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Full Length Research

Evaluation of a community intervention for women victims of domestic violence in the Gaza strip

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A range of therapeutic interventions and services for victims of domestic violence have been reported and evaluated in recent years, mostly in western countries. There is less knowledge on the impact of such programmes in developing countries, in particular those exposed to political conflict at the same time. The aim of this study was to establish the short-term impact of a community intervention of group counseling and vocational training for women victims of domestic violence in the Gaza Strip. The sample consisted of 99 women aged 16-42 years, who had been referred to three centers of the Women Empowerment Programme. Pre- and post-intervention (six months) assessments included completion of the Revised Conflict Tactics Scale, the Brief Symptom Checklist, and the Connor-Davidson Resilience scale. Following the intervention, participants significantly improved on most mental health symptoms, in particular those of emotional nature. Total domestic violence, minor psychological abuse, and incidents of sexual assaults also significantly decreased, although there was no change in resilience scores. These promising findings indicate the importance of developing integrated programmes targeting both domestic violence and associated mental health difficulties, which are tailored to different cultural needs.

Key words: Domestic violence, interpersonal violence, empowerment, coping, Gaza strip, mental health, intervention.

INTRODUCTION

Domestic violence is an increasing social and public health concern. Estimates indicate that between 20 and 30% of all women have experienced some form of abuse from an intimate partner during their lifetime (Campbell and Lewandowski, 1997; Kaighobadi et al., 2009). It is estimated that up to 25% of visits to emergency departments by women are related to domestic violence (Houry et al., 2008). The problem is pervasive worldwide and can also take specific cultural manifestations such as female genital mutilation, dowry related violence, femicide, rape, and honor crimes (Anderson and Aviles, 2006; Kulwicki, 2002). Psychological presentations are as prevalent as physical symptoms, as women are more likely to also suffer from depression, anxiety and suicide attempts (Ellsberg et al., 2008; Goodman et al., 2009; Thompson et al., 2002).

Most researches arise from Western Societies, although findings are beginning to emerge from a range of cultures with broadly consistent patterns. For example, Akar et al. (2010) explored the frequency of spousal domestic violence among 1,178 married women who attended primary health care services in Ankara, the capital of Turkey. A very high proportion (77.9%; n=918) stated that they had been exposed to at least one type of spousal violence during their lifetime. The most reported type was economic violence (60.4%), followed by controlling behaviors (59.6%), emotional (39.7%), physical (29.9%) and sexual violence (31.3%).

In addition to other researches from Middle East countries, studies from areas such as the Gaza Strip maybe of particular interest, as the population was also

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exposed to ongoing political conflict. Thabet et al. (2007), in a study of 125 women from the Gaza Strip, found high rates of exposure to domestic violence and mental health problems. Among this sample, 14.7% of the participants reported emotional distress that fulfilled diagnostic criteria for Post-Traumatic Stress Disorder (PTSD), while 18% suffered from anxiety symptoms of moderate to severe intensity, and 15.7% from moderate to severe depression.

In order to inform interventions and services, other studies explored the more prominent coping strategies adopted among different socio-cultural groups. Coping is defined as a process through which people try to understand, make sense of, and deal with personal or circumstantial critical situations (Lazarus and Folkman, 1984), and it includes behaviors and actions used to minimize stress (Mitchell et al., 2006). Coping with Intimate Partner Violence (IPV) involves multiple behavioral manifestations, ranging from positive to negative, help-seeking to self-destructive behaviors.

Giesbrecht and Sevcik (2000) interviewed Canadian women who had been referred to a Christian women's shelter, and found that they identified spirituality and identity within their faith and community as integral to their traumatic experiences. As a result, many women viewed both their experience and recovery from abuse as occurring within the context of their faith, and usually turned to their religious communities for support. Some of these communities minimized, denied, or enabled the abuse, whereas others provided much needed social support, practical assistance, and spiritual encouragement. Overall, social support from religious institutions (such as churches, synagogues and mosques) has been found to be a key factor in many women's abilities to rebuild their lives and family relationships.

