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Developing spontaneity and well-being in women victims of domestic violence

Abstract

In this paper we present the results of the last stage of the research project Empower Daphne that involved the participation of six countries belonging to the EU in two phases: I) validation of the theoretical model on which basis rests the construct of well-being and spontaneity; II) analysis of Morenian psychodrama intervention efficacy. 407 university students were part of the non-clinical sample in the first phase and 136 women victims of domestic violence made up the clinical sample for the second phase. During the six month the women took part in psychodramatic sessions, together with individual interviews. At the beginning and the end of the six month, a questionnaire was administered consisting of a well-being and a spontaneity scales. In the article we present the results that compare well-being and spontaneity between clinical and non-clinical samples, and between the clinical cut-off scores highlighted in the literature and the scores of clinical sample. The findings demonstrate interesting differences between two sample: observed lower levels of spontaneity and well-being in women victims of domestic violence, both before and after the psychodramatic intervention.

Keywords: Psychodrama, well-being, spontaneity, domestic violence, European project.

Introduction

Project EMPoWER (Empowerment of Woman Environmental Research) is part of the DAPHNE III Program, sponsored by the European Union. The Empower Daphne Program is a research-intervention project that focuses on the problem of gender-based violence, particularly within the family and the mother-daughter relationship. The aim is to end the cycle of re-victimization of women that have been victims of violence, helping women that have been victims of violence become aware of their co-responsibility in taking on the role of the victim and unconsciously perpetuating this pattern through their daughters. This is accomplished through the use of two intervention methods: the ecological and psychodramatic method (Testoni, Cottone, Armenti & Guglielmin, 2011).

The theoretical background supporting our project intervention originates from the hypothesis that socio-cultural factors contribute to promoting violence against women and that these factors are transmitted over time by the women themselves to their daughters through an upbringing where submission is implicit (Testoni, Guglielmin, Pogliani & Silvestrin, 2010). It follows therefore that the intervention should begin from the women that have been victims of violence, so that they themselves can become aware of the mechanism of transmission of violence which includes taking on a victim role so that they can bring about a change in their lives (Testoni & Codato, 2011).

We utilized a longitudinal research design separated into two stages: the first stage consisted in validating the cross-cultural hypothesis model and the second stage instead, was the intervention phase conducted with women victims of violence, this phase was further divided into two stages: pre-intervention and post-intervention.

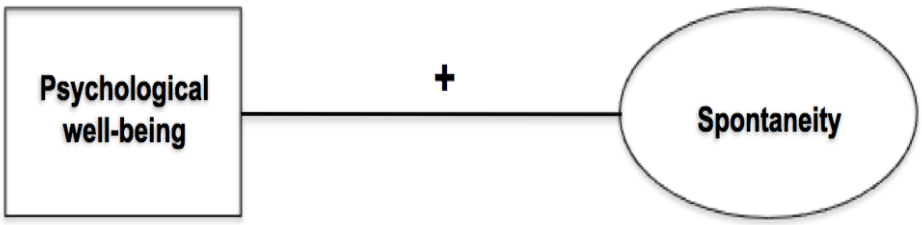
Objectives and hypothesis

According to Moreno (1947), the psychodramatic method is an elective intervention method for supporting women who are caught up in victim-perpetrator relationships.

We used a longitudinal research design and structured it into two stages: the first stage of validation with a non-clinical sample, aimed at verifying the theoretical model, and enabled us to set the underlying assumptions for the six countries studied in the project (Italy, Austria, Portugal, Romania, Bulgaria and Albania) and make cross-cultural comparisons; the second stage of the intervention used a clinical sample, and was aimed at verifying the effectiveness of the psychodramatic method.

Our hypothesis is that high levels of spontaneity are associated with psychological well-being and that women who have been victims of violence demonstrate levels of spontaneity and well-being that are lower than in the general population, levels that would increase after the intervention (Figure 1).

Figure 1. Main Hypothesis



Participants and instruments

The participants in the first stage of the validation were 407 university students, aged between 18 and 24 years (M= 20.58, SD= 1.48). Table 1 illustrates the sociodemographic characteristics of the sample for each country investigated.

