The Impact of The Freedom Programme on Construing, Coping and Symptomatology in Women who have Experienced Intimate Partner Violence: a Personal Construct Approach

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Contents

List of Tables

List of Figures

Abstract

The overall aim of the present research is to contribute to the literature base regarding interventions for women who have experienced Intimate Partner Violence (IPV). The research utilised questionnaires and repertory grid technique to investigate the impact of The Freedom Programme, a group intervention for women who have experienced IPV. 24 participants at pre-intervention and 18 participants at post-intervention completed the measures. The findings suggest that the intervention can be beneficial in terms of lowering: severity of symptoms; utilisation of emotionally focused coping strategies, utilisation of less helpful coping strategies and Triadic Conflict (Bell, 2004). There was a tightening of construing at post-intervention. Participants reported the most helpful aspects of the intervention were 'Universality' and 'Personal Contact'. The most unhelpful aspects were finding it difficult to speak in a group context and the practicalities of the group. The author concludes that the programme provides a valuable first step for women who have experienced IPV, however, development of services that follow on from the intervention need to be more focused to meet individual needs. Recommendations for future research include more longitudinal research, which encompasses Randomised Control Trail methodology reviewing packages of support. There is also a need to conduct research with harder to access women who have experienced IPV.

1. Introduction

The current research aims to examine the impact of a group intervention, The Freedom Programme, on women who have experienced Intimate Partner Violence (IPV) from a Personal Construct Psychology perspective, with 'impact' measured by changes in measures conducted at pre-intervention and post-intervention.

This chapter will first introduce the subject area of IPV, with relevant terminology and statistical information regarding the estimated frequency of IPV in the United Kingdom. Next, a summary of predominate explanations for why women stay in abusive relationships, followed by literature relating to the consequences of experiencing IPV. Then a summary of coping styles utilised by women who have experienced IPV will be presented, followed by a section documenting the historical progression and current format of group interventions for women who have experienced IPV. Lastly, a description of The Freedom Programme, the intervention at the source of this research will be presented.

The theoretical position of the research, Personal Construct Psychology, will then be introduced with an explanation of key concepts relevant to the current research and a justification for using this approach in research with women who have experienced IPV. Finally, the author will present the rationale for the current research and specify the research hypotheses. For the literature search strategy employed in this research, please see Appendix 1.

1.1. Terminology

1.1.1 Intimate Partner Violence

The American Centres for Disease Control and prevention (CDC, 2010) divide Intimate Partner Violence (IPV) into four categories (Saltzman, Fanslow, McMahon, & Shelley, 2002). First, physical violence, defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Second, sexual violence, which is divided into: a) use of physical force to compel a person to engage in a sexual act against his or her will; b) the attempted or completed sex act involving a person who is unable to understand or consent; c) abusive sexual contact. Third, threats of physical or sexual violence using words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical

harm. Fourth, psychological or emotional violence involving trauma to the victim caused by acts, threats of acts, or coercive tactics. This includes stalking, which is generally referred to as 'harassing or threatening behaviour that an individual engages in repeatedly' (CDC, 2010).

For the reader's reference throughout the research the term 'women who have experienced IPV' will be used to describe women who are still in abusive relationships and those who have left their abusive relationships. The author recognises that men also experience IPV; however, this will not be discussed due to the scope of the current research.

1.1.2. Domestic Violence

In the United Kingdom (UK) the definition of 'Domestic Violence' is used for policy and statistic collation and covers psychological, physical, sexual, financial and emotional abuse. Following a British Government Consultation in March 2013 the Home Office widened the definition of Domestic Violence to 'Domestic Violence and Abuse', which now encompasses those aged 16-17 and includes coercive control (Home Office, 2013)[1].

1.2. Prevalence of Intimate Partner Violence

Abuse of women by their partners is a worldwide phenomenon (WHO, 2001, 2010; Watts & Zimmerman, 2002). The World Health Organisation (WHO) suggests a lifetime prevalence of between 10%-50% for all women worldwide (WHO, 2010).

At the time this research was written the most recent publication of the Home Office's British Crime Survey was published in 2012 based on data collected between 2011 and 2012. The results stated that 7.3% of women (1.2 million) reported having experienced IPV between 2011 and 2012. 24% of women stated that they had experienced IPV since the age of 16. Women aged between 16 and 24 were more likely to be victims of IPV. The highest risk group for IPV were women who had separated from their abusive partners (1 in 5 of recorded victims). It is likely that the survey results are underestimated because of the reliance on self-report (Stanko, 2000).

1 The previous definition defined domestic violence as a single act or incident. The new definition recognises that patterns of behaviour and separate instances of control can add up to abuse - including instances of intimidation, isolation, depriving victims of their financial independence or material possessions and regulating their everyday behaviour (Home Office, 2013).

1.3. Recent UK Government Legislation regarding Intimate Personal Violence

In 2010, Baroness Stern reviewed the handling of sexual and physical violence complaints by public authorities. As a result of this review the coalition government published its strategic vision outlining their ambition to end violence against women and girls. In 2012 the UK government allocated nearly £40 million in stable funding until 2015 for specialist local support services and national helplines for women who have experienced IPV.

1.4. Explanations for why women stay in abusive relationships

Recent changes in UK legislation are promising, but they are not comprehensive enough to end IPV. Many researchers agree that the problem is far broader, encompassing widespread cultural, social, economic, political and psychological factors (Matjasko, Niolon, & Valle, 2013). Explanations for this vary a great deal, and due to the scope of this research only a very brief account of the three predominant theories will follow.

1.4.1. Social Learning Theory

Social Learning Theory suggests that from a young age women can learn that abuse is acceptable. This is positively reinforced as family members also accept the abuse and institutions fail to appropriately identify and punish perpetrators (Cochran, Sellers, Wiesbrock, & Palacios, 2011). Criticisms of this perspective state that individuals are perceived as passive receivers of societal ideals, without agency or ability to critically review their circumstances (Forsyth, 2010).

1.4.2. Feminist Perspective

The Feminist Perspective emphasises the gender and power inequality in opposite-sex relationships as the root cause of IPV (Dutton, 2006). This perspective states that societal messages sanction a male's use of violence and aggression throughout his life, and the prescribed gender roles that dictate how men and women should behave in their intimate relationships (Caprioli, 2005). Feminist theorists conclude that IPV occurs as a result of living in a society that condones aggressive behaviours perpetrated by men. It also concludes that women are socialised to be non-violent.

One criticism of the Feminist perspective is that it is unable to account for IPV that occurs within same-sex relationships, which requires a more comprehensive analysis and

explanation. Also the perspective has limited utility in explaining IPV perpetrated by women (Dutton & Nicholls, 2005).

1.4.3. Integrative approaches

The integration of psychological, interpersonal, familial, social and cultural perspectives is suggested as the most suitable approach to consider when attempting to explain why women stay in abusive relationships (Lawson, 2003). There is general agreement among researchers that IPV has multiple causes at multiple levels and that integrative explanations must be utilised to help understand the phenomenon. Integrative models offer the most promise toward explaining the multiple determinants of intimate partner violence (Lawson, 2003).

1.5. The Consequences of Intimate Partner Violence

There has been a great deal of research that investigates the consequences related to experiencing IPV. In this section a brief summary of significant research will be presented.

Research with women who have experienced IPV has found that participants meet the diagnostic criteria for a large number of mental health conditions (Trevillion, Oram, Feder, & Howard, 2012). The two conditions most frequently associated with women who have experienced IPV are Post Traumatic Stress Disorder (PTSD) (Taft, Watkins, Stafford, Street, & Monson, 2011) and Depression (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012). IPV is also associated with drug and alcohol addictions (Fowler & Faulkner, 2011). Of most concern is the link between IPV and suicidal ideation and suicide (McLauglin, O'Carroll, & O'Connor, 2012; Pico-Alfonso et al., 2006; Salari, 2008; Thompson, Kaslow, & Kingree, 2002).

Research has found that women who have been chronically and repetitively abused by their partners over a number of years exhibit the highest levels of symptom severity. This is referred to as the 'dose-response effect' where severity of abuse and severity of symptoms are linked (Golding, 1999; Kaysen, Rosen, Bowman, & Resick, 2010; Kira, Lewandowski, Somers, Yoon, & Chiodo, 2012; Lacey, McPherson, Samuel, Sears, & Head, 2013; Machado, de Azevedo, Facuri, Vieira, & Fernandes, 2011; O'Donovan, Neylan, Metzler, & Cohen, 2012; Pico-Alfonso et al., 2006).

There are several criticisms of the 'dose-response effect'. Researchers suggest that it is too reductionist and an insufficient explanation of trauma sequelae (Kaysen, et al., 2010). Researchers suggest other factors play a role in the impact of trauma, like context (Bhandari, Winter, Messer, & Metcalfe, 2011), socio-economic status (McLaughin et al., 2012) and personal resilience (Collishaw et al., 2007). In the longitudinal Isle of Wight study, Collishaw et al. (2007), found, from a sample of adults who had experienced repetitive childhood abuse, 55% reported psychiatric difficulties in adulthood, but 45% did not. This suggests that a range of contextual and individual factors impact on the sequelea of trauma (Bhandari et al., 2011; Kaysen, et al., 2010).

Physically, women who have experienced IPV may also have a number of long-term and short-term physical health problems (WHO, 2010; Wu, Huff, & Bhandari, 2010). The health risks for pregnant women are substantial, with potential loss of a foetus (Jejeebhoy, 1998). Serious physical injury can also lead to the death of women (WHO, 2010; Campbell, Glass, Sharps, Laughon, & Bloom, 2007).

Systemically, IPV can impact upon women's relationships (Hughes & Chau, 2013; Kaukinen, Meyer, & Akers, 2013) and employment (Swanberg, Macke & Logan, 2006) and women can experience judgement and stigma from society (Chang et al., 2005). Women who have experienced IPV frequently access health services (Campbell, 2002), being admitted more and medicated more than women who have not experienced IPV (Koss, Koss, & Woodruff, 1991; Wisner, Gilmer, Saltzman, & Zink, 1999). It is almost impossible to attempt to calculate the cost of IPV to the UK economy (Gold et al., 2011), but research by Walby (2009) has estimated that around £15,730 million a year (in 2008) was spent on the direct and indirect services required as a consequence of IPV. This includes government provision of health, justice, child protection and welfare services.

1.6. Intimate Partner Violence and coping style

There is no agreed definition of coping styles between all researchers (Carver, Scheier, & Weintraub, 1989). This may be because coping is a fluid and flexible ability (Mitchell et al., 2006) and people are able to utilise more than one method at any one time (Lazarus, 2006). Research also suggests that all coping is adaptive (Brady, Gorman-Smith, Henry, & Tolan, 2008) and utilisation will vary across cultures and contexts (Lee, Pomeroy, & Bohman, 2007;

Shannon, Logan, Cole, & Medley, 2006). The author recognises that there is a wealth of literature regarding coping; however, due to the scope of the current research this cannot be explored. For the purposes of the current research the terms Problem Focused Coping, Emotionally Focused Coping and Less Helpful Coping will be used with reference to the IPV literature. These distinctions are used because they are based on Carver et al.'s (1989) model, which is used in the current research.

1.6.1. Problem Focused Coping

Within the coping literature Problem Focused Coping (PFC) is typically defined as managing stress by actively attempting to problem-solve by use of planning or of instrumental support. This can also be referred to as 'approach' coping as the individual attempts to approach the problem (Littleton, Horsley, John, & Nelson, 2007). Research suggests that women who experienced IPV and utilised PFC have lower rates of depression, a greater sense of mastery over problems and higher levels of self esteem (Gavranidou & Rosner, 2003). Reviere et al. (2007) found women with an experience of IPV who were utilising PFC had lower suicide attempts and were employing strategies to try and leave the relationship. Shechory's (2013) research findings suggest that women in refuges utilised PFC more frequently in comparison to a control group comprised of women who had and hadn't experienced IPV.

Within this literature there is also the suggestion that psychological distress is lower in women who are utilising the following types of PFC: active coping (Kanagaratnam et al., 2012; Kemp, Green, Hovanitz, & Rawlings, 1995); planning (Reviere, et al., 2007); and utilising instrumental support and problem solving (Sullivan, Schroeder, Dudley, & Dixon, 2010). However, a meta-analysis by Littleton (2007) has found no relationship between utilisation of PFC and psychological distress.

1.6.2. Emotionally Focused Coping

Within the coping literature Emotionally Focused Coping (EFC) is typically defined as managing stress through changing the emotional response (Carver, et al., 1989). The following EFC strategies have been associated with women who have experienced IPV: utilising emotional support (Lettiere & Spano Nakano, 2011; Reviere et al., 2007; Richards & Branch, 2012; Sullivan et al., 2010); acceptance (Ting, 2010); and utilisation of religion (Bradley, et al., 2005; Reviere et al., 2007; Ting, 2010). Some research suggests women who

have experienced IPV are more likely to utilise EFC (Zink, Jacobson, Pabst, Regan, & Fisher, 2006). Lily and Graham-Bermann's (2010) research suggests that women who have experienced IPV and utilise EFC are more likely to develop PTSD whereas women who utilised PFC were less likely to develop PTSD. However, a meta-analysis by Littleton (2007) has found no relationship between utilisation of EFC and psychological distress.

1.6.3. Less Helpful Coping

Within the coping literature, Less Helpful Coping (LHC) is typically defined as avoidance of dealing with the stressor. This is sometimes also referred to as avoidance coping or maladaptive coping. Research suggests that LHC utilisation can lead to increased psychological distress (Krause, Kaltman, Goodman, & Dutton, 2008; Littleton et al., 2007). Waldrop and Resick (2004) have found that as violence within the relationship increases so too does the utilisation of LHC. Some research regarding coping in women who have experienced IPV has found a high incidence of LHC methods including: behavioural disengagement (Calvete, Corral, & Estevez, 2007, 2008; Iverson et al., 2013); substance use (Guggisberg, 2009); and avoidance (Amirkhan, 1990; Krause et al., 2008; Sullivan et al., 2010; Ting, 2010).

1.6.4. Limitations of coping literature

One of the limitations of the coping literature is that there are no agreed classifications or agreed measures, making investigations and comparisons of the literature problematic. Coping styles are difficult to classify as they are flexible and constantly evolving depending on the context and the individual (Shechory, 2013). In addition to this, typically, samples are drawn from clinical services where they are accessing support. This forms a bias, with a higher incidence of help-seeking behaviour within the sample (Waldrop & Resick, 2004). There are also many factors that place constraints upon utilisation of coping; for example, resources available and the responsiveness of the potential help sources. It is possible that someone who receives negative responses to their help seeking behaviour may avoid asking for help again. In addition to this, the help has to be available so that it can be sought. All these factors will impact upon coping style utilisation.

1.7. Group Interventions for women who have experienced IPV

The next section will present the context, research and limitations of research regarding group interventions for women who have experienced IPV. The author recognises that there are a variety of other interventions available to women who have experienced IPV; however, due to the scope of the current research they will not be discussed.

1.7.1. Group Interventions for women who have experienced IPV: The historical context

Using groups as a means of sharing and imparting knowledge is not a new phenomenon (Ettin, 1999; Maslow, 1963; Shelburne, 1988; Simon, 1978; Stevens, 1982). In the UK group psychotherapy initially developed independently, by pioneers Siegfried Foulkes and Wilfred Bion, during the 1930s and 1940s.

In the 1970s IPV became the focus of national attention in the UK arising from the women's movement within the contexts of feminism and women's rights. Women's Aid was set up in 1974 to provide practical and emotional support to women and children who had experienced IPV in the UK (Janovicek, 2007). One facility provided by organisations was that of the 'Battered Women's Shelter'(Janovicek, 2007), which became a recognised necessity to enable women to escape their abusers during the 1980's (Roberts, 2002). As the utilisation of shelters or refuges increased, the number of women living together with similar experiences also increased. Initially, refuge staff used group meetings as a means of efficiently imparting information about IPV. Over time women began to use these meetings to share their experiences and provide feedback to others (Roberts, 2002). It is these meetings that are recognised as the first group interventions for women who had experienced IPV (Janovicek, 2007).

In an attempt to support women who were still living with their abusive partners the group format was extended, by community agencies, to more public settings. As groups developed they began to include a number of different elements, providing not only emotional, but also practical support (Roberts, 2002). The group intervention has now become the most common form of intervention accessed by women who have experienced IPV (Stith & McCollum, 2011).

1.7.2. Group Interventions for women who have experienced IPV: Efficacy Research

In 2010 the World Health Organisation (WHO) conducted a review of research regarding interventions for women who have experienced IPV. They conclude that none of the interventions could be considered to be 'effective'[2] due to a lack of empirical research. The only programmes found to be 'effective' were school-based programmes to prevent violence within dating relationships. The WHO (2010) concludes that there was an emerging evidence-base of effectiveness, but that there was a need for more empirical research.

The emerging evidence-base suggests, in terms of outcome measures, that interventions increase the internal locus of control and self esteem (Tutty et al., 1993; Roberts, 2002; Home Office, 2005), and decrease the amount of abuse being experienced, stress, the severity of symptoms, and the feeling of social isolation (Crespo & Arinero, 2010, Home Office; 2005). Research also suggests interventions impact on attitudes and beliefs (Tutty, 1996; Zosky, 2011; Nabi & Horner, 2001; Home Office, 2005).

Contrary to this, other research has found little or no difference between pre-intervention and post-intervention, in measures of: cognitions, expression of emotion, anger, self esteem, contentment and level of abuse experienced (Holiman & Schilit, 1991; Rubin, 1991). Despite lack of change on measures participants did report that intervention had been a positive experience. A possible explanation for this is that the measures used were not sensitive enough or the wrong things were being measured. Research (Bhui & Buchanan, 2004; Home Office 2005) suggests careful consideration must be given to which measures relate well to the goal of an intervention for women who have experienced IPV.