Previous research analyzed different dimensions of religious coping, and identified negative and positive utilization of religion and spirituality in crisis situations and problem solving (Pargament et al., 1998). Prayer has been singled out as the most used form of private coping for African-Americans (Mitchell et al., 2006; Shorter-Gooden, 2004), and women in conservative faith communities (Drumm et al., 2006). A victimization survey among churches in the Northwest Pacific region of the United States identified that four types of coping behaviors were: informal coping, professional help-seeking, negative coping, and crisis outreach (Popescu et al., 2010). While religious behaviors were less influential than expected for this particular population, current victimization and childhood victimization played a significant role in establishing a model of coping and help-seeking for intimate partner violence survivors within these faith communities.

In studying the context of Arab societies and its relevance to the way women cope with abuse, it is important to take into account several issues, including the structure and values of the family, and the status of men and women, in particular within the Arab family. Despite changes in the modern family because of urbanization, the family's structure as a cohesive unit remains the most significant social institution through which individuals and groups are taught their cultural values (Barakat, 1993; Haj-Yahia, 2000). Whereas society used to be built on the extended family, this structure has begun to split into nuclear family units. Nonetheless, both nuclear and extended families still enjoy higher priority than the individuals in those units (Haj-Yahia, 2002). Arab women living in Middle Eastern countries are thus often inhibited in seeking help from the authorities; instead they tend to approach relatives or local religious leaders (Haj-Yahia, 2002; Shalhoub-Kevorkian, 2000). Studies among immigrant Arab communities in Western countries also found that traditional values regarding marital and sex-role expectations and cultural and religious beliefs influence women's attitudes about domestic violence, as well as their help-seeking behaviors (Raj and Silverman, 2002; Sakalh, 2001).

Such evidence on underpinning psychosocial and cultural factors has informed interventions and services (Grossman et al., 2010; Riger and Staggs, 2011; Wathen and MacMillan, 2003). The majority of these studies highlight feminist, cognitive-behavioral, interpersonal, and couples therapy as the primary theoretical frameworks informing interventions (Kubany et al., 2003 and 2004; Lundy and Grossman, 2001).

From a service context, the evaluation studies of counseling services for battered women in Western countries suggest that supportive, psycho-educational, shelter- and community-based individual and group counseling may be an effective model for improving self-esteem, affect (anxiety, depression, and hostility), assertiveness, social support, locus of control, coping abilities, and self-efficacy (Howard et al., 2003; McNamara et al., 2008). Despite the growing evidence on interventions and their effectiveness, there is still limited knowledge on the appropriateness of interventions in Non-Western societies, in particular those exposed to wider political conflict and trauma, i.e. where women are exposed to two levels (individual and collective) of abuse. The aim of this study was to investigate the short-term impact of such a community intervention that included group counseling and vocational training on the empowerment and mental health of women victims of domestic violence in the Gaza Strip.

MATERIALS AND METHODS

The setting

The strategic vision of the Women Empowerment Programme (WEP) is to promote and sustain communities which are based on caring for and involving women and children in the Gaza strip. This is provided by an independent and non-profitable Palestinian Non-Governmental Organization (NGO) and provides capacity building of stakeholders, widows' care, and child development programmes. In implementing its strategy to fulfill its vision, the WEP is guided by

human rights principles, including accountability and rule of law, transparency, tolerance, empowerment, participation and inclusion, equality, equity, non-discrimination, and attention to vulnerable groups.

The objective of the mental health intervention described in this paper was to improve women's mental health well-being, in order to be better equipped to deal with significant life changes and challenges, conflict and psychological pressures; and to promote a supportive family climate. This was achieved by 12 group counseling sessions over a period of six months, which were facilitated by Clinical Psychologists and Social Workers. The therapeutic intervention was complemented by a vocational training programme that consisted of sewing, hair dressing, writing, and pottery.

Subjects

All women (single, married or divorced) who asked to receive services for domestic violence–related concerns and were admitted to the Empowerment of Women Victims of Domestic Violence Community Mental Health Intervention Programme across three centers in the Gaza Strip, were invited to participate. The sample included 110 women recruited from consecutively self-referrals to the Women Empowerment Programme in the Gaza Strip (Table 1). Of those, 99 completed both the programme and the post-intervention measures. The age of women ranged from 16-42 years (mean=25.6, SD=6.4); 60.6% were single, 34.3% married, and 5.1% divorced. Overall, 70.7% lived in urban areas, 22.2% in camps, and 7.1% lived in villages; they were mostly housewives (74.4%). According to family monthly income, the vast majority (84.8%) were earning less than $300 per month.