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Table 1. Non clinical sample

		Age (years)		
Country	***N***	***Range***	***M***	***SD***
Italy	83	19-24	20.99	1.38
Austria	73	18-24	20.68	1.38
Bulgaria	63	18-24	19.88	1.73
Portugal	67	18-24	20.73	1.61
Romania	52	18-24	20.44	1.16
Albania	69	18-24	20.57	1.27

There were 136 women that took part in the second stage of the intervention, these women were victims of domestic violence, aged between 15 and 68 years (*M*= 36.6, *SD*= 12.95), and on average had 11 years of education (*SD*= 3.98). Table 2 highlights the sociodemographic characteristic of the sample for each country investigated.

Table 2. Clinical sample

		Age (years)			*Education (years)*	
Country	***N***	***Range***	***M***	***SD***	***M***	***SD***
Italy	14	26-58	38.64	9.37	13.21	3.86
Austria	33	16-68	41.15	12.78	12.13	3.26
Bulgaria	21	22-66	39.71	12.02	14.33	2.49
Portugal	17	24-68	46.4	12.72	7.9	3.26
Romania	33	19-62	33.18	9.15	11.48	3.55
Albania	18	15-24	20	3.38	7.38	3.10

The construct of *psychological well-being* was investigated by administering the CORE-OM (Clinical Outcomes in Routine Evaluation Outcome Measure) (Evans at al., 2002), while the construct of *spontaneity* was measured using the SAI-R (Spontaneity Assessment Inventory- Revised) (Kipper & Shemer, 2006).

Results

The results of the analysis carried out for each country confirm the hypothesis that high levels of spontaneity are associated with psychological well-being and that in a clinical sample, levels of spontaneity and psychological well-being increase after the intervention. For a detailed view of the results relative to the validation of the theoretical model in the six different countries that took part in the Empower Daphne project, please refer to the earlier work of Testoni et al. (2012a, 2013a, 2013b). Also with regard to the findings relative to the efficacy of the Empower project intervention, please refer to the earlier work of Testoni et al. (2012b, 2013c).

We will now present the results that compare levels of well-being (CORE-OM) and spontaneity (SAI-R) between the clinical sample and the non-clinical sample, both prior

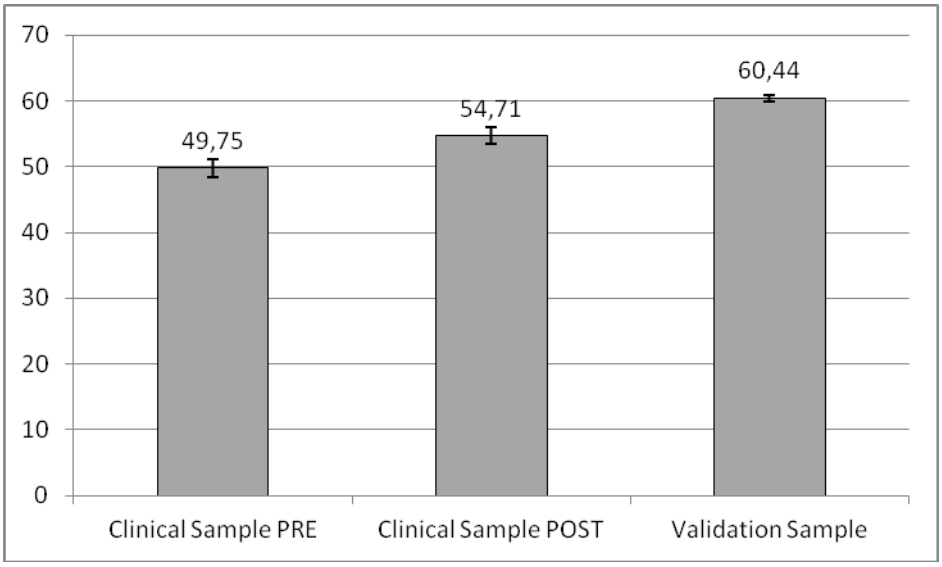
to the intervention and after the intervention, and the comparisons with the clinical *cut-off* scores.