Research by Cox and Stoltenberg (1991) has found that the same intervention[3] used with two different groups of women had different outcomes, with both experimental groups exhibiting positive responses on different measures in comparison to no change in the control group. These differences could be due to a number of factors, for example, the participants self assigned to either the control or experimental group and the groups were

2'Effective' refers to interventions being supported by multiple well-designed studies showing prevention of perpetration and/or experiencing of intimate partner and/or sexual violence. Strategies are deemed 'effective' if one or more empirically sound studies have demonstrated their effectiveness.

3 The intervention comprised of Cognitive Therapy, Self Assertiveness Training, Developing Problem Solving abilities, Vocational Counselling and Body Awareness Training.

demographically different. Additionally participants in one group completed additional measures.

There are also more general factors which may have contributed to the differences between the groups in Cox and Stoltenberg's (1991) research. One such factor is the role played by the therapeutic alliance, which is the relationship between the therapist and the client. In outcome research a good therapeutic alliance is consistently related to positive therapeutic outcomes (Burnett & McNeill, 2005; Rex & Rivett, 1999; Trotter, 2000, 2007). Another factor is the impact of the group dynamics or group climate on outcomes. Group climate refers to various dimensions of the helpful relationship qualities (engagement, cohesion, empathy, alliance) and unhelpful relationship qualities (conflict, avoidance) that are present during group interventions and impact on outcomes (Ryum, Hagen, Nordahl, Vogel, & Stiles, 2009). Research investigating the impact of group climate on outcome measures has found that following group therapy higher ratings of engagement were associated with reduced scores on all outcome measures (Ryum, et al., 2009). Higher ratings of group conflict have been associated with group drop-out (Brown, 2000). The implications of these findings are that good relationships with the therapist and other group members are likely to be related to therapeutic improvement.

In 1970 Irvin Yalom theorised 'Curative Factors' or therapeutic factors necessary for therapeutic improvement. He states these as: The Instillation of Hope; Universality; Imparting of Information; Altruism; Corrective Recapitulation of Primary Family Group; Development of Socializing Techniques; Imitative Behaviour; Catharsis; Existential Factors; Direct Advice; and Interpersonal Learning[4]. Yalom's theory has been highly influential around the world (Stone, 2000; Vlastelica, Urlic, & Pavlovic, 2001). Elliott (1985) proposed a theory of factors that may be unhelpful during therapy. He states these as: Misperception; Negative Counsellor Reaction; Unwanted Responsibility; Repetition; Misdirection Events; and Unwanted Thoughts[5]. Elliott (1985) also states helpful therapeutic factors as: Gaining a New Perspective; Problem Solution; Clarification of the Problem; Focusing Awareness; Understanding; Client Involvement; Reassurance and Personal Contact.

4 For a detailed description of each factor please see Appendix 2
5 For a detailed description of each factor please see Appendix 3

Some of the factors stated by Yalom (1979) and Elliott (1985) have been reported as beneficial when women who have experienced IPV participated in group-interventions. These factors are: Universality; Catharsis; The Receipt of Understanding; Learning; and Sharing (Beeble, Bybee, Sullivan, & Adams, 2009; Fortin, Guay, Lavoie, Boisvert, & Beaudry, 2012; Larance & Porter, 2004; McWhirter, 2011; Morales-Campos, Casillas, & McCurdy, 2009; Grip, Almqvist, & Broberg, 2011; Home Office, 2005). In addition to this, women report the receipt of practical guidance regarding how to access local services and resources as beneficial (Nabi & Horner, 2001; Postmus & Hahn, 2007).

1.7.3. Limitations within the group intervention literature

1.7.3.1. Research limitations: Design

There is a lack of empirical research regarding group treatment for women who have experienced IPV (Abel, 2000; Tutty et al., 1993; Wathen & MacMillan, 2003; Home Office, 2005; WHO, 2010). Often research conducted has small sample sizes, based within short term follow up and rarely uses control groups. An explanation for this is that the majority of women who take part in research are often recruited from refuges. This is relevant because often women access refuges in crisis situations; therefore, to deprive women of a refuge place and access to other services in order to meet Randomised Control Trial methodological requirements is both unethical and immoral (Rubin, 1991). As research participants often come from refuges this clearly biases the participant sample as women who access refuges may have certain characteristics. Also, following a refuge stay it is sometimes very difficult to re-contact women for longitudinal research as they may not give contact information or may have returned to their partner.

Additionally, it is very difficult to control for extraneous variables such as the therapeutic alliance and group climate. Lastly, there is still much uncertainty about what outcome measures relate well to the goals of interventions for women who have experienced IPV (Bhui & Buchanan, 2004; Home Office 2005).

1.7.3.2. Research limitations: Context

Another possible explanation for the lack of empirical research is that many interventions are often conducted within the Social Care or Charity sectors, which may not have the skills to conduct empirical research and have only recently started to routinely employ evaluation

methods within their practice (Dichter & Rhodes, 2011). There is a recognised need for more outcome evaluation within these sectors (Postmus, Severson, Berry, & Yoo, 2009; Sullivan et al., 2010).

1.7.3.3. The interventions

A difficulty for intervention implementers in this field is that women who have experienced IPV form a very diverse and eclectic sample (Watts & Zimmerman, 2002). They are also at varying stages of 'recovery', with some still in relationships, some planning to leave, and some who have left. Interventions are generally not tailored to these specifications and instead have an 'all are welcome' policy. The inability to clearly define best practice could be linked to the variability within this large population, as different styles and structures may work more effectively with different subgroups of women who have experienced IPV. Researchers have proposed that better outcomes would be achieved if interventions were tailored more to the individual's needs (Gondolf, 1998; Jonker, Sijbrandij, & Wolf, 2012; Norton & Schauer, 1997).

Another difficulty within this field is that many of the interventions are manualised because they are often delivered by facilitators without formal therapeutic qualifications (Abel, 2000). This may impact upon the facilitator's ability to manage the group and tailor the intervention to the group. Abel (2000) suggests that increased professionalization could result in more successful treatment outcomes for women who have experienced domestic violence. Morran (2011) suggests there is a need for practitioners to be skilled in more than the mechanics of programme delivery.

1.8. The Freedom Programme

1.8.1. The Freedom Programme: Origins and Structure

The group intervention upon which this research is based is called 'The Freedom Programme'. The programme is now run nationally and the manual and resource book can be accessed in fourteen different languages.

Pat Craven originally devised the programme in 1999 while she was working as a probation officer with male perpetrators of domestic violence in The Wirral, Merseyside, UK. The programme draws on the Duluth Model, which is an American cognitive therapy programme

used with male perpetrators of IPV. It is based on a 'violence as patriarchal' model, placing focus on the men's use of violence and abuse, rather than any of the other parties concerned. This programme has been adapted for women who have experienced IPV and examines attitudes and beliefs concerning the actions and responses of both male perpetrators and women who have experienced IPV. The programme aims to counter the phenomenon whereby women who have experienced abuse have little or no understanding of what has happened to them and feel largely to blame. It aims to provide an opportunity for women to develop ways of thinking and behaving to protect themselves, their children and others from harm and to provide them with the knowledge they need to achieve this.

The Freedom Programme consists of twelve weekly two-hour sessions held in community and children's centres using two facilitators. Facilitators usually have experience working within IPV services and some of the facilitators have experienced IPV themselves. In order to be a facilitator one must complete a two-day training programme run by Pat Craven. Facilitators then use a manual to deliver the programme and resource books are available for the women who attend.

1.8.2. Freedom Programme research

There has, to the author's knowledge, been no published research regarding The Freedom Programme. A number of unpublished evaluatory studies have been conducted across the UK asking women what they felt they gained as a consequence of the intervention. In summary, women reported that The Freedom Programme: increased awareness; confidence; acceptance; reflection; wellbeing; and empowerment. It changed beliefs, anxiety levels, understanding, knowledge about how to identify abusive men and decision-making. (Mackintosh, 2006; Wallace, 2006; Le Darcy, 2007; Monti, 2005; Bowden & Young, 2006; Williamson & Abrahams, 2010; Kent & Medway Council, 2010; Sutton Affinity, 2011). Participants stated that they gained strength from sharing and meeting people with similar experiences and that this gave them a sense of belonging in a friendly environment where they did not feel judged (Durham Council, 2006).

1.8.3. Limitations of the Freedom Programme

1.8.3.1. The theoretical basis of The Freedom Programme: The Duluth Model

Critics suggest that the Duluth model represents a reductionist approach to human behaviour (Ward et al., 2007). Macrae and Andrew (2000) suggest that The Duluth Model doesn't allow the person the opportunity to reconstruct an acceptable personal identity, one that allows a sense of purpose, fulfilment and growth. The wider research suggests the model is largely ineffective (Eisikovitis & Edleson, 1989) and can render women less safe (Edleson and Grusznski, 1989). Some authors suggest that the popularity of the model has arisen in a context of economically driven, one-size-fits-all approaches to the complexity of human behaviour (Bhui & Buchanan, 2004). Dutton and Corvo (2007, p4) insist that the Duluth Model was 'developed by people who didn't understand anything about therapy'. Despite its limitations it remains one of the most popular interventions to be used with male perpetrators of IPV and forms the basis for many female 'victim' programmes (Gondolf, 2007).

1.8.3.2. The content of The Freedom Programme

The author has some criticisms regarding the programme's content and questions whether focusing on the 'perpetrator' and his beliefs and actions is useful to empowering women and helping them to realise the role played by them in the relationship. The typography of the male characters referred to within the intervention is derived from the intervention creator's experience and not based on empirical research or theory[6]. This means that there is no empirical research regarding the content or benefit of the programme.

Also, making such clear distinctions between 'good' and 'bad' men may make establishing 'normal' relationships difficult as no man can live up to the ideal man presented within the programme. Additionally, many of the women who attend the programme are already aware that they were in an abusive relationship, which is why they sought out the programme; therefore, descriptions of abuse may be an unnecessary component of the intervention.

Lastly, it is unclear what the long term aims of the programme are and what women are expected to use from the intervention in the real world. Skills such as empowerment and

6 For male typographies used in the Freedom Programme please see Appendix 4

the development of problem-focused coping skills, which would be beneficial to this client group, are lacking from the intervention.

1.8.3.3. The delivery setting of the Freedom Programme

As Intimate Partner Violence is considered a 'social problem' (Lawson, 2003, Morran 2011), interventions for IPV, like The Freedom Programme, are often held within the Social Care and the charity sector. Because of this some interventions provided by these organisations are not developed as a consequence of research and are not subject to the regulatory guidelines, such as the National Institute of Clinical Excellence, which is used by the National Health Service to provide guidance about evidence-based practice. In addition to this, these organisations are not subject to the same outcome monitoring utilised by the National Health Service and do not routinely conduct empirical research reviewing interventions, which they provide.

1.9. Theoretical Position of the current research

The next section will briefly describe Personal Construct Psychology (PCP)[7] and define constructs and elements. Next IPV will be considered from a PCP perspective and relevant research stated. Following this PCP in relation to the current project will be discussed and finally how PCP may inform clinical practice with women who have experienced IPV.

1.9.1. Personal Construct Psychology

Personal Construct Psychology, developed by George Kelly (1955), suggests that an individual is a 'scientist' conducting experiments to gain meaning about their world. The outcome of the experiment either validates or invalidates constructions of the world that the individual holds. If the experiment outcome invalidates a construct then the individual may make a modification to their constructs of their world to incorporate the invalidation (Kelly, 1955). Kelly suggests that constructs enable an individual to anticipate and make predictions about future events, interpret events and make sense of the world by adding to already established constructs. This provides a framework within which we can come to understand and appreciate how another person theorizes about their world (Kelly, 1955). Kelly suggests that

7 For a more detailed description of PCP please refer to George Kelly's (1955/1991) original texts.

psychological distress occurs as a result of prediction failures or invalidations within a person's construct system.

1.9.2. Constructs and Elements

Kelly states that the constructs themselves are binary and only exist in relation to their opposite, for example, 'hot' is a construct because of its relation to 'cold'. Kelly suggests that a construct without an opposite will not be integrated into one's construct system. Constructs are not limited to verbal labels as they can occur pre-verbally and can transcend language (Kelly, 1955). We develop our own construct system, which is made up of a number of constructs, by noticing similarities between events, or people, which we simultaneously contrast with other events, or people. The term 'element' is used to describe such events or people.

The process of 'construing' is defined by Winter (1992) as active and ongoing attempts to make sense of our world and to anticipate future events. This involves making, testing and revising hypotheses and looking for repeated themes in our experiences.

Not all constructs are used in every situation because they have a limited 'range of convenience' (Kelly, 1955), meaning how applicable the construct may be to a range of events. Some ranges of convenience are very large, for example, the construct 'beautiful' could be applicable to people, places and things. However, the construct 'finicky' is applicable to only a very small number of things.

1.9.3. Personal Construct Psychology and Intimate Partner Violence

Intimate Partner Violence occurs within a relational, social, cultural and historical context. PCP is, therefore, well suited to examine this phenomenon as the theory takes into consideration the influence of these factors on a person's constructs. The exploration of constructs that an individual uses to make sense of their world is central to PCP (Warren, 1998). This theory takes into consideration not only the cultural context within which an individual is placed, but also recognises the importance of the sense that the individual makes of that context and how this is individualised, can be modified via experiments, and is influenced by society, history, economics and politics (Walker, Costigan, Viney, & Warren, 1996).

Within personal construct theory, The Sociality Corollary (Kelly, 1955) states that we are able to play a role in a relationship with others to the extent that we can construe their constructions. Most relationships are dependent upon some mutually held constructs, for example, constructs about monogamy and relationship roles. In an abusive relationship women may subsume the constructions of male power that their partner and society hold at the expense of their own views. IPV or the threat of IPV forms a power imbalance within the relationship, which is maintained by the roles within the relationship. In order to fulfil her role in the relationship she may be required to have an acceptance of him and his way of construing.

The Modulation Corollary (Kelly, 1955) suggests that some constructs are impermeable and resistant to modification regardless of our experiences. The notion of impermeable constructs within the context of IPV could be linked to the constructions held by society of male privilege and dominance over women, which if unchallenged maintain and contribute to society's collusion with the oppression of women (Morran, 2011). One could argue that until the society as a whole is able to change its construction then it may be very difficult for individual construing to change.

PCP brings hope for change to individual construing despite societal constructs. Kelly (1955) viewed therapy as a potentially liberating process of re-construction. PCP proposes that if individuals are helped to recognise societal constructions and constructions mutually held, for example between them and their abusive partner, it may create potential to reconstrue experiences and create alternative future options, therefore, creating liberation from being 'a victim of either her past history or her present circumstance' (Kelly, 1955, p. 30). Additionally, this understanding may help women to make sense of their situation in which they take some responsibility for the change process. Personal construct theory holds that in order to break the repetitive cycles one has to acknowledge their responsibility for their own behaviours and attitudes (Dalton & Dunnett, 2005; Winter, 1992).

Finally, considering the concept of relational construing (Procter, 2002) may be useful within interventions for IPV. It states that when we relate to people using individual constructs such as 'abuser' or 'abused' these constructs govern and shape actions towards the other and can

lead to recursive and repeating patterns of interaction in which couples can become trapped. Procter suggests that moving from individual construing of each partner to relational construing, where the relationship is considered, is helpful in ameliorating this tendency and creates potential for alternative construing (Procter, 2002).

1.9.4. Personal Construct Psychology and Intimate Partner Violence Research

Most research with women who have experienced IPV has utilised standardised measures or semi-structured and open-ended interviews. These types of assessment draw on theoretical constructs and rarely take account of the individual's perspective. PCP proposes that people have different experiences and, therefore, construe events differently, what Kelly refers to as the Individuality Corollary. PCP offers a way to explore the individuality between women who have experienced IPV and the similarities (The Commonality Corollary[8]) between them. This provides a richer understanding of the construing of women who have experienced IPV.

There is PCP literature regarding IPV, however, to the author's knowledge only two studies have used repertory grid technique (see section 1.10.1.) to explore the construct systems of women who have experienced IPV. Soldevilla, Aslan and Winter (2012) have compared the repertory grid data of women who had experienced IPV in Spain and control participants. Aslan (2012) has explored the structural characteristics of the construct systems of women in the UK who had experienced IPV and conducted systematic analysis of the construct content. The findings will be further described in the section 1.10. There is also a growing body of research regarding male 'perpetrators' of IPV from a PCP perspective. Macrae and Andrew (2000) have been instrumental in the incorporation of PCP informed interventions into 'recovery' programmes for male 'perpetrators' in Scotland. For a review of this literature please see Morran (2011).

1.9.5. Personal Construct Psychology and the current research

The current research aims to investigate the construing of women who have experienced IPV and examine the impact of the intervention on their construing. PCP provides a theoretical understanding of how change may or may not occur during a group intervention. The Experience Corollary (Kelly, 1955) states that we continually revise our personal constructs

8 The Commonality Corollary: To the extent that one person employs a construct of experience that is similar to that employed by another, his psychological processes are similar to those of the other person.

as the result of experience, so the group could provide a context to extend constructions. However, the Modulation Corollary (Kelly, 1955) suggests that changes to construing may not occur as not all new experiences lead to a revision of personal constructs, as some constructs are impermeable and resistant to modification regardless of our experiences.

1.10. Personal Construct Psychology measurement

The construct systems of the participants in the current research will be investigated using Repertory Grid Technique (RGT). The next section will present RGT and measures of RGT data to be used in the current research.

1.10.1. Repertory Grid Technique

Kelly devised Repertory Grid Technique (RGT) as a means of putting PCP into practice (Jankowicz, 2004). The technique has been described as a form of structured conversation, with the aim to discover how an individual construes their world (Fransella, Bell, & Bannister, 2004). It can be adapted to elicit descriptions of any range of experiences, people or objects, but the most common use is in assessing descriptions of the self and important others (Fransella, et al., 2004). A brief summary of the RGT will follow, but for a more detailed description of the process please read section 2.2.7.

Within the current research the elements of interest are the *self*, *ideal self* and significant other persons. The constructs are elicited by participants being asked to identify similarities and differences between the elements. For example, a participant may state that one element, her *partner*, is 'aggressive' and the other, her *mother*, 'not aggressive'. Following elicitation of the constructs the participant is then asked to rate how 'aggressive' each element is using a Likert scale[9]. The results are measures of construction, which are not only idiographic in content but also standardised and quantifiable in structure, making a statistical analysis possible.