Research procedure

The data was collected between March and August 2008, by trained Psychologists working with the target group. The women involved in this programme were assessed at the beginning by three Psychologists and three Social Workers as a part of the routine intake in the centers. Each participant was interviewed individually and was asked about the type of violence she may have experienced, which included questions on family, community, and political violence due to repeated traumatic events. Sociodemographic variables were collected, including family structure, number of children, and family income. Research measures were completed again after six months, i.e. following the completion of the intervention.

Measures

Revised Conflict Tactics Scale (CTS2 – Straus et al., 1996)

The CTS2 is a 36-item self-report instrument designed to measure the extent to which partners in a dating, cohabiting, or marital relationship; engage in psychological and physical attacks on each other; and their use of reasoning or negotiation to deal with conflicts during the past 12 months. The measure also examines the two aspects of abuse by a partner: sexual coercion and physical injury from assaults. Psychological aggression and physical assault are further divided into minor and severe subscales. Negotiation is a six-item scale defined as actions taken to settle a disagreement through discussion. This scale includes three cognitive and emotional items. Cognitive items are examples of discussion foci, e.g. suggestion of a compromise to a disagreement. Emotional items measures the extent to which positive affect is communicated by asking about expression of feelings of care and respect for the partner, e.g. "I showed my partner I cared, even though we disagreed".

Psychological aggression is defined as the use of verbal and non-verbal acts that have the effect of being critical or controlling the partner. Examples of minor psychological aggression (4 items) are insulting or swearing at a partner, whereas severe psychological aggression (also 4 items) includes destroying a belonging or threatening to hit a partner. Physical assault describes the specific acts that fit the definition of physical violence. Minor physical assault (5 items) includes pushing or slapping, whereas severe physical assault (7 items) includes beating, kicking, burning, or using a gun or knife on a partner. Physical injury includes 7 items, and sexual assault 3 items.

The CTS has been used previously in the Arabic culture (Haj Yehia, 2000). The Arabic translated version of the instrument was used, following translation and back translation, and only minor differences between the two translations were established. This Arabic version was subsequently given to a panel of four bilingual and bicultural Arabic researchers, to ensure congruence across both the Arabic and English versions of the instrument. Scoring the CTS2 follows the principles used to score the CTS1 (Straus et al., 1996). Response categories range from "0=never", to "6=more than 20 times" for each of the tactics with the referent period being the past 12 months. Prevalence refers to the percentage of the participants that reports at least one instance of the behavior in question. Chronicity refers to the frequency of occurrence of behaviors among those who report at least one incident for the behavior in question. In the present study, the scale had acceptable reliability, with Cronbach's alpha coefficient of 0.95 (95% Confidence Intervals 0.93-0.96). The split half was 0.75.

Brief Symptom Checklist (BSI-53 - Derogatis, 1993)

The BSI is a 53-item self-report symptom inventory designed to assess mental health symptoms in clinical groups and the general population. Each item of the BSI is rated on a 5-point scale of distress, ranging from 0 ("not at all") to 4 ("extremely"). The BSI is a brief form of the SCL–90–R, which is a self-report inventory, developed and used in a variety of settings. The English version of the BSI comprises 53 items selected to best reflect nine primary symptom dimensions of the SCL–90–R in a brief measurement scale, as follows: somatization (7 items), obsessive-compulsive (6 items), depression (6), interpersonal sensitivity (4), anxiety (6), hostility (5), phobic anxiety (5), paranoid ideation (5) and psychoticism (5 items), plus 4 additional items. In this study, the Cronbachs' alpha coefficient was 0.89 (95%; CI= 0.85-0.92), with a splitting half of 0.89.

Connor-Davidson Resilience Scale (CD-RISC) (Connor and Davidson, 2003)

The CD-RISC contains 25 items, all of which carry a 5-point range of responses, as follows: not true at all (0), rarely true (1), sometimes true (2), often true (3), and true nearly all of the time (4). It comprises five subscales: personal competence, high standards, and tenacity (7 items); trust in one's instincts, and tolerance of negative affect (7 items); strengthening effects of stress, positive acceptance of change, and secure relationships (5 items); control (3 items); and spiritual influences (3 items). The scale is rated on how the subject felt over the past month. The total score ranges from 0–100, with higher scores reflecting greater resilience. In this study the scale was translated into Arabic by the first author, and was back translated by the second author, with minimal changes. For this study, the Chronbach's alpha coefficient was 0.92 (95% CI=0.90-0.94), and the splitting half was 0.81.

