, the basic rules are the same: the woman remains in control.

Women from the third group, despite a high level of neuropsychological adaptation, experience severe depression. During this period, a woman is faced with the task of creating her future. Her relationship with the world was forever changed by trauma, and now she must develop a new relationship. At this point, the work of the psychologist often focuses on the development of motivation and initiative. The psychological environment creates a protected space in which imagination can be given freedom of action. This is a testing ground for translating fantasy into a solid decision and action. This is a period of trial and error, where a woman learns to make mistakes and enjoy unexpected success. At this point, a woman can notice the positive aspects of herself that have been formed in the traumatic experience, even admitting that it was reached at too high a price.

5. Conclusion

Thus, we can notice a tendency for changes in skills and characteristics of the development of the traumatic situation, starting from the acute stage of being in a traumatic situation. When women get to a safe place, they experience a temporary short euphoric state. At the same time, they live a clear alarm and do not have enough personal energy for activity, which is expressed in asthenic tendencies. At the assimilation stage, when the obtained experience is “welded together,” it can be noted that, on the one hand, neurotic symptoms are reduced. However, gloomy views remain (apparently due to the traumatic situation), as well as some characterological features (such as a tendency to addiction). Also, women can remain anxious, i.e., not sufficiently neuropsychically adapted.

But overcoming trauma is never final, and recovery is never complete. The impact of the traumatic event continues to be reflected throughout the life cycle. Many women, especially those who have experienced prolonged, repeated trauma, acknowledge that trauma has limited and distorted their ability to interact with other people. However, for each stage of psychological trauma, it is necessary to develop a separate system of psychological interventions, due to significant differences in the characteristics of the current and assimilation of traumatic experience. In this regard, at an early stage, work is needed to support and regain minimal control over life. At the stage “after the trauma,” women who have experienced domestic violence, in the process of group work with a psychologist, experience cathartic states of trauma, thereby assimilating the experience gained and also regaining control of the situation. Women from the third group need to work with their motivation and desire for self-realization. Their focus is shifting to interpersonal relationships, and they need to focus on the present, not the past.

References

- [1] Fergusson, Fergusson, D. M., Horwood, L. J., & Ridder, E. M. (2005). Partner violence and mental health outcomes in a New Zealand birth cohort. *Journal of Marriage and Family*, 67, 1103-1119.
- [2] Mechanic, M., Weaver, T., & Resick, P. (2008). Mental health consequences of intimate partner abuse: A multidimensional assessment of four different forms of abuse. *Violence Against Women*, 14, 634-654.
- [3] Senter, K. E., & Caldwell, K. (2002). Spirituality and the maintenance of change: A phenomenological study of women who leave abusive relationships. *Contemporary Family Therapy*, 24, 543-564.
- [4] Soloveychik, M. Y. (2002) *Rescue: The skills of psychological counseling*. SPb., Russia: European House.
- [5] World Health Organization. (2013). *Violence against women is a global health problem of epidemic proportions*. Retrieved from https://www.who.int/mediacentre/news/releases/2013/violence_against_women_20130620/ru/.
- [6] World Health Organization. (2014). *State of the world report on violence prevention 2014*. Retrieved from https://www.who.int/violence_injury_prevention/violence/status_report/2014/ru/.