Although there are other measures of semantic space and conceptual structure, such as the semantic differential and Q-Sort, these generally supply dimensions of meaning to the client

9 For a more detailed description of the process please read section 2.5.

rather than elicit them. Interview and narrative methods may allow elicitation of a client's constructs but are generally less suitable for the examination of structural features of construing.

1.10.2. Repertory Grid Technique Data investigation

An explanation of the measures derived from the RGT data used in the current research will follow.

1.10.2.1. Self in relation to Ideal Self

RGT data can be used to calculate the distance between the *self* and the *ideal self*. For example, if a participant were to construe her *self* as very different to her *ideal self* then the distance between the two would be large. It has been suggested that a large *self* to *ideal self* distance is indicative of psychological distress (Higgins, 1987; Makhlouf-Norris & Jones, 1971; Ribeiro, Feixas, Maia, Senra, & Dada, 2012) and, therefore, a positive therapeutic oucome may be for a client's *self* to *ideal self* distance to decrease.

Research conducted with women who had experienced IPV suggests that as the distance between construal of *self* and *ideal self* increased, the participant's symptom severity also increased (Aslan, 2012). Aslan (2102) has found no relationship between the *self* and *ideal self* distance and self esteem. Soldevilla, Aslan and Winter (2012) have found no significant difference between *self* to *ideal self* distance in women who had experienced IPV and the control participants.

In the wider PCP literature, regarding the impact of trauma, Sewell (2005) has suggested that experiencing trauma can lead to a discrepancy in the construing of the *self* and *ideal self*. Freshwater, Leach and Aldridge (2001) have found a larger *self* to *ideal self* distance with a group of participants who had experienced childhood sexual abuse compared to the control group. In contrast to Aslan (2012) research finds a relationship between larger *self* to *ideal self* distance and lower self esteem (Silber & Tippett, 1965).

In the wider PCP intervention literature regarding changes at post-intervention the following group interventions have found a reduction in distance between the *self* and the *ideal self* at post-intervention: group psychotherapy (Caine et al. 1981; Catina & Tschuschke, 1993);

group cognitive therapy (Neimeyer, Heath, & Strauss, 1985; Winter, 1985); group psychotherapy for women with postnatal depression (Morris, 1987); interpersonal transaction groups (Winter et al., 1997; Winter, Gournay, & Metcalfe, 1999); guided autobiography groups with older people (Botella & Feixas, 1992); and group treatment for incest (Alexander, 1987).

1.10.2.2. Extremity

RGT data can be used to calculate *extremity*. This is the extent to which people tend to use the extreme points on bipolar construct scales as opposed to the more central points, therefore, construing in very extreme ways (Shafenberg, 2006). This is often described as 'black and white' thinking, which is suggestive of rigid construing. For example, a participant may be rating elements on the construct of 'aggressive' or 'not aggressive' and only rate elements at either end of the spectrum, as opposed to being able to be more flexible and consider an element as 'aggressive at times'. It has been suggested that a higher *extremity* is associated with psychological distress (Arthur, 1966; O'Donovan, 1965; Hamilton, 1968) although Bonarius (1971) suggests *extremity* needs to be viewed as part of an array of other measures and not considered in isolation. In a review of literature Fransella et al., (2004) suggest that there is no satisfactory means of measuring *extremity*.

Research conducted with women who have experienced IPV found higher *extremity* in the participant sample compared to control participants (Soldevilla, Aslan & Winter, 2012). Aslan (2012) has found no significant relationships between *extremity* and measures of severity of symptoms, self esteem or abuse history.

In the wider PCP literature regarding the impact of trauma, research has found high *extremity* in participants who have experienced trauma in comparison to control participants (Erbes & Harter, 1999; Sewell et al., 1996; Shafenberg, 2006). In contrast to this other research has found no differences in *extremity* between clinical and control participants (Feixas, Erazo-Caicedo, Harter, & Bach, 2008). Higher *extremity* has also been found in individuals with depression (Feixas-Viaplana, Cipriano, & Dominguez, 2007).

1.10.2.3. Tightness of Construing

According to Kelly (1955) psychological movement occurs as a consequence of fluid ongoing tightening and loosening of constructs; 'loosening up old ones and tightening up the tentative formulations which begin to take shape in the resulting disarray' (Kelly, 1955; p484).

RGT data can be used to calculate *tightness of construing*. A tighter construct system would be limited to testing very few alternative predictions for making sense of their experience, whereas, a looser construct system would be open to varying alternative predictions for understanding and anticipating the world (Neimeyer, 1987). Tighter construct systems, therefore, enable more certainty about predictions; however, they make predictions more prone to invalidation because of their limited applicability. Tighter construct systems have been linked to psychological distress (Feixas et al., 2007).

Research conducted with women who have experienced IPV suggests that experiencing a higher frequency of physical abuse correlated with tighter construing (Aslan, 2012). Soldevilla, Aslan and Winter (2012) have found that the participants had tighter construct systems in comparison to the control participants.

In the wider PCP literature regarding the impact of trauma, it is suggested that experiencing trauma can lead to tighter construing (Sewell et al., 1996). Contrary to this Erbes and Harter (1999) did not find a relationship between experience of trauma and *tightness of construing* and Feixas et al., (2008) have found no difference in construing between clinical and control participants. Sewell and Cromwell (1990) have found that participants who have tighter *construing* following a trauma are more likely to experience anxiety. This links to the cognitive psychology literature which suggests that psychological flexibility is a fundamental aspect of health (Kashdan & Rottenberg, 2010).

In the wider PCP intervention literature regarding changes following a group intervention it is suggested that individuals with a tight personal construct system may be threatened by the prospect of reconstruction because this would necessarily involve change in their core constructs. Consistent with this prediction are findings that tight construing is associated with poor response in group treatment for alcoholics (Orford, 1974), group analytic psychotherapy (Winter, 1983), and personal construct group psychotherapy (Morris, 1987).

1.10.2.4. Conflict

The repertory grid data enables several possible analyses of conflict by examining the relationship between elements and constructs. The two utilised in this research are that of *triadic conflict* and *implicative dilemmas*.

1.10.2.4.1. Triadic Conflict (Bell, 2004)

Triadic conflict, developed by Bell (2004), indicates inconsistencies and contradictions in repertory grids. Conflicts may result in ambivalence rather than decisive choice if elements are construed in conflicting ways (Bell, 2004). Bell (2004, p54) states two conditions where triadic conflict may arise: firstly, an element is similar or close to one construct's pole and at the same time is different to or distant from another construct's pole, where the two construct poles are similar or close. Secondly, an element is at the same time similar or close to two constructs that are themselves different or distant. An example of triadic conflict could be if person may construe 'happy' people as 'domineering' yet construe an element (e.g. a friend) as 'happy' but 'not domineering', which invalidates the 'happy-domineering' construction. Research conducted with women who have experienced IPV has found no correlation between the amount of *triadic conflict* and severity of symptoms (Aslan, 2012).

1.10.2.4.2 Implicative Dilemmas

Implicative dilemmas (IDs), proposed by Hinkle (1965) and further refined by others (Feixas & Saúl, 2004; Feixas, Saúl & Sánchez Rodríguez, 2000; Rowe, 1971; Ryle, 1979; Tschudi, 1977; Winter, 1982, 1992), involve an awareness of an implicit cost associated with embracing one's *ideal self*. For example, at repertory grid interview a woman may construe her *self* as unhappy but her *ideal self* as happy. Happiness, however, is also construed to be a characteristic of people who are also domineering, rude and violent. Therefore, in order for the woman to move closer to 'happiness' and her *ideal self* she would have to become more domineering, rude and violent which she may be unwilling to do. Ultimately, whilst the woman construes happiness in this way she may abandon strivings toward becoming happy, which may not be desirable but is preferred to becoming domineering, rude and violent.

Research conducted with women who have experienced IPV found that these women had more *IDs* than control participants (Soldivilla, Aslan & Winter, 2012). Research by Aslan (2012) found no correlation between the number of *IDs* and severity of symptoms.

In the wider PCP literature regarding *IDs* research has found a relationship between a higher number of *IDs* and symptom severity (Badzinski & Anderson, 2012; Feixas, Saul, & Avila-Espada, 2009; Feixas-Viaplana et al., 2007; Melis et al., 2011). Feixas et al. (2009) stresses that the mere presence of *IDs* is not an indicator of psychopathology but that they seem to play a relevant role in mental health. Research by Dorough, Grice and Parker (2007) indicates that dilemmas were not generally predictive of psychological well-being after controlling for variability in self-discrepancies.

In the wider PCP literature, resolution of dilemmas has also been observed as a consequence of group analytic therapy (Caine et al., 1981) and Personal Construct Psychotherapy (Feixas & Saul, 2006; Feixas & Saul, 2004). In a literature review by Winter (2003) eight of nine studies demonstrate change in dilemmas at post-intervention, but not always in a direction that indicated the intervention to be beneficial. Most notably, Norris (1977) found that young offenders came increasingly to associate rule breaking with independence during their time in a detention centre.

1.11. Rationale of the current study

Literature reviews conducted by The Home Office (2005) and The WHO (2010) suggest that a greater understanding of women who have experienced IPV is needed. The current research sets out to replicate and extend the previous Personal Construct Psychology literature base by investigating the construing of women who have experienced IPV, which may contribute to our understanding of this client group.

The literature reviews conducted by The Home Office (2005) and The WHO (2010) also recommend that more evaluations of group interventions for IPV is a research priority as there is a distinct lack of quantitative research investigating interventions for women who have experienced IPV (WHO, 2010; Home Office, 2005; Wathen & MacMillan, 2003; Taft, et al., 2010; Abel, 2000). The current research will investigate the impact of The Freedom Programme by using repertory grid technique measures and questionnaire measures and propose the clinical implications of the findings.

In addition to this, the current research aims to add to the literature base regarding the impact of the intervention on coping styles and group climate. Finally, an investigation of what aspects of the intervention participants found helpful and unhelpful will add to the literature base regarding the most beneficial aspects of group treatment for this client group.

The following research hypotheses will be explored:

1.12. Hypotheses

1.12.1. Pre-Intervention Hypotheses

1.12.1.1. Hypothesis 1: Results relating to Self to Ideal Self Distance[10]

Hypothesis 1 predicted *self* to *ideal self* distance on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI)[11]; Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 1 also predicted *self* to *ideal self* distance would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

1.12.1.2. Hypothesis 2: Results relating to Extremity[12]

Hypothesis 2 predicted *extremity* on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI)[13]; Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 2 also predicted *extremity* would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

10 *Self* to *Ideal Self* distance was calculated using Idiogrid Repertory Grid Software. Using the Repertory Gird participant data the software calculates how differently the participant construes their actual and ideal selves.
11 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)
12 E*xtremity* was calculated using Idiogrid Repertory Grid Software and is the extent to which people tend to use the extreme points on bipolar scales as opposed to the more central points.
13 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)

1.12.1.3. Hypothesis 3: Results relating to Tight Construing[14]

Hypothesis 3 predicted *tighter construing* on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI); Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 3 also predicted *tighter construing* would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

1.12.1.4. Hypothesis 4: Results relating to Conflict

Hypothesis 4 predicted *triadic conflict* on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI); Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 4 also predicted *triadic conflict* would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

1.12.1.5. Hypothesis 5: Results relating to Implicative Dilemmas

Hypothesis 5 predicted the participants with *implicative dilemmas* (*IDs*) between their *self* and *ideal self* on the repertory grid would have higher scores on: Global Severity Index (GSI); Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and higher utilisation of Less Helpful Coping (LHC). Hypothesis 4 also predicted participants with *implicative dilemmas* (*IDs*) would have lower utilisation of Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC).

1.12.1.6. Hypothesis 6: Results relating to the Global Severity Index at Pre-intervention

Hypothesis 6 predicted Global Severity Index (GSI) scores would be positively correlated with scores on the: Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 6 also predicted GSI scores would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

14 *Tightness of construing* was calculated using Idiogrid Repertory Grid Software. It is measured by the percentage of variance accounted for by the first principal component on the Repertory Grid. The first component accounts for the largest amount of variance in the data.

1.12.1.7. Hypothesis 7: Results relating to Coping Styles at Pre-intervention

Hypothesis 7 predicted Less Helpful Coping (LHC) utilisation would be positively correlated with the Index of Spouse Abuse: Non Physical (ISA: NP) and Index of Spouse Abuse: Physical (ISA: P). Hypothesis 7 also predicted Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation would be negatively correlated with the Index of Spouse Abuse: Non Physical (ISA: NP) and Index of Spouse Abuse: Physical (ISA: P).

1.12.2. Hypotheses regarding change during the intervention

1.12.2.1 Hypothesis 8: Results relating to change in grid measures between Pre-intervention and Post-intervention

Hypothesis 8 predicted that there would a significant decrease in repertory grid measures of: *self* to *ideal self* distance; *extremity*; *tightness of construing*; *implicative dilemmas* and *triadic conflict* between pre-intervention and post-intervention.

1.12.2.2. Hypothesis 9: Results relating to the General Degree of Correlation (GDC)[15] between Pre-intervention and Post-intervention Repertory Grid

Hypothesis 9 predicted GDC between pre-intervention and post-intervention repertory grids would positively correlate with change[16] in the Global Severity Index (GSI)[17] and Less Helpful Coping (LHC). Hypothesis 9 also predicted GDC between pre-intervention and post-intervention repertory grids would negatively correlate with change[18] in Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC)

1.12.2.3. Hypothesis 10: Results relating to the number of intervention sessions attended

Hypothesis 10 predicted the number of sessions attended would negatively correlate with change[19] in: Global Severity Index (GSI)[20]; Less Helpful Coping (LHC) and General Degree of Correlation (GDC) between pre-intervention and post-intervention grids. Hypothesis 10 also

15 General Degree of Correlation (GDC) informs us about change in construing. A high General Degree of Correlation between pre-intervention and post-intervention repertory grid is associated with less change in construing. A low General Degree of Correlation between their pre-intervention and post-intervention repertory grid would indicate there had been a change in construing.
16 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore an improvement on GSI and LHC would be indicated by negative change score.
17GSI is the overall score calculated from the Brief Symptom Inventory (BSI)
18 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore an improvement on EFC and PFC would be indicated by positive change score.
19 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore negative change score would indicate an improvement on GSI and LHC.
20GSI is the overall score calculated from the Brief Symptom Inventory (BSI)

predicted number of sessions attended would positively correlate with change[21] in Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC).

1.12.2.4. Hypothesis 11: Results relating to change in Global Severity Index (GSI)[22] between pre-intervention and post-intervention

Hypothesis 11 predicted that there would be a significant decrease in GSI Scores from pre-intervention to post-intervention.

1.12.2.5. Hypothesis 12: Results relating to change in Coping Styles between Pre-intervention and Post-intervention

Hypothesis 12 predicted there would be a significant decrease in Less Useful Coping (LHC) utilisation from pre-intervention to post-intervention. Hypothesis 12 also predicted that there would be a significant increase in Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation from pre-intervention to post-intervention.

1.12.2.6. Hypothesis 13: Results relating to change in Group Climate between pre-intervention and post-intervention

Hypothesis 13 predicted that there would be a significant increase in imagined (pre-intervention) and experienced (post-intervention) levels of Engagement. Hypothesis 13 also predicted there would be a significant decrease between imagined (pre-intervention) and experienced (post-intervention) levels of Avoidance and Conflict.

1.13. Research Questions

Research Question 1: Are participants closer to the average grid at post-intervention?
Research Question 2: What were the elements and constructs that changed the most from pre-intervention to post-intervention?
Research Question 3: What were the factors that participants found most helpful and non-helpful in relation to the intervention?

21 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore positive change score would indicate an improvement on EFC and PFC.
22 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)

1.14. Case Studies

Case Presentation Study 1: The participant who demonstrated the most change on repertory grid measures from pre-intervention to post-intervention.

Case Presentation Study 2: Presentation of the participant with the most *implicative dilemma*s within her repertory grid.

2. Method

This chapter will be divided into five sections. First, the design will be discussed with information regarding the participant sampling method and the intervention. Second, the measures will be described. Third, the research procedure will be presented, followed, by the data analysis procedure. Finally, the ethical considerations will be discussed.

2.1. Design

The research design used in this study was a repeated measures longitudinal design. Participants were interviewed pre-intervention and again, three months later, post-intervention, to ascertain if change had occurred in the measures at post-intervention. In an ideal research scenario a matched cases experimental design would have been employed, randomly assigning participants to the experimental or control conditions. This was, however, not possible as it would have been unethical to deny participants the intervention and, additionally, it was not in the researcher's power to deny services.

2.1.1. Participant Sampling Method

At pre-intervention twenty-four participants volunteered to participate in the research, forming a convenience sample. It is unclear how many potential participants were made aware of the research and so a response rate is unknown. In an ideal research scenario a stratified sampling method could have been used, however it was not possible to collect participants in this way as the participant group are difficult to engage and access. Therefore, the researcher relied upon volunteers, which the researcher recognises will have caused a bias.

Participants were included in the research if they were female, eighteen years old and over, had experienced Intimate Partner Violence (IPV) and were planning to participate in the Freedom Programme[23] in September 2012. It was also necessary for participants to be able to comprehend and speak English to a level that would allow them to complete the measures and the interview. An exclusion criterion was women unable to give informed consent to participate in the research due to mental impairment.

23 Participants planning on attending the Freedom Programmes in one of the five locations where the researcher had been granted permission to collect research data.

At post-intervention contact was attempted with all twenty-four participants. Of these twenty-four participants, eighteen agreed to complete post-intervention measures, which is a 71% post-intervention response rate. Shapiro et al., (1995) suggests a sample size of at least twenty is generally considered necessary to provide sufficient statistical power to detect change during therapy. All twenty four data sets were used in the pre-intervention analyses. The data from the six participants who did not complete post-intervention measures was not included in post-intervention analyses. Of the six other participants, who did not participate at post-intervention, four were contacted but declined participation and two were un-contactable.