Spontaneity

We calculated the averages of the non-clinical and clinical samples on the scale of spontaneity using the SAI-R. During the validation phase, the respondents in the non-clinical sample had an average response rate of 60.44 (*SD*= 9.76); while the average score for the clinical sample was 49.75 (*SD*= 16.48) in the pre-intervention phase and equal to 54.71 (*SD*= 14.74) in the post-intervention phase.

Chart 1 show the differences between the mean scores of the non-clinical sample and the clinical sample. The analysis showed significant differences between the mean scores of the non-clinical sample and the mean scores of the clinical sample, both pre-intervention (*t(541)*= -9,12 *p*< .001) as well as post-intervention (*t(541)*= -5,14 with *p*< .001). Therefore, women that are victims of domestic violence display indices of spontaneity that are lower than the non-clinical population both before the intervention as well as after the intervention, despite the fact that in the latter case there is a significant improvement. (Testoni at al., 2012b, 2013c).

Chart 1. Differences between mean scores of spontaneity



Psychological well-being

We calculated the averages of the non-clinical and clinical sample on the scale of psychological well-being using the CORE-OM. During the validation phase, the respondents in the non-clinical sample had an average score equal to 1.17 (*SD*= .52); while the total average in the clinical sample was 1.65 (*SD*= .56) in the pre-intervention phase, and equal to 1.41 (*SD*= .59) in the post-intervention phase.

As for the different domains underlying the construct of psychological well-being, we reported the following average scores

For the dimension of **subjective well-being,** the average score in the non-clinical sample was 1.17 (*SD*= .52), while the average score in the pre-intervention clinical sample was equal to 2 (*SD*= .74) and 1.41 (*SD*= .59) post-intervention. For the

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dimension **symptoms,** the average score of the non-clinical sample was 1.25 (*SD*= .74), while the average score of the clinical pre-intervention sample was 1.97 (*SD*= .81) and 1.53 (*SD*= .83) at post-intervention. For the dimension of **functioning**, the average response score in the non-clinical sample was equal to 1.44 (*SD*= .63), while the average score of the clinical sample prior to the intervention was 1.79 (*SD*= .59) and 1.69 (*SD*= .66) after the intervention. For the dimension of **risk,** the average score of the non-clinical sample was equal to .15 (*SD*= .34), while the average score in the clinical pre-intervention sample was .48 (*SD*= .63) and .33 (*SD*= .54) post-intervention. Lastly, for the dimension **non risk,** the average score of the non-clinical sample was equal to 1.39 (*SD*= .60), while the average score for the clinical sample prior to the intervention was equal to 1.90 (*SD*= .61) and 1.64 (*SD*= .65) post intervention.

Chart 2 and 3 highlight the differences between the average non-clinical and clinical scores on each domain of the CORE-OM. A review of the figures demonstrate significant differences between the mean scores of the non-clinical and clinical samples, both before the intervention (*t(541)*= 9.09 as well as *p*< .001) after the intervention (*t(541)*= 4.51 with *p*< .001). These results illustrate how women that are victims of domestic violence demonstrate indices of psychological distress that are higher compared with the non clinical population both before and after the intervention, even though in the latter case there is a significant improvement (Testoni at al., 2012b, 2013c).