Table 1. Participants' socio-demographic characteristics (N = 99).

Socio-demographic variable	N	%
Marital status		
Single	60	60.6
Married	34	34.3
Divorced	5	5.1
Education		
Not educated	3	3.0
Elementary	5	5.1
Primary	18	18.2
Secondary	48	48.5
Diploma	13	13.1
University	12	12.1
Area of residence		
Middle area	31	31.3
Gaza	46	46.5
Rafah South	22	22.2
Occupation		
Housewife	74	74.4
Unskilled worker	2	2.4
Employee	9	9.2
Others	14	14.0
Average monthly income ($)		
Less than 300	84	84.8
301 to 500	10	10.1
Above 500	5	5.1

Statistical analyses

The SPSS version 16 was used for data entry and analyses. Frequencies of the demographic variables were initially obtained. The t-paired test was used to compare changes in questionnaire scores pre- and post- intervention.

RESULTS

Changes in domestic violence scores

We used a paired t-test to compare the pre- and post-intervention scores, i.e. over a period of six months (Table 2). The total mean domestic violence score at baseline was 49.6 (SD= 46.8) which decreased significantly post-intervention to a mean of 32.1, with a mean difference of 17.1 (t=3.9, p=0.001). The negotiation mean significantly decreased from 17.5 to 13.6, with a mean difference of 3.9 (t= 2.7,p=0.01); minor psychological abuse significantly decreased from a mean of 9.7 to 3.7, with a mean difference of 5.6 (t=6.7, p=0.001); sexual assault decreased from a mean of 1.2 to 0.3, with mean difference 0.9 (t=2.1, p=0.04). However, no significant differences were found in major psychological, physical assault, and physical injury scores.

Changes in mental health scores

As shown in Table 3, the total mean score for mental health symptoms was 77.7 (SD=32.5), which after six months decreased to 68.0 (SD=36.5). This decrease reached a statistically significant level (t=2.3, p=0.02). Regarding the subscales, obsessive compulsive mean scores significantly decreased from 10.9 to 9.8 (t=2.36, p=0.02), interpersonal sensitivity mean scores significantly decreased from 6.6 to 5.6 (t=2.4, p=0.02), anxiety scores significantly decreased from 9.9 to 8.5 (t=2.8, p=0.01), and phobic anxiety scores significantly decreased from 8.1 to 7.2 (t=2.75, p=0.01). There were no significant changes in depression, somatization, hostility, paranoid, or psychotic symptoms scores.

Table 2. Mean differences in domestic violence (CTS2) scores after intervention.

Domestic violence assessment	Paired differences					95% CI of the difference		t	df	Sig. (2-tailed)
	Mean	SD	Mean D.	Std. Dev.	SE of mean	Lower	Upper			
Total domestic violence-first assessment	49.27	48.40	17.13	40.87	4.41	8.37	25.89	3.89	85.00	<0.001
Total domestic violence-second assessment	32.14	38.59								
Negotiation-first assessment	17.48	13.89	3.88	13.41	1.43	1.03	6.72	2.71	87.00	0.01
Negotiation-second assessment	13.60	13.91								
Minor psychological-first assessment	9.74	8.89	5.98	8.33	0.89	4.21	7.74	6.73	87.00	<0.001
Minor psychological-second assessment	3.76	6.33								
Major psychological-first assessment	5.45	7.60	0.80	8.66	0.93	-1.04	2.65	0.87	86.00	0.39
Major psychological-second assessment	4.64	8.30								
Major physical-first assessment	6.25	9.71	1.61	9.25	0.99	-0.36	3.58	1.62	86.00	0.11
Major physical-second assessment	4.64	8.30								
Physical injury- first assessment	4.64	10.23	2.66	9.13	0.97	0.73	4.59	2.73	87.00	0.01
Physical injury-second assessment	2.77	8.64								
Sexual assault-first assessment	1.20	3.60	0.91	4.05	0.43	0.05	1.77	2.09	86.00	0.04
Sexual assault-second assessment	0.29	1.78								

Table 3. Mean differences in mental health symptoms (BSI-53 scores) after intervention.