2.1.2. The Intervention

The intervention was The Freedom Programme, a twelve week programme open to women who have experienced Intimate Partner Violence. For more information please see section 1.8.1. The intervention ran September 2012 to December 2012. The participants came from five programmes run across Hertfordshire, Essex and Kent.

2.1.3. Intervention facilitation

All facilitators had undertaken a two-day training run by the intervention creator Pat Craven. There were six facilitators in total, four facilitators responded to the researcher's request to give background information. The first facilitator worked as a Children's Centre Manager The second had worked in refuges for many years and was the founder of services in her area. The third had personal experience of IPV. The fourth had worked in IPV services for 5 years, initially as a support worker before being promoted to the outreach team. This facilitator now runs programmes full time, running six programmes weekly across Hertfordshire and Essex. No facilitators had recognised counsellor or therapist qualifications, which Abel (2000) states as a common occurrence for facilitators of interventions for women who have experienced IPV.

2.2. Measures

2.2.1. Demographic Information Questionnaire[24]

The researcher devised the Demographic Information Questionnaire, which was completed by all participants. The following demographic information was collected: Age; Marital Status; Sexual Orientation; Race; Nationality; Ethnic Origin; Religion; Highest Level of Education Completed; Number of Dependents; Support Being Received Currently; Support Received Historically; and Number of Freedom Programme Sessions Attended.

2.2.2. The Brief COPE Inventory (Carver, 1997)[25]

The Brief Cope Inventory (BCI, Carver, 1993) is an approved shortened version of The COPE Inventory (Carver, Scheier, & Weintraub, 1989). Carver (1997) found that the BCI had adequate internal reliability and a consistent factor structure with The COPE Inventory. The BCI is a twenty-eight item self-report questionnaire developed to assess a broad range of coping responses, several of which have an explicit basis in theory (Carver, Scheier, & Weintraub, 1989). A factor analysis conducted by Carver et al. (1989) provides a way of dividing participant responses into three 'Coping Styles': Problem Focused Coping[26] (PFC); Emotionally Focused Coping[27] (EFC); and Less Useful Coping[28] (LUC).

The instructions inform participants to complete the questionnaire whilst thinking about how they are coping with the current stressful situation in their lives. Respondents are then presented with items pertaining to examples of the three coping styles. PFC items include: active coping; planning; and use of instrumental support. EFC items include: utilisation of emotional support; positive reframing; acceptance; denial; and use of religion. Lastly, LUC items include: venting; behavioural disengagement; substance use; and self-distraction. Participants rate each item, recording the frequency of how often they are utilising that item by selecting one of the following four options: I haven't been doing this at all; I've been doing this a little bit; I've been doing this a medium amount; I've been doing this a lot. Participants completed the BCI at pre-intervention and post-intervention.

24 For measures used please see Appendix 5

25 For measures used please see Appendix 5

26 See definition in section 1.6.1

27 See definition in section 1.6.2

28 See definition in section 1.6.3

Carver, Scheier, & Weintraub (1989) do not provide an overall coping index score and do not suggest a particular way of generating a dominant coping style for a given person. There are also no instructions for 'adaptive' and 'maladaptive' composites. For the purposes of the current research participants' responses for PFC, EFC and LUC were summed up and the score calculated for each. This score was then changed to a percentage to create percentage utilization scores per participant for each Coping Style.

2.2.3. The Brief Symptom Inventory (Derogatis, 1993)[29]

The Brief Symptom Inventory (BSI, Derogatis, 1993) is an approved shortened version of The Symptom Checklist-90 (SCL-90) (Derogatis & Cleary, 1977). The measure retains the consistency, reliability and validity of its longer counterpart (Derogatis & Melisaratos, 1983). The BSI is intended to measure the intensity of symptom severity. The fifty-three items can be divided into nine subscale scores (somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism) or the fifty-three items are summed up for an overall score, the Global Severity Index (GSI). The GSI was used in the current research as a measure of symptom severity, with a higher score indicating higher levels of psychological distress.

The instructions inform participants to endorse their experience of each symptom's occurrence over the past seven days. Participants are then provided with 53 items and choose one of the following responses to reflect the frequency of the occurrence: not at all; a little bit; moderately; quite a bit; extremely. There is a 'refused' option for respondents who do not wish to comment. Participants completed the BSI at pre-intervention and post-intervention.

Derogatis (1993) published data regarding the BSI derived from 423 adult psychiatric inpatients, 1002 adult psychiatric outpatients, 974 adult non-patients and 2408 Adolescent non-patients. The mean GSI of the psychiatric outpatient group was 1.32 and the mean GSI of the non-patient group was .30. According to Derogatis (1993), a GSI score exceeding .63 represents an entrance into the 'dysfunctional' population.

29 For measures used please see Appendix 5

2.2.4. The Group Climate Questionnaire Short Form (GCQ - S) (Tschuschke, Hess, & Mackenzie, 1991)[30]

The Group Climate Questionnaire Short Form (GCQ-S, Tschuschke et al., 1991) is an approved shortened version of The Group Climate Questionnaire (MacKenzie & Dies, 1983). GCQ-S is a self-report questionnaire measuring how members regard their group experience (Tschushke, et al., 1991). The questionnaire uses twelve items to measure Engagement (a positive working group atmosphere), Conflict (reflecting tension and anger in the group) and Avoidance (behaviour indicating avoidance of personal responsibility in the group work by the members) (Tschuschke, et al., 1991).

Participants are presented with items representing group scenarios encompassing Engagement, Conflict or Avoidance. The instructions informed participants to endorse their experience of each item on a 7-point Likert scale, with options: 1: Not at all; 2: A little bit; 3: Somewhat; 4: Moderately; 5: Quite a bit; 6: A great deal; 7: Extremely.

For the purpose of this research, at pre-intervention participants were asked to rate what levels of Engagement, Conflict and Avoidance they imagined would be present in the group. At post-intervention participants were asked to rate what levels of Engagement, Conflict and Avoidance they had actually experienced in the group. A higher score represents higher levels of Engagement, Conflict and Avoidance.

There are no instructions on how to calculate 'adaptive' and 'maladaptive' levels of Engagement, Avoidance and Conflict; therefore, the measure offers a perspective on experience rather than a composite score. For the reader's reference throughout this chapter 'Group Climate' will be used to define the three composites.

2.2.5. Index of Spouse Abuse (ISA-30; Hudson & McIntosh, 1981)[31]

The Index of Spouse Abuse (ISA-30, Hudson McIntosh) is a thirty item self-report scale intended to measure the frequency with which respondents have experienced intimate partner violence. The questionnaire includes eleven items pertaining to physical abuse that form the ISA: P composite score and nineteen items pertaining to types of non-physical

30 For measures used please see Appendix 5
31 For measures used please see Appendix 5

abuse which form the ISA: NP composite score. Participants rated the frequency of the abuse on each item using a five-point Likert scale with the options: 1: Never; 2: Rarely; 3: Occasionally; 4: Frequently; and 5: Very Frequently. Participants completed the ISA at pre-intervention only, as all participants were no longer in abusive relationships.

Participants ISA: NP and ISA: P scores are calculated using a formula stipulated by Hudson & McIntosh (1981). Each calculation produces a score between 0 and 100. In Hudson & McIntosh's (1981) original study the mean score for ISA: NP is 58.9 and ISA: P is 45.2 for women who had experienced IPV. For women who had not experienced IPV the mean score for ISA: NP is 8.3 and for ISA: P is 3.8. The authors have found good validity for their measure in comparison to previous studies indicating good internal consistency and reliability ranging from $\alpha = .91$ to .92. The Cronbach's alpha coefficient for the scale in the present study is .92.

2.2.6. Helpful and Non-helpful Aspects of Therapy Questionnaire (Llewelyn, 1984)[32]

The Helpful and Non-helpful Aspects of Therapy questionnaire (HNATQ, Llewellyn, 1984) was only given to participants at post-intervention. The instructions request participants to write down the helpful and the non-helpful aspects of the intervention. At the end of the questionnaire respondents were asked to rate overall how they found the intervention on a five-point Likert scale with: 1: Very Helpful; 2: Fairly Helpful; 3: Neither Helpful or Unhelpful; 4: Fairly Unhelpful; 5: Very Unhelpful.

For the purposes of this research questionnaire responses were collated and response frequencies recorded. Responses were then categorised, by the researcher and an independent rater, using Elliott's Model of the Helpful and Non-helpful Events of Brief Counselling (Elliott, 1985)[33] and Yalom Curative Factors Model (1970)[34]. Elliott's (1985) model was devised from Llewelyn's (1984) research regarding the development of the Helpful and Non-helpful Factors of the Brief Counselling Questionnaire. Comments unaccounted for by either model were identified and recorded.

32 For measures used please see Appendix 5
33 For a detailed description of each factor please see Appendix 3
34 For a detailed description of each factor please see Appendix 2

2.2.7. Structured interview: The Repertory Grid (Kelly, 1955)

Repertory Grid Technique is a method devised by Kelly (1955) as a means of putting Personal Construct Psychology into practice (Jankowicz, 2004). The technique aims to investigate the personal construct systems of respondents. Kelly defines constructs as the individual's unique system of interconnected meanings. Kelly (1955) stipulates that a person's reality is based upon their dichotomous constructs of the world and that constructs can be accessed via the technique, giving a glimpse into their reality.

The repertory grid Interview procedure has four stages (Jankowicz, 2004). First, participants were made aware of the topic area by reading the information sheet. Second, pre-determined elements, based upon the research questions, were given to participants (see 2.5.1.1). Participants then elicited six constructs (see 2.5.5.2) and were provided with eight constructs (see 2.5.5.3). The decision was made to provide elements and certain constructs to ensure comparative analysis could be conducted. Lastly, participants were asked to rate the elements against the constructs.

2.2.7.1. The Repertory Grid Procedure[35]

2.2.7.1.1. Provided Elements

Twelve elements were provided to participants. Participants were asked to provide names for the elements for ease of reference during the interview; however, this was not compulsory. The following elements were recorded in the vertical columns of a blank grid in the order listed below: *self*; *mother; father; ex partner; self in a relationship; self not in a relationship; ideal self; ideal partner; woman I like; man I like; woman I dislike; man I dislike; and fictional male character I like.*

2.2.7.1.2. Construct Elicitation

The triadic elicitation method was used to elicit six constructs from individual participants (Kelly, 1955). Fransella et al. (2004) informs us that it is not possible to draw firm conclusions regarding the superiority of the triadic elicitation method over dyadic method, but it was the researcher's preference to use the triadic elicitation method.

35 For measures used please see Appendix 5

The elicitation process ran as follows:
The participant was shown three flashcards with an element on each. Elements were shown to the participant in order. For example, the first, second and third elements were shown and the first construct was elicited. Then the second, third and fourth elements were shown and the second construct was elicited. This was followed by the third, fourth and fifth elements and so on. The following standardised question was asked each time:

'In which important way are two of these people similar making them different to the third?'

The explanation of the differences between the three people yielded an emergent construct pole. Participants were then asked:

'*Can you think of a word or phrase to describe the opposite of (emergent construct pole)?'*

The answer provided the implicit construct pole. Together, the emergent and implicit construct poles form a construct. The first eight elements were used to elicit the constructs *(self, mother, father, ex partner, self in a relationship, self not in a relationship, ideal self and ideal partner*), as these were the most important elements in relation to the research questions. Altogether six constructs were elicited using the triadic method based on the eight elements.

2.2.7.1.3. Provided Constructs
Eight constructs were provided based upon teachings within The Freedom Programme and to allow comparison within and between participants.

The provided grid constructs were: Bully / Friend; Bad Parent / Good Parent; Headworker / Confidence Booster; Jailer/ Liberator; Sexual Controller / Lover; King or Queen of the Castle / Partner; Liar / Truthteller; Persuader / Negotiator.

The researcher's decision to have both elicited and supplied constructs is based on literature (Kelly, 1955) that suggests it is an individual's own elicited constructs which have most meaning. Here supplied elements and constructs were provided so that data could be

compared between participants and between pre-intervention and post-intervention (Fransella, et al., 2004).

2.2.7.1.4. Rating the elements: The rating scale method

The elicited and supplied constructs were written onto a repertory grid containing the elements. The elicited and supplied constructs were then written onto flash cards along with a Likert scale ranging from one to seven. The emergent construct pole always had a rating of seven and the contrast or implicit construct pole a rating of one (Fransella, et al., 2004). One flash card at a time was then placed in front of the participant. The following question was then asked of the participant with each element.

'On this scale from one to seven, with (for example) Bully being at number one and (for example) friend being at number seven, where would you put (element) on this scale?'

This process was continued until a rating had been obtained for each element on each construct pair.

2.2.7.1.5. Reliability and Validity of Repertory Grid Technique (RGT)

Reliability, the consistency of a measure or the ability of a measure to get the same result repeatedly, is hard to assess with regard to RGT data due to the fluidity of constructs. As a result traditional test theory cannot always be applied to repertory grid data (Bell, 1990). With regards to validity, the extent to which a test measures what it claims to measure, it is more difficult to assess because RGT aims to gather data about an individual's reality rather than an absolute truth. Fransella et al.'s, (2004) review of the literature regarding reliability and validity, states that overall studies indicate good reliability and validity for RGT.

2.3. Research Procedure

2.3.1. Recruitment process

Pat Craven, creator of the Freedom Programme, was contacted and asked to grant permission for the research to be conducted, which she agreed to. Following this, a research proposal was submitted to the University of Hertfordshire Ethics Department and approval was received in August 2012. The researcher organised meetings with Hertfordshire County Council (HCC), who provide services for people in Hertfordshire, UK. HCC agreed to

collaborate in the research and gave contact details for managers of Children's Centres where the Freedom Programme was running in Hertfordshire. After contact with eight Children's Centre managers two managers were in a position to take part in the research and meetings were held to explain the research and organise practical matters such as rooms where participants could be seen and the availability of crèche resources for their children whilst participants were being interviewed. Next, contact was established with the charity Safer Places, who provide facilitation of the Freedom Programme across Hertfordshire and Essex, UK, in Children's Centres and Community Centres. The research proposal was taken to the Safer Places board of directors and they agreed to collaborate. Contact was attempted with Women's Aid, Hertfordshire but they did not respond. Following this other branches of Women's Aid were contacted. One branch manager, based in Kent, UK, responded and agreed to collaborate. After the relationships with HCC, Safer Places and Women's Aid were established the researcher was permitted to have regular contact with eight support workers who passed the research information sheet to women whom they knew intended to start The Freedom Programme[36] in September 2012. The researcher was also permitted to speak to the women at the end of the first session at five different Freedom Programme venues about the research and take contact information from women who wished to participate.

2.3.2. Pre-Intervention research interview

Participants were met for their research interview appointment in Children's Centres, Refuges, or at home. All meetings were conducted in a private room with only the researcher and the participant present. During the interview participants were again given the information sheet and asked to read it and if they had any questions relating to it. Then consent was explained and the consent form given to the participant. If, after discussion of consent, the participants were willing to participate, the consent form was signed and the interview proceeded. All women who were met consented to participate in the research and gave consent to be contacted at post-intervention.

36 the researcher had been granted permission to recruit participants from five Freedom Programmes

The pre-intervention interview schedule ran as follows:

- Information Sheet
- Consent Form
- Demographic Information questionnaire
- Structured Interview: Repertory Grid (Kelly, 1955)
- The Brief Cope (Carver, 1997)
- The Brief Symptom Inventory (Derogatis, 1993)
- Group Climate Questionnaire – Short Form (How participants imagined the group would be) (Tschuschke, et al., 1991)
- Index of Spouse Abuse (Hudson & McIntosh, 1981)
- Debrief Information Sheet

For each questionnaire the instructions were read aloud to the participant and they were asked if they understood what was required of them. Participants then independently completed questionnaires so as to minimise the impact of the researcher on the respondent; however, participants were informed that they were able to pose questions to the interviewer at any time. The Repertory Grid Technique interview procedure is presented in section 2.2.7.1.

Following completion of measures participants were verbally debriefed by means of the Debrief Information Sheet being read to participants and a discussion of this followed. This sheet directed participants to local and national supportive services if they so required. It also had an optional section for them to leave contact information if they wished to receive a summary of the research findings.

2.3.3. Post- Intervention research interview

The procedure was the same as at the pre-intervention interview (section 2.3.2), except for the interview schedule components.

The post-intervention interview schedule ran as follows:

- Information Sheet
- Consent Form
- Demographic Information Questionnaire[37]
- Structured Interview: Repertory Grid (Kelly, 1955)
- The Brief Cope (Carver, 1997)
- The Brief Symptom Inventory (Derogatis, 1993)
- Group Climate Questionnaire – Short Form (How participants actually experienced the group) (Tschuschke, et al., 1991)
- Helpful and Non-helpful Aspects of Intervention Questionnaire (Llewelyn, 1984)
- Debrief Information Sheet

2.4. Data analysis

All raw data collected was and is kept securely in a locked draw and password protected on a computer. The raw data will all be destroyed in five years.

2.4.1. Repertory Grid Data analysis

Repertory grid data was collated and input into Idiogrid version2.4 computer software (Grice, 2002). Idiogrid is a computer software package specifically designed to analyse repertory grids. To calculate *triadic conflict* Idiogrid data was imported into Gridstat (Bell, 2004).

Before formal analysis of the data, an 'Eyeball analysis' (Jankowicz, 2004) was conducted in order to become familiar with the data and ensure data was entered correctly. Idiogrid (Grice, 2002) and Gridstat (Bell, 2004) analyses outcomes were recorded in the Statistical Package for the Social Sciences (SPSS, Version 20, IBM Corp, 2012).

2.4.1.1. The Slater Analysis: Single Grid (Slater, 1977)

The Slater Analysis: Single Grid (Slater, 1977) was conducted on all pre-intervention grids and all post-intervention grids.

37 At post-intervention the Demographic Information Questionnaire was updated to include number of sessions attended and supportive services currently being received.