Chart 2. Differences between total mean scores of psychological distress

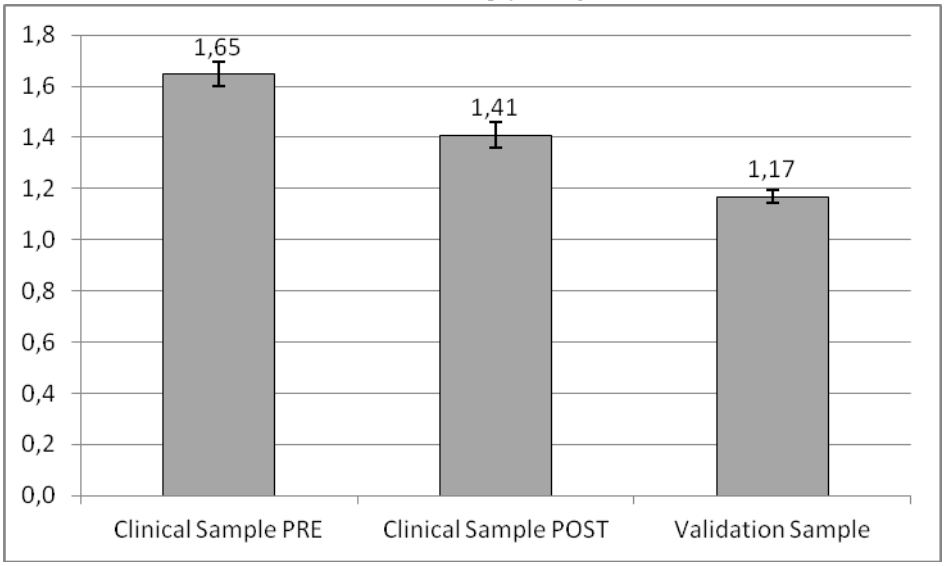
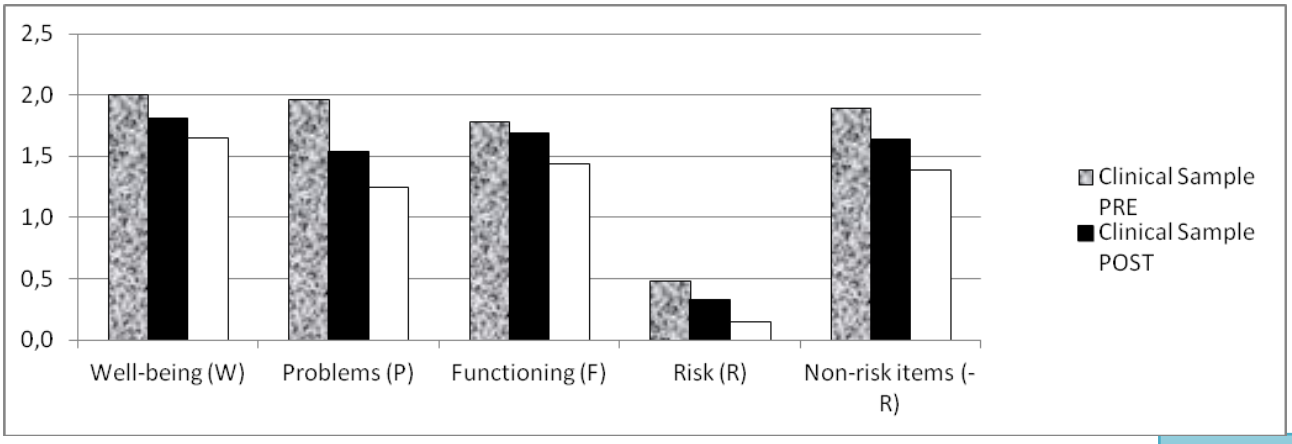


Chart 3. Differences between total mean scores of psychological distress domains



Note: Well-being (W), Problems (P), Functioning (F), Risk (R), Non-risk items (-R)

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A review of the scores demonstrate significant differences between average scores obtained by the non-clinical sample and the scores obtained by the clinical sample both before the intervention (Table 3) as well as after the intervention (Table 4).

Table 3. Students *t* (non-clinical vs. clinical ex-ante)

CORE-OM Domains	***t***	***df***	***sig.***
Subjective well-being	4.59	541	.001
Problems	9.58	541	.001
Functioning	5.76	541	.001
Risk	7.75	541	.001
Non-risk	8.58	541	.001

Table 4. Students *t* (non-clinical vs. clinical ex-post)

CORE-OM Domains	***t***	***df***	***sig.***
Subjective well-being	2.12	541	.034
Problems	3.76	541	.001
Functioning	4.01	541	.001
Risk	4.45	541	.001
Non-risk	4.21	541	.001

These results illustrate how women that are victims of domestic violence demonstrate indices of psychological distress that are higher compared with a non clinical population both before and after the intervention, even though in the latter case there is a significant improvement (Testoni et al., 2012b, 2013c).