Mental health symptoms assessment	Paired differences						95% CI of the difference		t	df	Sig. (2-tailed)
	Mean	SD	SE Mean	Mean	Std. Dev.	SE of Mean	Lower	Upper			
Somatization-first assessment	10.50	5.81	0.62	0.88	6.04	0.64	-0.40	2.15	1.36	87.00	0.18
Somatization-second assessment	9.63	6.61	0.70								
Obsessive compulsive -first assessment	10.97	4.49	0.48	1.20	4.80	0.51	0.19	2.21	2.36	88.00	0.02
Obsessive compulsive -second assessment	9.76	4.76	0.50								
Interpersonal sensitivity-first assessment	6.63	3.64	0.39	1.03	4.06	0.43	0.18	1.89	2.40	88.00	0.02
Interpersonal sensitivity second assessment	5.60	3.78	0.40								
Depression-first assessment	9.60	5.25	0.56	1.06	5.81	0.62	-0.17	2.29	1.71	87.00	0.09
Depression-second assessment	8.55	5.56	0.59								
Anxiety-first assessment	9.98	5.15	0.55	1.48	4.99	0.53	0.42	2.54	2.77	87.00	0.01
Anxiety-second assessment	8.50	5.13	0.55								
Hostility-first assessment	6.92	3.68	0.39	0.44	3.99	0.42	-0.40	1.28	1.04	88.00	0.30
Hostility-second assessment	6.48	3.94	0.42								
Phobic anxiety-first assessment	7.82	4.06	0.43	1.17	3.99	0.43	0.32	2.02	2.75	87.00	0.01

Table 3. Continues

Phobic anxiety-second assessment	6.65	4.21	0.45								
Paranoid-first assessment	7.93	4.83	0.51	0.70	5.07	0.54	-0.37	1.78	1.30	87.00	0.20
Paranoid-second assessment	7.23	4.82	0.51								
Psychosis-first assessment	7.63	4.38	0.47	1.08	4.30	0.46	0.17	1.99	2.36	87.00	0.02
Psychosis-second assessment	6.55	4.56	0.49								
Total BSI-first assessment	76.89	33.23	3.63	8.89	34.93	3.81	1.31	16.47	2.33	83.00	0.02
Total BSI-second assessment	68.00	36.56	3.99								

Changes in resilience scores

The total mean resilience at the first assessment was 81.9 (SD=17.9), which increased to 84.4 (SD =21.6) post-intervention. However, this difference did not reach a statistically significant level (t=-1.26, p=0.21). Similarly, the mean personal competence scores increased from 25.9 to 26.3, which did not reach statistical significance (t =-0.89, p=0.37). Trust in one's instincts scores (21.4 vs. 21.9), positive acceptance of change (16.3 vs. 17.0), control (10.0 vs. 10.2), and spiritual influences scores (8.5 vs. 8.6) were similar in both assessments (Table 4).

DISCUSSION

This study evaluated the impact of a therapeutic intervention combined with vocational training and psychosocial support for women who suffered domestic violence in three designated centers across the Gaza Strip. The overall findings indicate a significant reduction in some abusive experiences, predominantly sexual assaults and psychological abuse of lesser severity (in contrast with major trauma which did not change significantly), increase in the ability to negotiate conflict, and improvement in emotional distress and symptoms. There was no change in resilience scores. Compared to previous researches on similar programmes and interventions, the intervention had to be adapted to take into consideration the cultural characteristics of the participants, as well as their societal exposure to political conflict during this period, i.e. in addition to individual trauma and abuse.

These findings are promising in establishing improvements in some domestic violence behaviours, possibly through the enhancement of negotiation and reasoning tactics measured by the CTS2. Many abusive behaviours, however, persisted, and this indicates the need for longer interventions as well as more statutory (social work) input, and involvement of partners or extended family (more relevant to this culture), where this is appropriate.

In contrast, there was improvement in several mental health symptoms, predominantly of emotional nature, which is the common type of impact from trauma and abuse. More positive mental health following counseling and psychosocial support was consistent with previous evidences from interventions for victims of abuse and domestic violence (e.g. McNamara et al., 2008; Howard et al., 2003; Kubany et al., 2004). The mechanisms that underpin the impact of therapeutic interventions are often not fully understood, as ill mental health is the effect of abuse, but it can also hinder women's empowerment to break from the abusive cycle. In that regard, it is important to integrate interventions that target both domestic violence and mental health causes and effects, and this was the rationale behind the development of this programme.