2.4.1.1.2. Self in relation to Ideal Self

The Slater analysis produced standardised Element Euclidean Distances indicating the distance between the elements *self* and *ideal self* (described in 1.10.2.1). The distance between the two elements indicates how similar the participant construes the two elements to be. This score was recorded for every participant at pre-intervention and post-intervention in SPSS. There has been considerable research and clinical applications of this measure (Fransella et al., 2004). Winter (1992) suggests that a distance of more than 1.5 indicated that the elements are very different and one of less than 0.5 that the elements are very similar. A limitation of this measure is that *self* to *ideal self* distance scores are impacted by affective responses to self-evaluations, in that individuals vary in the extent to which they are able to accept their flaws and faults (Fransella, et al., 2004).

2.4.1.1.3. Extremity

The Slater analysis produced a sum of squares score used to measure *extremity* (described in 1.10.3.). The score is suggested to indicate the extent to which people tend to use the extreme points on bipolar scales as opposed to the more central points. This score was recorded for every participant at pre-intervention and post-intervention in SPSS. There has been some debate regarding different measures of *extremity* (Hetherington, 1988; Landfield, 1977). In a review of literature regarding *extremity* Fransella et al., (2004) concludes that there was no satisfactory means of measuring *extremity* at the time of the review.

2.4.1.1.4. Tightness of Construing

The Slater analysis produced a Principal Components Analysis (PCA). PCA is a statistical procedure used for summarising the numerical information in a repertory grid. This procedure transforms the elements and constructs into a number of components, which explain the maximum possible variance within the grid. For the purposes of this research the Percentage Variance Accounted for by the First Factor (PVAFF), which was available from the Eigenvalue Decomposition data, was recorded for every participant at pre-intervention and post-Intervention in SPSS. PVAFF is the percentage that indicates the importance of the main dimension of meaning. If this dimension accounts for a high percentage of variance it indicates a degree of one-dimensionality in the individual's construing and suggests the other dimensions have less weight (Fransella, et al., 2004). Winter (1992) suggests that PVAFF is a measure of *tightness of construing* (described in 1.10.4.), with a higher percentage

of variance accounted for in the data being linked to tighter construing. The PVAFF has also been found to have good test-retest reliability (Caputi and Keynes, 2001; Smith, 2000) and good convergent reliability when compared to other structural measures of differentiation (Baldauf Cron, & Grossenbacher, 2010). Bell (2003) has shown this measurement to be good but not infallible.

The principal component analysis also enables a two dimensional plot depicting the relationship between the participant's elements and constructs to be produced; this illustrates the participant's construct system regarding the loadings of each element and construct on the first two components (Winter, 1992). The plots were used in the case studies, which can be found in sections 3.4.1 and 3.4.2.

2.4.1.1.5. Conflict

2.4.1.1.5.1. Triadic Conflict (Bell, 2004)

Repertory grid data was imported from Idiogrid version2.4 computer software (Grice, 2002) into Gridstat (Bell, 2004), in order for a *triadic conflict* analysis to be conducted. *Triadic conflict*, (described in 1.10.2.4.1.), developed by Bell (2004), indicates conflicts, inconsistencies and contradictions in repertory grids between two constructs and one element. His method assesses all possible triads formed by two constructs and each element to identify *conflict*. Similarities or differences between constructs and elements are operationalized as the rating of the element on the construct, and those among constructs as their Euclidean distances (Feixas, et al., 2009). The presence of *triadic conflict* is assumed when the longest distance in any three points (two constructs and one element) does not exceed the sum of the other two (Bell, 2004). The score was recorded for every participant at pre-intervention and post-Intervention in SPSS.

2.4.1.1.5.2. Implicative Dilemmas (IDs)

An Implicative Dilemma analysis was conducted on *self* and *ideal self* elements. *implicative dilemmas* occur when the preferred pole of one construct is associated with the non-preferred pole of another construct (described in 1.10.2.4.2). Discrepant constructs are identified as those constructs on which the *self* and *ideal self* elements are rated on opposite construct poles and congruent constructs are identified as those when the *self* and the *ideal self* elements are at the same construct pole. An Implicative Dilemma is a correlation

between a discrepant and a congruent construct in a way that the desired change in the former is associated with an undesired change in the latter (Feixas, Saúl, and Sánchez Rodríguez, 2000). Feixas and Saul (2004) define the presence of *IDs* in a repertory grid whenever the correlation between the scores given to a discrepant construct and those given to a congruent construct is .20 or higher. The number of *implicative dilemmas* was recorded for every participant at pre-intervention and post-Intervention in SPSS.

2.4.1.2. The Slater Analysis: Two Grids and Multiple Grids (Slater, 1977)

All pre-intervention and post-intervention grid comparisons used only the supplied constructs; all elicited constructs were excluded from all grid comparison analyses. Slater Analysis: Two Grids (Slater, 1977) was used to generate the general degree of correlation between pre-intervention and post-intervention participant grids. This score was recorded for every participant in SPSS.

Slater Analysis: Multiple Grids (Slater, 1977) was conducted to create an average pre-intervention grid and an average post-intervention grid. This calculated the mean grid ratings for each group. From this Idiogrid is able to calculate how much each participant's grid correlates with the average grid. A Slater Analysis: Two Grids was also conducted with the pre-intervention average grid and the post-intervention average grid, in order for the two grids to be compared.

2.4.1.3. Grid of Differential Change for Elements and Constructs

Idiogrid created a Grid of Differential Changes, which compared the average grids at pre-intervention and post-intervention. The two average grids were first centred about their respective construct means, and the second centred grid (post-intervention) was then subtracted from the first centred grid (pre-intervention). The Slater analysis measure of percentage sum of squares was then examined on the resulting Grid of Differential Changes in order to see which elements and constructs were most different between the two grids.

2.4.2. Questionnaire data

Questionnaire data was collated and input to Microsoft Excel Spreadsheet computer software. In Excel the questionnaire totals were calculated. The totals were then input into the Statistical Package for the Social Sciences SPSS, Version 20, (IBM Corp, 2012).

2.4.2.1. Calculating 'change' in questionnaire measures

Change in the Global Severity Index (GSI) and Less Helpful Coping (LHC) was calculated by subtracting the pre-intervention score from the post-intervention score. Therefore a negative change score would indicate an improvement on GSI and LHC as a decrease is the desired outcome.

Change in Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC) was also calculated by subtracting the pre-intervention score from the post-intervention score. In this case a positive change score would indicate improvement on EFC and PFC utilisation as an increase is the desired outcome.

2.4.3. Analysis of hypotheses using the Statistical Package for the Social Sciences (SPSS, Version 20, IBM Corp, 2012)

Questionnaire and repertory grid data were investigated, to see if the data met the criteria for the parametric assumptions[38]. To add to this investigation a visual inspection of histograms was conducted. The data was skewed and the assumptions of normality and linearity were not met. Therefore the non-parametric tests were utilised during the analysis.

For correlational analyses the non-parametric Spearman's rank correlation coefficient was used and for group comparisons the non-parametric Mann-Whitney U test or Wilcoxon Signed Rank test was used.

For hypotheses that give a predicted direction to the results, a one-tailed test was employed. If the results were opposite to what had been predicted in the hypothesis a two tailed test was used. The level of significance was $p<0.05$, in order to decrease the possibility of making a Type 1 error the level of significance could have been decreased to $p<0.01$. In order to decrease the possibility of making a Type 2 error effect size was investigated.

38 Parametric assumptions are: normality, homogeneity of variance, and independent errors

2.5. Ethical Considerations

2.5.1. Confidentiality

Participants were all given an information sheet that outlined how their information was going to be securely stored and how their names and identifiable information would be changed to ensure confidentiality. All raw data will be destroyed after a period of five years (February, 2018)

2.5.2. Right to withdraw

Participants were informed, both in writing on the information sheet and verbally, of their right to withdraw from the research interview at any time and that this would not impact upon their access to supportive services.

2.5.3. Management of participants' distress

Included in the information sheet was a section explaining to participants that due to the emotive topic of the research they might experience emotional distress during the research interview. Participants who became distressed were offered time to take a break. The interviewer used therapeutic skills acquired from the Doctorate in Clinical Psychology training to help lessen the distress of participants and normalise becoming distressed. Following the research interview participants were debriefed and given the Debriefing Information Sheet[39], which included contact information of local supportive services.

2.5.4. Time considerations

Participants were informed prior to the interview, via the information sheet and verbally, that the research interview could take up to an hour and a half. Due to the length of the interview participants were offered regular breaks in order to assist their levels of concentration and because it was an emotive topic. It was also explained that the research interview could be completed over two occasions if requested; however, no participants required this.

39 For measures and forms used please see Appendix 5

3. Results

This chapter will be divided into five main sections. The first section will describe the characteristics of those who participated in the research (pre-intervention n= 24, post-intervention n= 18) and provide descriptive statistics pertaining to the questionnaire measures. The second section will present the results from the hypotheses, including additional findings. The third section will present an exploration of research questions findings. The fourth section will present two participant case studies. Finally, a summary of the findings will be presented

3.1.1 The participant sample

Table 1 presents information regarding the organisations the participants were recruited from, what geographical region they were living in and what supportive services they were receiving. Table 2 presents demographic information of the sample population. The sample includes participants from a range of ages, ethnicities, religions and levels of education. The age range of the sample varies between 20 and 61 years with the mean age being 37.29 years (standard deviation (SD) = 11.38). At post-intervention 18 participants completed measures, which is a 71% post-intervention response rate.

Table 1: Organisational affiliation and services accessed by participants

Organisation participant recruited from		Sample n	Sample (approx %)
	Hertfordshire County Council	3	13%
	Safer Places (Herefordshire & Essex)	12	50%
	Women's Aid (Kent)	9	38%
Geographical Region		Sample n	Sample (approx %)
	Hertfordshire	10	42%
	Essex	5	21%
	Kent	9	38%
Support received / currently receiving		Sample n	Sample (approx %)
	The Freedom Programme	24	100%
	Weekly meetings with a support worker	16	66%
	Living in a woman's refuge	14	58%
	Currently receiving therapy	11	46%
	Received therapy in the past	11	46%

Table 2: Demographics of Sample Population

Age	Sample n	Sample (approx %)
20 – 24	4	17%
25 – 29	4	17%
30 - 34	2	8%
35 – 39	5	21%
40 – 44	3	13%
45 – 49	2	8%
50 – 54	2	8%
55 - 59	1	4%
60 – 64	1	4%
Nationality		
White British	15	63%
Black British	2	8%
Black African	2	8%
Mixed Caribbean	1	4%
White Polish	1	4%
White Brazilian	1	4%
White Romanian	1	4%
White Turkish	1	4%
Religion		
None	8	33%
Christian	7	29%
Russian Orthodox	2	8%
Muslim	2	8%
Buddhist	1	4%
Spiritualist	1	4%
Church of England	1	4%
Jehovah Witness	1	4%
Other	1	4%
Education		
Primary School	1	4%
Secondary School	14	59%
Some Additional Training	1	4%
College	2	8%
Undergraduate University	2	8%
Post Graduate University	4	16%
Relationship Status		
Single	9	38%
Separated	8	33%
Married	3	13%
Prefer not to say	3	13%
Divorced	1	4%
In a relationship	0	0%
Living with partner	0	0%
Dependents		
0	0	0%
1	12	50%
2	7	29%
3	2	8%
4	2	8%
5	1	4%

3.1.2 Questionnaire Measures

Table 3 presents the Means and Standard Deviations of participant scores on the research measures. Regarding the Brief Symptom Inventory (BSI) (Derogatis, 1993), Derogatis suggests a Global Severity Index score exceeding .63 represents an entrance into the 'dysfunctional' population. For the current research participants' pre-intervention GSI score was (M= 1.52, SD= .69) and their post-intervention GSI score was (M= .99, SD= .60) as stated in Table 3. Both these scores exceed the 'dysfunctional' score as stated by Derogatis, this suggests that at pre-intervention and post-intervention participants are in the dysfunctional range, however, there is a decrease at post-intervention.

Within the current study, the sample means for Index of Spouse Abuse (ISA) (Hudson & McIntosh, 1981) were ISA: NP (M= 64.88 SD= 21.66) and ISA: P (M= 50.43, SD= 23.89), presented in Table 3. These scores are both higher than the scores of Hudson and McIntosh's sample of women who had experienced IPV (ISA: NP, M=58.9; ISA: P, M=45.2).

Table 3: Means and Standard Deviations for research measures

Questionnaire Measures	Pre-intervention (n= 24)	Post-Intervention (n= 18)
Brief Cope: Problem Focused Coping - percentage utilisation	M= 81.60, SD= 12.70	M= 78.94, SD= 13.44
Brief Cope: Emotionally Focused Coping -percentage utilisation	M= 65.94, SD= 9.97	M= 59.31, SD= 8.65
Brief Cope: Less Useful Coping - percentage utilisation	M= 56.38, SD= 12.45	M= 47.92, SD= 9.59
Brief Symptom Inventory	M= 1.52, SD= .69	M= .99, SD= .60
Group Climate Questionnaire: Engagement	Imagined M= 3.56, SD= 1.27	Actual M = 4.16, SD= .86
Group Climate Questionnaire: Conflict	Imagined M= .88, SD= .82	Actual M= .49 ,SD= .43
Group Climate Questionnaire: Avoidance	Imagined M= 2.93, SD= 1.21	Actual M= 2.76, SD= 1.11
Index of Spouse Abuse- Non Physical (ISA-NP)	M= 64.88 SD= 21.66	Not Applicable
Index of Spouse Abuse – Physical (ISA-P)	M= 50.43, SD= 23.89	Not Applicable
Repertory Grid Measures		
Self to Ideal Self distance	M=.63, SD=.23	M=.53, SD=.25
Extremity	M=741.92, SD=174	M=758.30, SD=216.8
Tightness of construing	M=73.48, SD=7.14	M=80.32, SD=9.87
Triadic Conflict	M=35.58, SD=3.32	M=26.49, SD=16.22
Implicative dilemmas	M=1.67, SD=3.86	M=2.11, SD=4.78

3.2. Pre-intervention Hypotheses

An investigation, including visual inspection of the histograms, of the entire sample's questionnaire data and repertory grid data, show data was not normally distributed. In addition to this, participant numbers were small so the most appropriate statistical procedures for analysis were non-parametric tests.

3.2.1. Hypothesis 1: Results relating to Self to Ideal Self Distance[40]

Hypothesis 1 predicted *self* to *ideal self* distance on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI)[41]; Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 1 also predicted *self* to *ideal self* distance would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

Analysis was conducted on 24 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. No significant correlations were found between *self* to *ideal self* distance and: GSI (r^s= .34, n= 24, p= .05, 1 tailed), ISA: NP (r^s = -.25, n= 24, p= .24, 2 tailed), ISA: P (r^s = -.28, n= 24, p= .19, 2 tailed), LUC (r= .22, n= 24, p= .30, 1 tailed), and PFC (r^s= -.16, n= 24, p= .23, 1 tailed). However, the correlation with the GSI fell only just short of significance.

Analysis found a significant moderate negative relationship between *self* to *ideal self* distance and EFC (r^s= -.37, n= 24, p= .04, 1 tailed) with a higher *self* to *ideal self* distances associated with lower utilisation of EFC.

3.2.2 Hypothesis 2: Results relating to Extremity[42]

Hypothesis 2 predicted *extremity* on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI)[43]; Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis

40 *Self* to *ideal self* distance was calculated using Idiogrid Repertory Grid Software. Using the Repertory Gird participant data the software calculates how close the participant is to their ideal.
41 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)
42 E*xtremity* was calculated using Idiogrid Repertory Grid Software and is the extent to which people tend to use the extreme points on bipolar scales as opposed to the more central points.
43 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)

2 also predicted *extremity* would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

Analysis was conducted on 24 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. No significant correlations were found between *extremity* and GSI (r^S= .13, n= 24, p= .27, 1 tailed), ISA: NP (r^S= .25, n= 24, p= .13, 1 tailed), ISA: P (r^S= .27, n= 24, p= .11, 1 tailed), LUC (r^S= -.07, n= 24, p= .75, 2 tailed), PFC (r^S= .03, n= 24, p= .89, 2 tailed) or EFC (r^S= .17, n= 24, p= .44, 2 tailed).

3.2.3. Hypothesis 3: Results relating to Tight Construing[44]

Hypothesis 3 predicted *tighter construing* on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI); Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 3 also predicted *tighter construing* would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

Analysis was conducted on 24 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. A significant moderate positive relationship was found between *tight construing* and GSI score (r^S= .48, n= 24, p= .01, 1 tailed). There were no significant correlations found between *tight construing* and ISA: NP (r^S= .18, n= 24, p= .20, 1 tailed), ISA: P (r^S= .19, n= 24, p= .19, 1 tailed), LUC (r^S= .30, n= 24, p= .8, 1 tailed), and EFC (r^S= .30, n= 24, p= .16, 2 tailed). A significant moderate negative correlation was found between *tight construing* and PFC (r^S= -.42, n= 24, p= .02, 1 tailed), with tighter construing associated with lower utilisation of PFC.

3.2.4. Hypothesis 4: Results relating to Conflict

Hypothesis 4 predicted *triadic conflict* on the repertory grid would be positively correlated with scores on the: Global Severity Index (GSI); Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and Less Helpful Coping (LHC) utilisation.

44 *Tightness of construing* was calculated using Idiogrid Repertory Grid Software. It is measured by the percentage of variance accounted for by the first principal component on the Repertory Grid. The first component accounts for the largest amount of variability in the data.

Hypothesis 4 also predicted *triadic conflict* would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

Analysis was conducted on 24 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. No significant correlations were found between *triadic conflict* and; GSI, (r^S= .07, n= 24, p= .39, 1 tailed), ISA: NP (r^S= -.31, n= 24, p= .14, 2 tailed), ISA: P (r^S= -.30, n= 24, p= .16, 2 tailed), LUC (r^S= -.04, n= 24, p= .86, 2 tailed), PFC (r= -.32, n= 24, p= .07, 1 tailed) or EFC (r^S= -.02, n= 24, p= .47, 1 tailed).