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Comparisons with the clinical cut-offs

Evans et al. (2002) and Connell et al. (2007) have identified some cut-off scores that provide a guideline for placing individuals into either clinical samples or non-clinical samples. Evans et al. (2002) provided cut-off scores of 1.19 for men and 1.29 for women (Table 5); the more recent work of Connell et al. (2007) identified a single cut-off score of 1 for both men and women.

Table 5. Clinical Cut-off, CORE-OM (Evans et al., 2002)

	Male	***Female***
Well-being (W)	1.37	1.77
Problems (P)	1.44	1.62
Functioning (F)	1.29	1.30
Risk (R)	.43	.31
Non-risk items (-R)	1.36	1.50
Total	1.19	1.29

In order to verify and evaluate if the scores obtained in the intervention group (pre and post) are above or below the cut-off scores, we carried out an analysis that took into consideration the clinical cut-offs reported in the literature, in each domain of the CORE-OM, compared to the average scores obtained by the intervention group of every partner country in all CORE-OM domains in the pre-intervention and post-intervention phase.

Table 6, reports on the average scores obtained in the initial stage and in the final stage of the intervention with respect to all CORE-OM domains.

Table 6. Average scores on the CORE-OM (intervention sample)

	PRE		***POST***	
Country	***M***	***SD***	***M***	***SD***
Italy	**1.69**	**.80**	**1.19**	**.72**
Well-being (W)	.22	.13	.18	.11
Problems (P)	.68	.37	.42	.36
Functioning (F)	.59	.26	.49	.26
Risk (R)	.20	.19	.09	.08
Non-risk items (-R)	1.49	.72	.09	.66
Austria	**1.71**	**.56**	**1.39**	**.74**
Well-being (W)	.25	.10	.20	.11
Problems (P)	.76	.22	.63	.31
Functioning (F)	.63	.22	.52	.31
Risk (R)	.07	.08	.04	.08
Non-risk items (-R)	1.63	.51	1.36	.70
Bulgaria	**1.73**	**.46**	**1.54**	**.38**
Well-being (W)	.25	.04	.22	.07

Problems (P)	.73	.28	.57	.25
Functioning (F)	.70	.15	.75	.13
Risk (R)	.06	.11	.05	.06
Non-risk items (-R)	1.67	.39	1.50	.35
Portugal	**1.83**	**.35**	**1.70**	**.40**
Well-being (W)	.26	.07	.24	.03
Problems (P)	.77	.23	.66	.27
Functioning (F)	.72	.14	.72	.12
Risk (R)	.08	.08	.08	.10
Non-risk items (-R)	1.75	.32	1.61	.33

(Continued)

	PRE		***POST***	
Country	***M***	***SD***	***M***	***SD***
Romania	**.20**	**.40**	**1.46**	**.37**
Well-being (W)	.23	.06	.24	.06
Problems (P)	.69	.28	.50	.25
Functioning (F)	.69	.15	.67	.14
Risk (R)	.06	.08	.04	.06
Non-risk items (-R)	1.61	.36	1.41	.33
Albania	**1.19**	**.66**	**1.10**	**.69**
Well-being (W)	1.19	.11	.17	.12
Problems (P)	.58	.33	.41	.28
Functioning (F)	.39	.20	.43	.20
Risk (R)	.09	.12	.08	.17
Non-risk items (-R)	1.09	.56	1.01	.54

Subjective well-being

In regards to the comparisons carried out for testing the domain of subjective well-being, the Mc Nemar test result was significant with a score of $p = .005$. The percentage of women that went from a score above the clinically significant threshold during the pre-intervention stage to a score below the threshold after the intervention (22,8%) is significantly higher than the percentage of women that went from a score under the threshold during pre-intervention, to a score above the threshold after the intervention (8,8%). The percentage of women whose score remains stable below the cut off scores both at the first and second test administration was equal to 25,7%, while the percentage of women that remained stable above the clinically significant cut-off scores was 42,6%.