Enhancing resilience is essential in protecting individuals from the impact of individual or collective trauma, and this was not found to improve, at least, in the short-term, in this study. This may require a longer intervention, or modify-cation to adjust to the particular cultural needs of this group such as focusing more on factors like religious and spiritual beliefs (Postmus et al., 2009). For example, Gillum et al. (2006), in a study of a community sample of 151 battered women who were participants in a community-based advocacy project, the majority (97%) noted that spirituality or God was a source of strength or comfort for them. The extent of religious involvement predicted, increased psychological well-being and decreased depression.

Future interventions may also need to understand better, thus maximize, access to family and social support networks. Barakat (1993) notes that, although traditional extended families are becoming harder to find in the Arab society, family members remain close, leaving little room for independence or privacy, and exerting strong influence regarding marriage, divorce, illness, and

Table 4. Differences in resilience scores (CD-RISC) after intervention.

Resilience assessment	Paired differences						95% CI of the difference		t	df	Sig. (2-tailed)
	Mean	SD	S.E Mean	Mean	SD	SE Mean	Lower	Upper			
Total resilience-first assessment	81.95	17.97	1.95	-2.54	18.52	2.01	-6.54	1.45	-1.26	84	0.21
Total resilience scores-second assessment	84.49	21.67	2.35								
Personal competence-first assessment	25.74	6.56	0.70	-0.66	6.92	0.74	-2.12	0.81	-0.89	87	0.37
Personal competence-second assessment	26.40	7.15	0.76								
Trust in one's instincts-first assessment	21.36	5.42	0.58	-0.55	5.71	0.61	-1.76	0.66	-0.90	87	0.37
Trust in one's instincts-second assessment	21.91	6.67	0.71								
Positive acceptance-first assessment	16.29	4.02	0.43	-0.70	4.78	0.51	-1.72	0.32	-1.37	86	0.17
Positive acceptance-second assessment	16.99	4.81	0.52								
Control-first assessment	9.93	3.00	0.32	-0.28	3.43	0.36	-1.00	0.44	-0.77	88	0.44
Control-second assessment	10.21	3.37	0.36								
Spiritual influences-first assessment	8.47	1.56	0.17	-0.13	1.84	0.19	-0.52	0.25	-0.69	88	0.49
Spiritual influences-second assessment	8.61	1.90	0.20								

death. Should a marital dispute arise, members of the immediate family and even some trusted distant relatives are consulted. Traditionally, they emphasize the holiness of family values, continuity, and the family's desire to save face. Maintaining family unity has significant cultural and social value, even if both spouses are unhappy with their marriage. Abu-Ras (2003) argued that Arab attitudes toward female behavior may thus focus on the concepts of shame and honor (Glazer and Abu-Ras, 1994). Therefore, individual interventions cannot be developed in silo from wider education and public campaigns.

This study also has a number of limitations. This involved a pre-post intervention design, without a control group. Interviews with participants would have provided a better understanding of the therapeutic process, and women's perceptions of which factors were helpful. The latter is important for future evaluation of similar multimodal programmes that include both psychological therapies and practical / vocational components, that is, it can be difficult to disentangle the impact and specificity of different programme activities.

Future studies could address these issues. In addition, they could consider and measure the relevance of cultural factors and how these could be incorporated in the intervention, there by maximizing the role of local communities and support networks, and helping victims of domestic violence who are concurrently exposed to collective political violence. Other methodological requirements from psychotherapy research concern the impact of the counseling environment, counselor characteristics, and client-counselor relationship quality on progress in counseling for women exposed to domestic violence. Longitudinal designs with control groups that evaluate well-defined programmes and interventions may be useful in understanding the effect of counseling for different groups of abused women.

Conclusions

This study contributes empirical evidence to the positive effects of community-based domestic violence counseling services for battered women in the Gaza Strip. These findings suggest that women who are victims of domestic violence may benefit from integrated counseling and vocational training to improve their mental health well-being and coping strategies in reducing the incidents and harmful effects of abusive relationships.

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