Additional Finding: A significant moderate positive correlation was found between *triadic conflict* and *extremity* (r^S = .48, n= 24, p= .02, 2 tailed).

3.2.5. Hypothesis 5: Results relating to Implicative Dilemmas

Hypothesis 5 predicted the participants with *implicative dilemmas* (*IDs*) on the repertory grid would have higher scores on: Global Severity Index (GSI); Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse: Physical (ISA: P) and higher utilisation of Less Helpful Coping (LHC). Hypothesis 5 also predicted participants with *implicative dilemmas* (*IDs*) would have lower utilisation of Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC).

Analysis was conducted on 24 sets of data using the Mann-Whitney U Test at an alpha level of .05.

3.2.5.1. Global Severity Index (GSI)

No significant difference was found between participants with and without *IDs* with regards to their GSI scores. Descriptive statistics show that participants with *IDs* scored marginally lower on the GSI (n= 7, Mean Rank = .11.93) than participants without *IDs* (n = 17, Mean Rank= 12.74). The Mann-Whitney U was found to be 55.5 (z= -.25, p= .80, 2 tailed).

3.2.5.2. Index of Spouse Abuse: Non Physical (ISA: NP)

No significant difference was found between participants with and without *IDs* with regards to their ISA: NP scores. Descriptive statistics show that participants with *IDs* scored marginally lower on the ISA: NP (n= 7, Mean Rank = 10.71) than participants without *IDs* (n=

17, Mean Rank= 13.24). The Mann-Whitney U was found to be 47 (z= -.79, n= 24, p= .46, 2 tailed).

3.2.5.3. Index of Spouse Abuse: Physical (ISA: P)

No significant difference was found between participants with and without *IDs* with regards to their ISA: P scores. Descriptive statistics show that participants with *IDs* scored marginally lower on the ISA: P (n= 7, Mean Rank = 11.14) than participants without *IDs* (n= 17, Mean Rank= 13.06). The Mann-Whitney U was found to be 50 (z= -.60, n= 24, p= .58, 2 tailed).

3.2.5.4. Less Useful Coping (LUC)

No significant difference was found between participants with and without *IDs* with regards to their LUC utilisation. Descriptive statistics show that participants with *IDs* scored marginally higher on utilisation of Less Useful Coping (n = 7, Mean Rank = 15.79) than participants without *IDs* (n = 17, Mean Rank = 11.15). The Mann-Whitney U was found to be 82.5 (z= 1.5, n= 24, p= .07, 1 tailed).

3.2.5.5. Emotionally Focused Coping (EFC)

No significant difference was found between participants with and without *IDs* with regards to their EFC utilisation. Descriptive statistics show that participants with *IDs* scored marginally higher on EFC (n= 7, Mean Rank = 15.86) than participants without *IDs* (n= 17, Mean Rank= 11.12). The Mann-Whitney U was found to be 83 (z= 1.50, n= 24, p= .15, 2 tailed).

3.2.5.6. Problem Focused Coping (PFC)

No significant difference was found between participants with and without *IDs* with regards to their PFC utilisation. Descriptive statistics show that participants with *IDs* scored marginally higher on Problem Focused Coping (n= 7, Mean Rank = 13.36) than participants without *IDs* (n= 17, Mean Rank= 12.15). The Mann-Whitney U was found to be 65 (z= .38, n= 24, p= .70, 2 tailed).

3.2.6. Hypothesis 6: Results relating to the Global Severity Index at pre-intervention

Hypothesis 6 predicted Global Severity Index (GSI) scores would be positively correlated with scores on the: Index of Spouse Abuse: Non Physical (ISA: NP); Index of Spouse Abuse:

Physical (ISA: P) and Less Helpful Coping (LHC) utilisation. Hypothesis 6 also predicted GSI scores would be negatively correlated with Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation.

Analysis was conducted on 24 sets of data using the Spearman's rank correlation coefficient an alpha level of .05. No significant correlations were found between GSI and ISA: NP (r^s= .22, n= 24, p= .15, 1 tailed) or ISA: P (r^s= .14, n= 24, p= .25, 1 tailed).

A significant moderate positive correlation was found between GSI and LUC (r= .41, n= 24, p= .02, 1 tailed). No significant correlations were found between GSI and PFC (r= -.18, n= 24, p= .20, 1 tailed) or EFC (r^s = .09, n= 24, p= .67, 2 tailed).

3.2.7. Hypothesis 7: Results relating to Coping Styles at pre-intervention

Hypothesis 7 predicted Less Helpful Coping (LHC) utilisation would be positively correlated with the Index of Spouse Abuse: Non Physical (ISA: NP) and Index of Spouse Abuse: Physical (ISA: P). Hypothesis 7 also predicted Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation would be negatively correlated with the Index of Spouse Abuse: Non Physical (ISA: NP) and Index of Spouse Abuse: Physical (ISA: P).

Analysis was conducted on 24 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. No significant correlations were found between LHC and ISA: NP (r^s= .004, n= 24, p= .49, 1 tailed), EFC and ISA: NP (r^s= .35, n= 24, p= .10, 2 tailed) or PFC and ISA: NP (r^s=.21, n= 24, p= .34, 2 tailed). No significant correlations were found between LHC and ISA: P (r^s= -.10, n= 24, p= .63, 2 tailed), EFC and ISA: P (r^s= .28, n= 24, p= .18, 2 tailed) or PFC and ISA: P (r^s= .09, n= 24, p= .67, 2 tailed).

3.2.8. Hypotheses regarding change during the intervention

3.2.9. Hypothesis 8: Results relating to change in grid measures between pre-intervention and post-intervention

Hypothesis 8 predicted that there would be a significant decrease in repertory grid measures of: *self* to *ideal self* distance; *extremity*; *tightness of construing*; *implicative dilemmas* and *triadic conflict* between pre-intervention and post-intervention.

Analysis was conducted on 18 pre-intervention and post-intervention data sets using the Wilcoxon Signed Rank Test at an alpha level of .05.

No statistically significant difference was found between pre-intervention and post-intervention *self* to *ideal self* distance (z= -1.25, p= .11, 1 tailed), with the median score decreasing from pre-intervention (Md = .64) to post-intervention (Md= .53).

No statistically significant difference was found between pre-intervention and post-intervention *extremity* (z= -.59, p= .28, 1 tailed), with the median score decreasing from pre-intervention (Md = 802.93) to post-intervention (Md= 747.15).

A statistically significant increase in *tightness of construing* at post-intervention was found (z= -2.72, p= .006, 2 tailed), with a medium effect size (r= -0.42). The median score on *tightness of construing* increased from pre-intervention (Md = 73.3) to post-intervention (Md= 78.75).

No statistically significant difference was found between pre-intervention and post-intervention number of *implicative dilemmas* (z= -.18, p= .86, 2 tailed), with the median score the same at pre-intervention (Md = 0) and post-intervention (Md= 0).

A statistically significant decrease in *triadic conflict* at post-intervention was found (z= -2.77, p= .003, 1 tailed), with a medium effect size (r= -0.43), the median *triadic conflict* score decreasing from pre-intervention (Md = 35.1) to post-intervention (Md= 32.75).

3.2.10. Hypothesis 9: Results relating to the General Degree of Correlation (GDC)[45] between Pre-intervention and Post-intervention Repertory Grid

Hypothesis 9 predicted GDC between pre-intervention and post-intervention repertory grids would positively correlate with change[46] in the Global Severity Index (GSI[47]) and Less Helpful

45 General Degree of Correlation (GDC) informs us about change in construing. A high General Degree of Correlation between pre-intervention and post-intervention repertory grid is associated with less change in construing. A low General Degree of Correlation between their pre-intervention and post-intervention repertory grid would indicate there had been a change in construing.
46 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore an improvement on GSI and LHC would be indicated by negative change score.
47 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)

Coping (LHC). Hypothesis 9 also predicted GDC between pre-intervention and post-intervention repertory grids would negatively correlate with change[48] in Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC)

Analysis was conducted on 18 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. The amount of individual 'change' was calculated by subtracting pre-intervention scores from post-intervention scores. No significant correlations were found between GDC and change in GSI (r^s= -.17, n= 18, p= .50, 2 tailed), LHC (r^s= .29, n= 18, p= .13, 1 tailed), EFC (r^s= .45, n= 18, p=.06, 2 tailed) or PFC (r^s= .19, n= 18, p= .46, 2 tailed).

3.2.11. Hypothesis 10: Results relating to the number of intervention sessions attended

Hypothesis 10 predicted the number of sessions attended would negatively correlate with change[49] in: Global Severity Index (GSI[50]); Less Helpful Coping (LHC) and General Degree of Correlation (GDC) between pre-intervention and post-intervention grids. Hypothesis 10 also predicted number of sessions attended would positively correlate with change[51] in Emotionally Focused Coping (EFC) and Problem Focused Coping (PFC)

Before the outcome of Hypothesis 10's findings is presented, Table 4 presents the level of attendance from participants. This information is only known for 18 participants, as six participants did not participate in the research at post-intervention. Four participants completed 100% of the Intervention, and the median level of attendance was nine sessions (Md= 8.50, SD=3.34).

48 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore an improvement on EFC and PFC would be indicated by positive change score.
49 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore an improvement on GSI and LHC would be indicated by negative change score.
50 GSI is the overall score calculated from the Brief Symptom Inventory (BSI)
51 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores. Therefore an improvement on EFC and PFC would be indicated by positive change score.

Table 4: Intervention attendance by participant (n=18)

Participant	Number of Sessions Attended	Attendance in %		Participant	Number of Sessions Attended	Attendance in %
1	5	41%		13	12	100%
2	7	58%		14	4	33%
3	3	25%		15	11	91%
5	11	91%		16	11	91%
6	6	50%		17	12	100%
7	2	16%		18	12	100%
8	8	67%		22	10	83%
9	9	75%		23	12	100%
11	8	67%		24	6	50%

* Participants 4, 10,12,19,20 &21 did not complete post-intervention measures

Analysis was conducted on 18 sets of data using the Spearman's rank correlation coefficient at an alpha level of .05. The amount of individual 'change' was calculated by subtracting pre-intervention scores from post-intervention scores. No significant correlations were found between number of sessions and change in; GSI (r^s = .19, n= 18, p= .45, 2 tailed), LUC (r^s = .24, n= 18, p= .32, 2 tailed), GDC (r^s= -.07, n= 18, p= .39, 1 tailed), EFC (r^s = .11, n= 18, p= .66, 2 tailed) or PFC (r^s = - .13, p= .30, 1 tailed).

Additional Finding: A significant moderate positive correlation was found between number of sessions attended and change in pre-intervention (imagined) and post-intervention (actual) levels of Group Avoidance (r^s = .62, n= 18, p= .006, 2 tailed), with higher number of sessions attended correlating with more decrease in Group Avoidance score.

3.2.12. Hypothesis 11: Results relating to change in Global Severity Index (GSI) between pre-intervention and post-intervention

Hypothesis 11 predicted that there would be a significant decrease in GSI Scores from pre-intervention to post-intervention.

Analysis was conducted on 18 sets of pre-intervention and post-intervention data using the Wilcoxon Signed Rank Test at an alpha level of .05. A statistically significant reduction in GSI scores was found at post-intervention (z= -2.37, p= .01, 1 tailed), with a medium effect size (r= -.42). The median score for BSI decreased from pre-intervention (Md = 1.35) to post-intervention (Md= .91).

3.2.13. Hypothesis 12: Results relating to change in Coping Styles between pre-intervention and post-intervention

Hypothesis 12 predicted there would be a significant decrease in Less Useful Coping (LHC) utilisation from pre-intervention to post-intervention. Hypothesis 12 also predicted that there would be a significant increase in Emotionally Focused Coping (EFC) utilisation and Problem Focused Coping (PFC) utilisation from pre-intervention to post-intervention.

Analysis was conducted on 18 sets of pre-intervention and post-intervention data using the Wilcoxon Signed Rank Test at an alpha level of .05.

A statistically significant reduction in LHC utilisation was found at post-intervention (z= -2.23, p=.02, 1 tailed with a medium effect size (r= .34). The median score for LHC decreased from pre-intervention (Md = 57.81) to post-intervention (Md= 50).

A statistically significant reduction in EFC utilisation was found at post-intervention (z= -2.25, p=.02, 2 tailed with a medium effect size (r=.34). The median score for EFC decreased from pre-intervention (Md = 67.50) to post-intervention (Md= 57.50). This is opposite to the predicted direction.

No statistically significant difference was found between pre-intervention and post-intervention PFC utilisation (z= -1.35, p=0.09, 1 tailed). The medan score for PFC decreased from pre-intervention (Md= 81.25) to post-intervention (Md = 78.94).

3.2.14. Hypothesis 13: Results relating to change in Group Climate between pre-intervention and post-intervention

Hypothesis 13 predicted that there would be a significant increase in imagined (pre-group) and experienced (post-group) levels of Engagement. Hypothesis 13 also predicted there would be a significant decrease between imagined (pre-intervention) and experienced (post-intervention) levels of Avoidance and Conflict.

Analysis was conducted on 18 pre-intervention and post-intervention data sets using the Wilcoxon Signed Rank Test at an alpha level of .05.

No statistically significant difference was found between imagined and experienced level of group Engagement (z= -1.10, p= .14, 1 tailed). The median score increased from pre-intervention (Md= 4) to post-intervention (Md= 4.1).

No statistically significant difference was found between imagined and experienced level of group Avoidance (z= -.54, p= .29, 1 tailed). The median score decreased from pre-intervention (Md= 3) to post-intervention (Md= .2.83).

No statistically significant difference was found between imagined and experienced level of group Conflict (z= -1.60, p= .056, 1 tailed). The median score decreased from pre-intervention (Md= .75) to post-intervention (Md= .50).

3.3. Research Questions

3.3.1. Research Question 1: Are participants closer to the average grid at post-intervention?

Research Question 1 aimed to investigate the pre-intervention and post-intervention average grids. Idiogrid created a pre-intervention average grid from the 24 pre-intervention participant Grids and created a post-intervention average Grid from the 18 post-intervention participant Grids. From this Idiogrid is able to calculate how much each participant correlates with the average grid.

To investigate if there was a statistically significant difference between correlation to the average grid at pre-intervention and post-intervention an analysis was conducted on 18 pre-intervention and post-intervention data sets using the Wilcoxon Signed Rank Test at an alpha level of .05. There was no significant difference between correlation to the average grid at pre-intervention and post-intervention (z= -1.210, p= .226, 2 tailed), with the median score increasing from pre-intervention (Md = .8) to post-intervention (Md= .85).

Table 5 presents the participants' correlation to the average grid at pre-intervention and post-intervention and the change between them.

Table 5: Participants' Correlation to the average grid at pre-intervention and post-intervention

Name	Correlation with average grid Pre-intervention	Correlation with average grid Post-intervention	Change[52] in grid between pre and post measures
Participant 1	.79	.86	.07
Participant 2	.68	.88	.20
Participant 3	.76	.85	.09
Participant 4	.57	*	*
Participant 5	.55	.89	.34
Participant 6	.81	.82	.01
Participant 7	.86	.85	-.01
Participant 8	.85	.83	-.02
Participant 9	.76	.77	.01
Participant 10	.73	*	*
Participant 11	.86	.88	.02
Participant 12	.78	*	*
Participant 13	.89	.87	-.02
Participant 14	.74	.70	-.04
Participant 15	.83	.78	-.05
Participant 16	.76	.85	.09
Participant 17	.85	.70	-.15
Participant 18	.87	.95	.08
Participant 19	.75	*	*
Participant 20	.85	*	*
Participant 21	.93	*	*
Participant 22	.75	.75	.00
Participant 23	.92	.90	-.02
Participant 24	.86	.91	.05

*Participant did not complete post-intervention Measures

52 Change was calculated by subtracting the pre-intervention scores from the post-intervention scores

3.3.2 Research Question 2: What were the elements and constructs that changed the most from pre-intervention to post-intervention?

Research Question 2 aimed to investigate the Grid of Differential Change. Idiogrid created a Grid of Differential Changes, which compared the average grids at pre-intervention and post-intervention. The two average grids were first centred about their respective construct means, and the second centred grid (post-intervention) was then subtracted from the first centred grid (pre-intervention). The Slater analysis measure of percentage sum of squares was then examined on the resulting Grid of Differential Changes in order to see which elements and constructs were most different between the groups.

Table 6 presents the elements that differed most between pre-intervention and post-intervention grids. The elements were: *man I don't like, fictional male character I like*[53], *mother, self in a relationship and ideal partner*. This difference was indicated by the higher percentage of the total sum of squares for these elements.

Table 6: Differential Changes Grid - percentage total sum of squares of elements

Element	Sum of squares	Percent total of sum of squares
Man I Don't Like	2.17	24.89
Fictional Male Character I Like	1.17	13.46
Mother	0.81	9.26
Self in a Relationship	0.80	9.20
Ideal Partner	0.59	6.74

Table 7 presents the constructs that differed most between pre-intervention and post-intervention grids. The constructs were: Sexual controller; King of the Castle; Bad Parent; and Bully. This difference was indicated by the higher percentage of the total sum of squares for these constructs on the Differential Changes Grid.

Table 7 Differential Changes Grid - percentage total sum of squares of constructs

Construct	Sum of squares	Percent total of sum of squares
Sexual Controller	3.07	35.16
King of the Castle	1.57	17.95
Bad Parent	0.98	11.19
Bully	0.79	9.01

53 For list of Fictional Male Characters I Like named in the research please see Appendix 8

Overall the general degree of correlation between the two average grids shows a very strong positive correlation (r= 0.99).

3.3.3 Research Question 3: What were the factors that participants found most helpful and non-helpful in relation to the intervention?

Research Question 3 aimed to investigate the factors which participants found helpful and non-helpful in relation to the intervention. Responses were collated from 18 participants and frequencies recorded. In total there were 114 responses, of which 84 (approx 74%) were helpful factors and 30 (approx 26%) were non-helpful factors. Similar responses were categorised together and given a category name based on the theme of the responses. If responses were deemed to be dissimilar a new category was formed. Table 8 presents the four most recorded 'helpful factor' responses and Table 9 presents typical examples of the four most recorded 'non-helpful factors' responses (for full list of responses and frequency of occurrence see Appendix 7).