Problems

The results of the McNemar test that were conducted to compare *Problems* items were significant ($p < .001$) in that the percentage of women that went from a score

above the clinically significant threshold in the pre intervention stage to a score below the threshold after intervention phase was (26,5%) and this is significantly higher than the percentages of women that recorded opposite results (5,1%). The percentage of women whose score remains stable below the clinically significant cut off scores both at the first and second test administration was equal to 27,9%, while the percentage of women that remained stable above the clinically significant cut-off scores was 40,4%.

Functioning

With regard to the *functioning* domain of the CORE-OM, the Mc Nemar test results were insignificant ($p = .169$) in that the percentage of women that went from a score above the clinically significant threshold in the pre stage to a score below the threshold after the intervention phase was (12,5%) which is not significantly higher than the percentage of women who had reverse results (6,6%). Eleven point eight percent of women had a score that remained stable below the clinically significant cut-off scores both at the first and second test administration, while the percentage of women that remained stable above the clinically significant cut-off scores was 69,1%.

Risk

The results on the McNemar test that compared the *Risk d*omain for all the countries involved in the project were statistically significant ($p = .002$). The percentage of women that went from a score above the threshold to a score below the threshold was 24,3%, while in 8.8% of cases the women went from scoring under the threshold to above the threshold. Thirty-seven-point five percent of women had a score that remained stable below the clinically significant cut-off scores both at the first and second test administration, while the percentage of women that remained stable above the clinically significant cut-off scores was 29,4%.

Non risk items

The Mc Nemar test results were statistically significant for the comparisons carried out for the non-risk items, ($p < .001$). The percentage of women that went from a score that was above the threshold to a score that was under the threshold was clinically significant (23,5%) and in fact, is significantly higher than the percentage of women that went from under the threshold score to above the threshold. (3,7%). The scores remained stable and under the threshold in 17.6% of cases, while the percentage of women whose scores remained stable over the clinically significant threshold was 55,1%.

Totals

The Mc Nemar test carried out for comparing totals was significant ($p < .001$). In fact, 24.3% of women scored above the clinically significant threshold scores in the pre-phase and finished under the threshold in the post phase, while only 5.9% of women's scores took the opposite direction. The percentage of women that remained stable under the clinically significant threshold scores both at the first as well as the second test administration was 17.16%, while the percentage of women that remained stable above the clinically significant threshold scores was 52.20%.

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Conclusion

In the present article, we outlined that the main objectives of project Empower was to first of all check the validity of the theoretical model on which the project hinges, through the administration of the SAI-R and CORE-OM, that measure indices of spontaneity and psychological well-being; secondly, another objective was to test the efficacy of various intervention models (ecological and psychodramatic) In the previous studies by Testoni et al. (2012a, 2013a, 2013b, 2012b, 2013c) it's possible to observe how the results confirm the hypothesis (in all the countries examined), that high levels of spontaneity are associated with psychological well-being and confirms that the two interventions used in our project, appear both to be effective support techniques that are appropriate in addressing the needs of women that are victims of domestic violence. In fact, the findings recorded by the test instruments seem to indicate that these interventions promote an increase in spontaneity and therefore psychological well-being. This is in line with the theoretical assumptions from which the project developed: to trigger the process of empowerment of women that have been victims of domestic violence, understood as the recovery of spontaneity and psychological well-being.

In specific, in this paper we presented the results concerning comparisons of levels of well-being and spontaneity between the clinical and non-clinical sample, and between the clinical cut-off scores highlighted in the literature and the scores of the patient sample.

The results show noteworthy differences between the non-clinical sample and the clinical sample. We measured lower levels of spontaneity and psychological well-being in women victims of domestic violence compared to the normal population, both before and after the psychodramatic intervention, although in the latter case there was a significant improvement (Testoni at al., 2012b, 2013c). Furthermore, the results that refer to the comparisons with the clinical cut-off scores in the literature, highlight how women victims of domestic violence exhibit indices of psychological distress that are higher with respect to the non-clinical population, both before and after the intervention, in all the domains underlying the construct, although in the latter case we witnessed a significant improvement.

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