Table 8: Frequency of 'helpful aspects' responses

Frequency of response recorded by different participants (approx % of all responses)	Examples of questionnaire responses
13 (11%)	'I don't feel alone'
13 (11%)	'I learnt a lot from the Freedom Programme'
10 (8%)	'The facilitators were very good'
6 (5%)	'We had a shared experience'

Table 9: Frequency of 'non-helpful aspects' responses

Frequency of response recorded by different participants (approx % of all responses)	Examples of questionnaire responses
2 (2%)	'I find it difficult to talk about me'
2 (2%)	'It's difficult for quiet ones to speak'
2 (2%)	'I wanted to talk more about my experience'
2 (2%)	'Some members talked too much'

Participants' responses were then categorised by a classification system proposed by Elliott (1985). This classification system was devised from the Helpful and Non-helpful Factors of Brief Counselling Questionnaire (Llewelyn, 1984), with a focus on individual counselling not group interventions. As a consequence of this it was predicted that there would be some

participant responses that could not be accounted for by Elliott's (1985) model, and so responses were also categorised using Yalom's (1970) Curative Factors Model for group therapy.

Table 9 presents Elliott's (1985) classification system listing eight helpful and six non-helpful factors in therapy. Also in Table 9 are questionnaire responses from participants that have been categorised according to Elliot's Model (1985) and the frequency with which these responses were given by separate participants. The researcher and an independent Trainee Clinical Psychologist conducted the classification. The inter-rater level of agreement for helpful factors was 90% and the inter-rater reliability level of agreement for unhelpful factors was 82%. For items in which a categorisation discrepancy occurred both raters re-familiarised themselves with the definition and then discussed the discrepancy until an agreement was reached. Table10 and 11 presents the final agreed categorisation of the helpful and non-helpful factors questionnaire data.

Table 10: Helpful factor questionnaire responses categorised by Elliott's (1985) Model

Helpful Factors	Quotes questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
New Perspective-insight*	'I learnt a lot from the Freedom Programme' (13) 'I feel like it opened my eyes' (1)	12%
Problem Solution*	'going through the different characters, like the Bully and headworker, helped me to recognise it' (1)	1%
Clarification of Problem*	'I don't feel it was my fault' (2)	2%
Focusing Awareness*	'I had never really realised it was abuse because I hadn't talked about it to anyone' (4)	4%
Understanding*	'I felt understood' (4) 'I felt listened to' (1) 'I didn't feel judged by anyone' (3) 'I felt acknowledged' (1)	8%
Client Involvement *		0%
Reassurance*	'I think we gave each other strength' (3) 'It was very supportive' (1) 'I found it reassuring' (1)	4%
Personal Contact *	'I don't feel alone' (13) 'We had a shared experience' (6) 'I felt connected to the group' (2) 'I made friends' (1) 'I made contacts' (1) 'We were able to use humour at times' (3) 'The group had a good atmosphere' (2) 'The facilitators were very good' (10)	33%

* For full definitions please see Appendix 3

Table 11: Non-Helpful factor questionnaire responses categorised by Elliott's (1985) Model

Non-helpful Factors	Quotes from questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
Misperception: *	'We were all very different' (1) 'We didn't really have things in common' (1) 'So many women act like victims' (1)	3%
Negative Counsellor Reaction*	'The facilitator hadn't experienced domestic violence, I think this made a difference' (1)	1%
Unwanted Responsibility*	'I wanted the facilitators to talk more' (1) 'Some people aren't ready to be there' (1) 'I find it difficult to talk about me' (2) 'I'm a private person' (1) 'It's difficult for quiet ones to speak' (2)	6%
Repetition*		0%
Misdirection events *	'I wanted to talk more about my experience' (2) 'Some members talked too much' (2) 'We talked about things that were of no interest to me' (1)	4%
Unwanted Thoughts *	'I just wanted to put it behind me' (1) 'It drags it all up' (1) 'I came away upset' (1) 'I felt old in comparison' (1) 'I worried I talked too much' (1)	4%

* For full definitions please see Appendix 3

Table 12 presents the remaining questionnaire responses that were unaccounted for by Elliott's model (1985).

Table 12: Questionnaire responses unaccounted for by Elliott's Model (1985)

Factors	Quotes from questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
Helpful	'It was good that it was a flexible group and you could attend sessions when you could' (1) 'I got information about other services that I could access' (1) 'It gave me hope' (3) 'I found it Inspiring' (1) 'The sessions about the Sexual Controller and the Bad Parent were important but very upsetting' (5)	10%
Non-helpful	'I think that some women had ulterior motives for attending the group, I think they had to come to get their benefits' (1) 'We didn't talk about how men came to be that way' (1) 'Group drop-outs were out of my control' (1) 'I wanted to do it alone' (1) 'I wanted more sessions' (1) 'The group was [sic]too far away from where I live' (geographically) (1) 'I was angry by some of the women's stories, I don't know why they let it [sic] go on (the abusive relationship)' (1) 'I can imagine that if a group had different women it could be difficult, everyone in our group was so nice.' (1) 'When you see people outside of the group and you don't know what to do' (1)	8%
	Total approximate percentage of factors unaccounted for by Elliott's model	18%
	Total approximate percentage of factors accounted for by Elliott's model	82%

Table 13 presents Yalom's (1970) categories listing eleven curative factors in group therapy. Also in Table 12 are questionnaire responses given by participants categorised according to Yalom's Model (1985) and the frequency with which separate participants gave this response. The researcher and an independent Trainee Clinical Psychologist conducted the classification. The inter-rater level of agreement for categorising using Yalom's Curative Factors was 75%. For items in which a categorisation discrepancy occurred both raters re-familiarised themselves with the definition and then discussed the discrepancy until an agreement was reached. Table 12 presents the final agreed categorisation of the helpful and non-helpful factors questionnaire data.

Table 13: Helpful factors questionnaire responses categorised by Yalom's Model (1970)

	Quotes from questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
Instillation of Hope*	'It gave me hope' (3) 'I found it Inspiring' (1)	4%
Universality *	'I don't feel alone' (13) 'We had a shared experience' (6) 'I felt connected to the group' (2) 'I made friends' (1) 'I made contacts' (1) 'I felt understood' (4)	24%
Imparting of information*	' I learnt a lot from the Freedom Programme' (13) 'I feel like it opened my eyes' (1) 'I got information about other services that I could access' (1) 'going through the different characters, like the Bully and headworker, helped me to recognise it' (1)	14%
Altruism*	'I think we gave each other strength' (3) 'It was very supportive' (1)	4%
Corrective recapitulation of primary family group*		0%
Development of socializing techniques*		0%
Imitative behaviour*		0%
Catharsis*	'The sessions about the Sexual Controller and the Bad Parent were important but very upsetting' (5)	4%
Existential factors*		0%
Direct Advice *		0%
Interpersonal learning *	'I didn't feel judged by anyone' (3) 'I felt acknowledged' (1) 'I felt listened to' (1) 'We were able to use humour at times' (3) 'I had never really realised it was abuse because I hadn't talked about it to anyone' (1)	8%

* For full definitions please see Appendix 2

Although Yalom's model focuses on the more positive curative factors the researcher used Yalom's model to categorise the Non-helpful aspects questionnaire responses by considering the opposite of Yalom's Curative Factors. Table 14 presents this categorisation.

Table 14: Non-helpful factors questionnaire responses categorised by the opposite of Yalom's Model (1970)

	Quotes from questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
Instillation of Hope*		0%
Universality *	'We were all very different' (1) 'We didn't really have things in common' (1) 'The facilitator hadn't experienced domestic violence, I think this made a difference' (1) 'I felt old in comparison' (1)	4%
Imparting of information*	'I wanted the facilitators to talk more' (1) 'We didn't talk about how men came to be that way' (1) 'We talked about things that were of no interest to me' (1)	3%
Altruism*	'So many women act like victims' (1) 'I was angry by some of the women's stories, I don't know why they let it [sic] go on' (the abusive relationship) (1)	2%
Corrective recapitulation of primary family group*		0%
Development of socializing techniques*		0%
Imitative behaviour*	'I find it difficult to talk about me' (2)	2%
Catharsis*	'I just wanted to put it behind me' (1) 'It drags it all up' (1) 'I'm a private person' (1) 'I worried I talked too much' (1) 'I wanted to talk more about my experience' (2) 'Some members talked too much' (2) It's difficult for quiet ones to speak' (2)	9%
Existential factors*	'I wanted to do it alone' (1)	1%
Direct Advice *		0%
Interpersonal learning		0%

* For full definitions please see Appendix 2

Table 15 presents the remaining questionnaire responses that were unaccounted for by Yalom's Model (1970).

Table 15: Questionnaire responses unaccounted for by Yalom's Model (1970)

Factors	Quotes from questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
Helpful	'I found it reassuring' (1) 'The group had a good atmosphere' (2) 'The facilitators were very good' (10) 'It was good that it was a flexible group and you could attend sessions when you could' (1) 'I don't feel it was my fault' (2)	14%
Non-helpful	'I think that some women had ulterior motives for attending the group, I think they had to come to get their benefits' (1) 'Some people aren't ready to be there' (1) 'Group drop-outs were out of my control' (1) 'I can imagine that if a group had different women it could be difficult, everyone in our group was so nice.' (1) 'I came away upset' (1) 'I wanted more sessions' (1) 'The group was [sic] too far away from where I live' (geographically) (1) 'When you see people outside of the group and you don't know what to do' (1)	7%
	Total approximate percentage of factors unaccounted for by Yalom's model	21%
	Total approximate percentage of factors accounted for by Yalom's model	79%

The categories with the highest number of responses categorised within them were 'Personal Contact'[54] from Elliott's Model and 'Universality'[55] from Yalom's Model. Table 16 presents the questionnaire responses that were unaccounted for by either model.

54 For a detailed description of each factor please see Appendix 2
55 For a detailed description of each factor please see Appendix 2

Table 16: Questionnaire responses unaccounted for by either model

Factors	Quotes from questionnaire responses (number of participants who reported that response)	Approximate % of all responses falling in each category
Helpful	'It was good that it was a flexible group and you could attend sessions when you could' (1)	1%
Non-Helpful	'I can imagine that if a group had different women it could be difficult, everyone in our group was so nice.' (1) 'The group was [sic] too far away from where I live' (geographically) (1) 'I wanted more sessions' (1) 'I think that some women had ulterior motives for attending the group, I think they had to come to get their benefits' (1) 'Group drop-outs were out of my control' (1) 'When you see people outside of the group and you don't know what to do' (1)	5%
	Total approximate percentage of factors unaccounted for by either model	6%
	Total approximate percentage of factors accounted for by both models	94%

Experience of intervention

The questionnaire also obtains a Likert scale rating for the participants' overall experience of the intervention. Of the 18 participants who completed post-intervention measures, 17 participants rated the intervention 'Very Helpful' and 1 rated the intervention as 'Fairly Helpful'.

3.4. Case Studies

3.4.1. Case Study Presentation 1: The participant who demonstrated the most change on repertory grid measures from pre-intervention to post-intervention

Pearl[56] is a 26 year old woman originally born in Poland. She had come to the UK with her abusive ex partner and their young son five years ago. At the time of the first research interview she was unemployed and living in a refuge. At the refuge she was receiving weekly supportive sessions with a refuge worker. At the time of the second research interview Pearl

56 Pseudonym used to ensure confidentiality

had been relocated to another part of the UK where her son had just enrolled in a local school and she was looking for work.

Table 17 presents Pearl's questionnaire results and some repertory grid measures. At post-intervention Pearl's symptom severity decreased substantially. With regards to coping styles, Pearl's utilisation did not change substantially between research interviews; her highest coping utilisation is for Problem Focused Coping (PFC), which is a helpful strategy. Coincidentally Pearl utilised PFC to a much higher extent than the sample average.

At post-intervention, Pearl's *self* element is closer to her *ideal self* element. Also Pearl's *self to ideal self* distance at post-intervention is closer to the average *self to ideal self* distance for the whole sample. With regards to her group experience she reports to having experienced far less Conflict within the group than she was expecting to encounter, but her expectations about group avoidance and engagement were similar to her actual experience of the group.

Pearl has the lowest degree of correlation between pre-intervention and post-intervention grids of the whole sample, suggesting the largest amount of change between pre-intervention and post-intervention repertory grid data of the entire participant sample. An additional factor that could explain the changes found at post-intervention is Pearl's background. It could be suggested that leaving her native country and establishing herself in the UK would have required the ability to problem-solve and be resilient. These abilities may contribute to her change at post-intervention and her ability to utilise the services that were available to her in order to re-establish herself in another area of the UK. This emphasises the role of individual differences between the women, which plays a key role in their outcome.

Table 17: Pearl's Questionnaire and Repertory Grid Measure outcomes

	Pre-Intervention		Post-intervention	
Questionnaire Measures	Pearl	Sample Mean	Pearl	Sample Mean
Brief Cope: Problem Focused Coping Utilisation	88%	M= 79%	83%	M=59%
Brief Cope: Emotionally Focused Coping Utilisation	70%	M= 65%	63%	M= 44%
Brief Cope: Less Useful Coping Utilisation	66%	M= 55%	68%	M= 36%
Brief Symptom Inventory: Global Severity Index Score	2.57	M= 1.52	.94	M= 0.99
Index of Spouse Abuse: Non Physical	47%	M= 65%	Not Applicable	Not Applicable
Index of Spouse Abuse: Physical	35%	M= 50%	Not Applicable	Not Applicable
	Imagined	Imagined	Experienced	Experienced
Group Engagement	4 / 6	M= 3.56 / 6	4.8/6	M= 4.16 / 6
Group Conflict	3.25 / 6	M= 0.88 / 6	.75 / 6	M= .49 / 6
Group Avoidance	3 / 6	M= 2.93 / 6	3.33 / 6	M= 2.76 / 6
Repertory Grid Measures	Pearl	Sample Mean	Pearl	Sample Mean
Self to Ideal Self distance	.70	M=.63	.63	M=.53
Extremity	486.62	M=741.92	551.85	M=758.30
Tightness of construing	72.79	M=73.48	79.19	M=80.32
Triadic Conflict	29.20	M=35.58	37.60	M=26.49
Implicative dilemmas	0	M=1.67	0	M=2.11

3.4.1.1. Repertory Grid

Pearl was supplied with 13 elements and 8 constructs. 6 constructs were elicited from her via the triadic elicitation technique and these are listed below. Table 18 presents Pearl's elements and Table 19 presents her constructs.

Table 18: Pearl's Elements

Elements
Self
Mother
Father
Ex Partner
Self in a Relationship
Self not in a Relationship
Ideal Self
Ideal Partner
Woman I like
Man I like
Woman I don't like
Man I don't like
Fictional Male Character I like

Table 19: Pearl's Constructs

Emergent Constructs	**Implicit Constructs**
Open to People	Outsider
Respectful	Disrespectful
Jealous	Not Jealous
Happy	Unhappy
Stable	Messy
In love	Hateful
Supplied Constructs	**Supplied Constructs**
Friend	Bully
Good Parent	Bad Parent
Confidence Booster	Headworker
Liberator	Jailer
Lover	Sexual Controller
Partner	King / Queen of the Castle
Truthteller	Liar
Negotiator	Persuader

3.4.1.2. Pearl's Principal Component Analysis

Pearl's Principal Component Analysis (PCA) plot for her pre-intervention repertory grid is presented in Figure 7 and her plot for post-intervention is presented in Figure 8. The horizontal axis represents the first principal component (PC1) and the vertical axis represents the second principal component (PC2). The elements and constructs are plotted on the graph according to their loadings on both PCs.

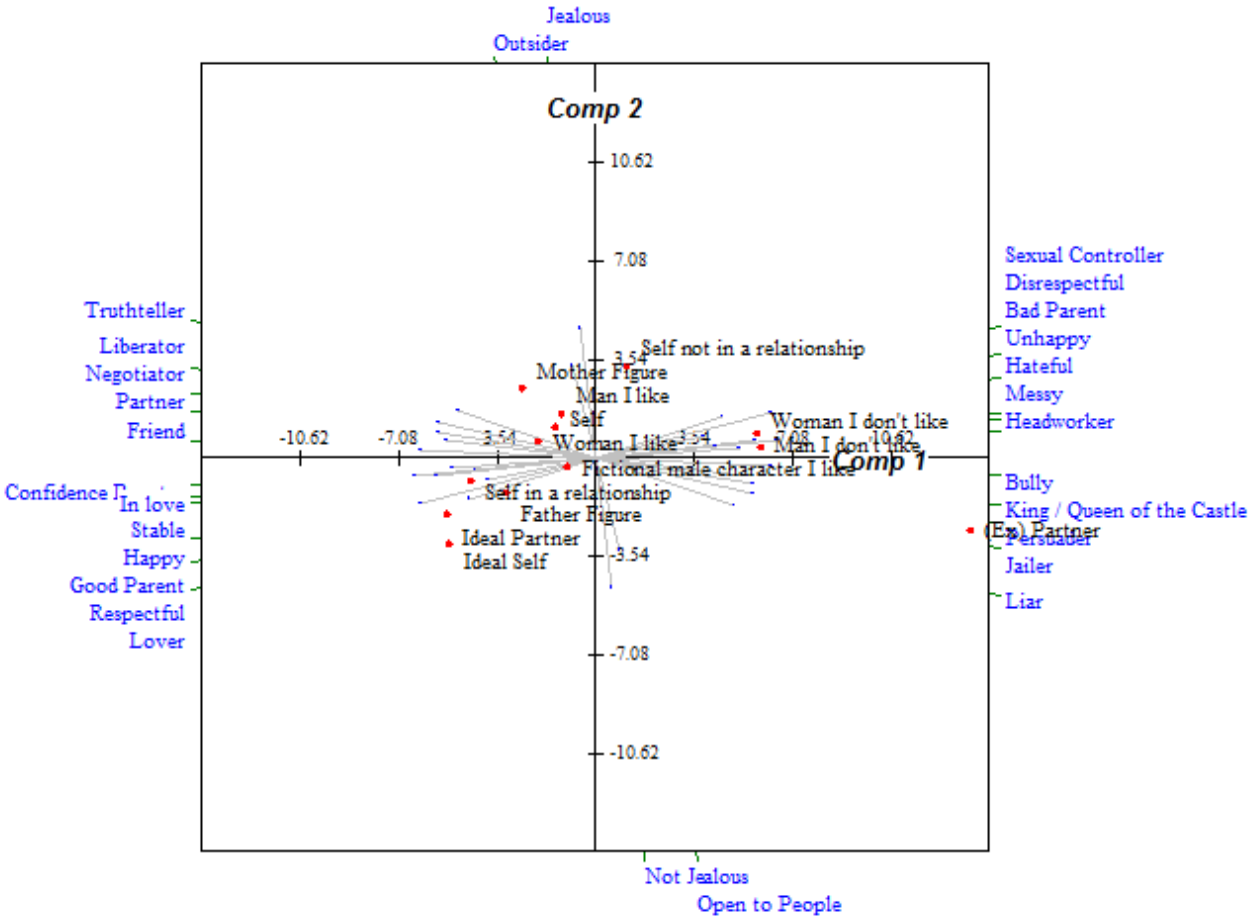
Discussion of Pre-intervention Plot (Figure 1)

The first axis (horizontal) accounts for 72.79% while the second axis explains 9.24% of the variance of the construct system. This might suggest a fairly one-dimensional construct system.

Pearl's elements: *self in a relationship; father; ideal partner; and ideal self* all form a cluster near to construct poles such as Friend, Confidence Booster and In Love. The elements *ex partner, man I don't like and woman I don't like* form another cluster, which is closer to more 'negative' construct poles such as Headworker and Bully. The construct poles discussed here are also the most important constructs to Pearl, illustrated by their close proximity to PC1.

An examination of the second component indicates that *self not in a relationship* is defined most extremely on PC2, being construed further towards the Jealous and Outsider position. This may suggest that Pearl feels more alone and jealous of others when she is single and that being in a relationship is a preferred position.

Figure 1: Pearl's Principal Component Analysis Plot at pre-intervention



Discussion of Post-intervention Plot (Figure 2)

The first axis (horizontal) accounts for 79.19 % while the second axis explains 11.89% of the variance of the construct system, which again suggests a one-dimensional construct system.

In comparing the pre-intervention and post-intervention plots there are some elements that retain very similar positions. For example, e*x partner* and *man I don't like* are very extremely plotted close to the more negative characteristics in contrast to *ideal self*, *Ideal Partner* and *father*, which are clustered together toward the more positive characteristics.

There are also certain differences between pre-intervention and post-intervention plots. Firstly, *self not in a relationship* is far more closely aligned to *ideal self* and closer to the more positive characteristics, which contrasts the more negative pre-intervention position of *self not in a relationship*. In addition to this, *self in a relationship* is now seen as closer to the Outsider construct pole whereas the *self not in a relationship* was close to it at pre-intervention. This could suggest that Pearl has started to change the way she thinks about being in relationships.

Secondly, the *ex partner*, although still closer to negative construct poles, has changed from being closer to King of the Castle and Persuader construct poles at pre-intervention to becoming closer to Headworker construct pole at post-intervention suggesting that some elaboration about the *ex partner* has occurred.

These plots suggest that although many of the elements have stayed in similar positions, elements that were the focus of the intervention have moved. Table 20 presents the differential changes between pre-intervention and post-intervention of the three elements that changed the most: *self* in Relationship; *self* not in Relationship; and *ex partner*.

Figure 2: Pearl's Principal Component Analysis Plot at post-intervention

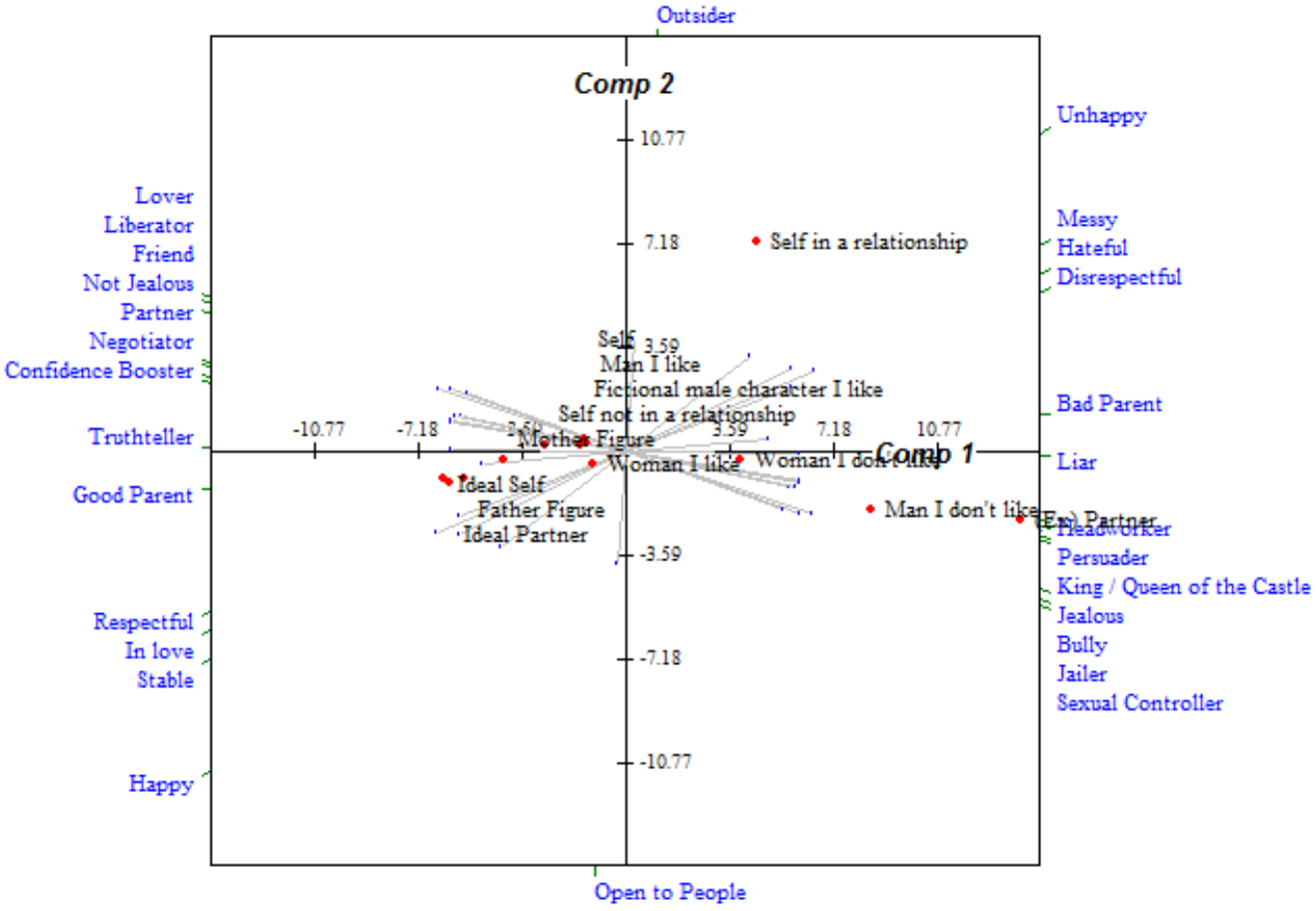


Table 20: Pearl's differential changes between pre-intervention and post-intervention elements

	Means	Sum of Squares	Percent Total Sum of Squares
Self in a Relationship	2.63	143.72	36.42
Self not in a Relationship	-0.73	48.41	12.27
Ex Partner	-0.51	47.57	12.05

Implicative dilemmas

At pre-intervention Pearl had three *implicative dilemma*s in relation to the elements *self not in a relationship* and *ideal self*. The dilemma was that *self not in a relationship* was construed as Jealous whereas *ideal self* was construed as Not Jealous. However, Pearl considered that Not Jealous people are also Jailers, Liars and Persuaders. Therefore, to move towards her *ideal self* as not being jealous she would also have to take on characteristics that are construed negatively.

At post-intervention Pearl original *implicative dilemmas* had resolved. Pearl had two new dilemmas at post-intervention: Pearl construed that when she is *in a relationship* she is an Outsider, whereas her *ideal self* is construed as Open to People. The dilemma occurs for Pearl in that she construes people who are Open to People to be Sexual Controllers and King of the Castle. Therefore it would be difficult for Pearl to move towards her *ideal self* when in a relationship.

3.4.2. Case Study Presentation 2: Presentation of the participant with the most Implicative Dilemma's within her repertory grid

Ruby[57] is a 48 year old woman of White British origin. She and her abusive ex partner are separated but still have some contact because of her teenage son. At the time of the first research meeting Ruby was unemployed and living in a refuge with plans to start a college course in the new academic year. In addition to the Freedom Programme Ruby had weekly supportive sessions with a refuge worker. Ruby did not complete the programme and left the refuge without means to be contacted again so did not participate in the research at post intervention.

Table 21 presents Ruby's questionnaire outcomes and some repertory grid measures. From this table it can be seen that many of Ruby's scores fall close to the sample average. In comparison to the sample average she has a high utilisation of Problem Focused Coping, which may account for her moving on quickly from the refuge. Unfortunately this meant that she was un-contactable during the time post-intervention measures were collected. Ruby imagined that there would be no Conflict within the group, which is lower than the sample average.

57 Pseudonym used to ensure confidentiality

Table 21: Ruby's Questionnaire outcomes and Repertory Grid Measures outcomes

	Pre-Intervention	
Questionnaire Measures	Ruby	Sample Mean
Brief Cope: Problem Focused Coping Utilisation	87.5%	M= 79%
Brief Cope: Emotionally Focused Coping Utilisation	60%	M= 65%
Brief Cope: Less Useful Coping Utilisation	66%	M= 55%
Brief Symptom Inventory: Global Severity Index Score	1.0	M= 1.52
Index of Spouse Abuse: Non Physical	72%	M= 65%
Index of Spouse Abuse: Physical	44%	M= 50%
	Imagined	Imagined
Group Engagement	4 / 6	M= 3.56 / 6
Group Conflict	0 / 6	M= 0.88 / 6
Group Avoidance	2 / 6	M= 2.93 / 6
Repertory Grid Measures	Ruby	Sample Mean
Self to Ideal Self distance	.68	M=.63
Extremity	804.31	M=741.92
Tightness of construing	70.21	M=73.48
Triadic Conflict	33.70	M=35.58
Implicative dilemmas	10	M=1.67

3.4.2.1. Repertory Grid

Ruby was supplied with 13 elements and 8 constructs. 6 constructs were elicited from via the triadic elicitation technique, and these are listed below. Table 22 presents Ruby's Elements and Table 23 presents her constructs.

Table 22: Ruby's Elements

Elements
Self
Mother
Father
Ex Partner
Self in a Relationship
Self not in a Relationship
Ideal Self
Ideal Partner
Woman I like
Man I like
Woman I don't like
Man I don't like
Fictional Male Character I like

Table 23: Ruby's Constructs

Emergent Constructs	**Implicit Constructs**
Easy Going	Temperamental
Money Orientated	More Satisfied
Very Considerate	Selfish
Respect others feelings	Disrespectful
Less Vulnerable	Vulnerable
Trusting	Distrusting
Supplied Constructs	**Supplied Constructs**
Friend	Bully
Good Parent	Bad Parent
Confidence Booster	Headworker
Liberator	Jailer
Lover	Sexual Controller
Partner	King / Queen of the Castle
Truthteller	Liar
Negotiator	Persuader

3.4.2.2. Ruby's Principal Component Analysis (PCA) Plot

Ruby's Principal Component Analysis (PCA) plot for pre-intervention can be seen in Figure 3. The horizontal axis represents the first principal component (PC1) and the vertical axis represents the second principal component (PC2). The elements and constructs are plotted on the graph according to their loadings on both PCs.

Discussion of Figure 3: pre-intervention Plot

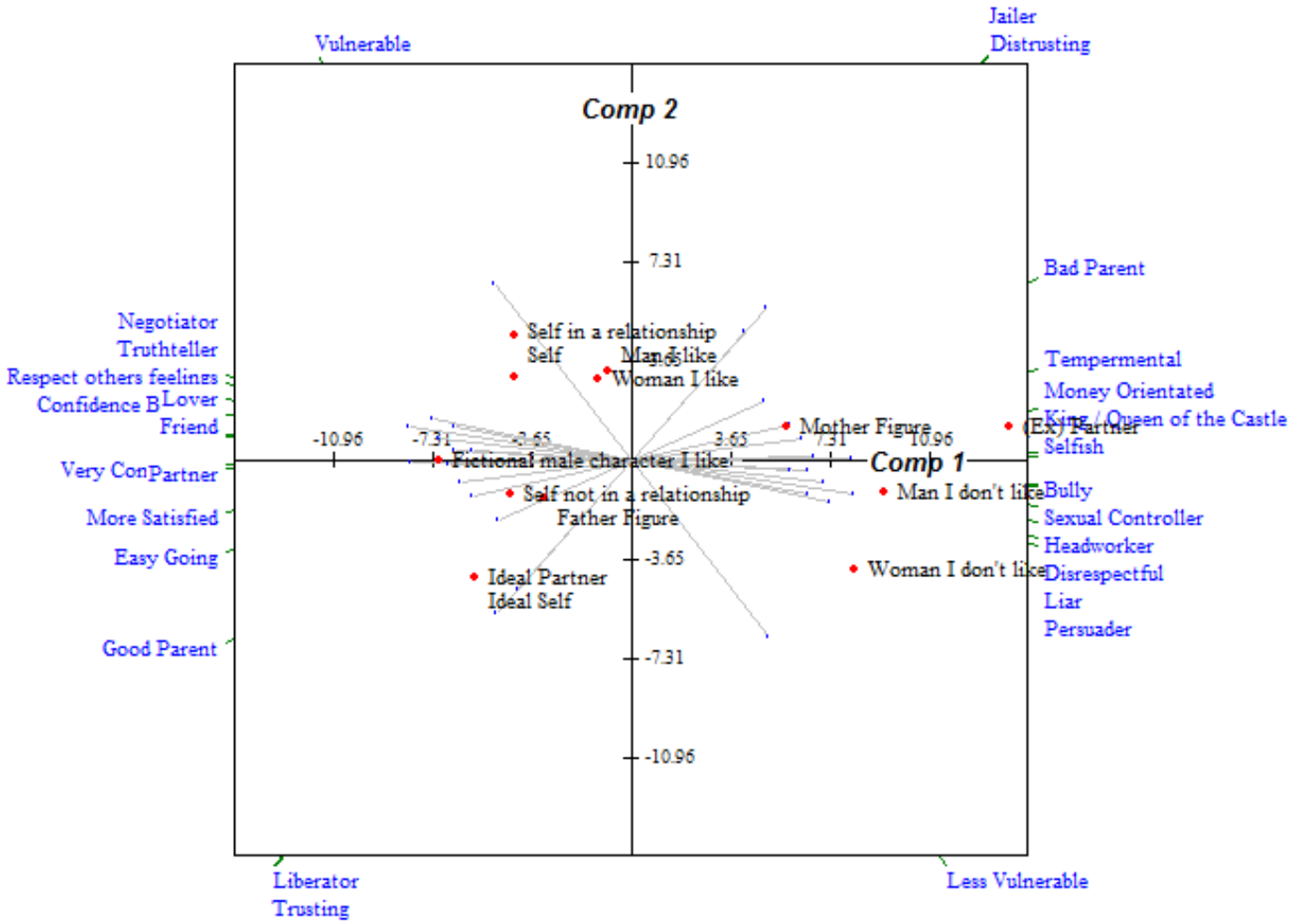
The first axis (horizontal) accounts for 70.21% while the second axis explains 13.75% of the variance of the construct system. This could suggest a fairly one-dimensional construct system.

The elements; e*x partner, mother, man I don't like,* and *woman I don't like* form a cluster around PC1 near to the construct poles Selfish and Bully, which appear to be the most important constructs for Ruby. At the opposite side of PC1 Friend, Partner and Very

Considerate appear to be important construct poles for Ruby, with *fictional male character I like* scoring highly toward these construct poles. Ruby had chosen Alfie Moon for her fictional character taken from the television series Eastenders. In the show Alfie Moon is a lovable character, although he has a difficult relationship with his wife.

An examination of the second component indicates that Ruby's *self in relationship* and *self* are close and score highly on the PC2 construct pole Vulnerable. This may suggest that Ruby sees herself as someone who is normally in relationships. Interestingly, Ruby's *self not in a relationship* and *ideal self* are close, suggesting that being in a relationship may stop the participant from moving towards her *ideal self*. Her *ideal partner* and *ideal self* are closer to the construct poles Liberator and Trusting.

Figure 3: Principal Component Analysis Plot at pre-intervention



3.4.2.3. Implicative Dilemmas

At pre-intervention Ruby had 10 dilemmas in relation to the elements *self* and *ideal self*. For Ruby *self* was construed as Vulnerable, whereas the *ideal self* was construed as Less Vulnerable. This created 10 dilemmas for Ruby because Less Vulnerable people are perceived as Temperamental, Money Orientated, Selfish, Disrespectful, a Bully, a Headworker and a Sexual Controller. Therefore Ruby may feel that to move closer towards her *ideal self* in terms of lack of vulnerability she would also have to take on the characteristics of these negative construct poles.

Similar dilemmas occurred when an Implicative Dilemma analysis was conducted on *self in a relationship* and *ideal self*. This suggests it would be difficult for Ruby to move towards her *ideal self* when in a relationship, which is similar to Pearl.

Interestingly, at the time of the research interview Ruby was not in a relationship. However, she rated her *self* element as closer to her *self in a relationship* element, which could suggest that a great deal of her identity comes from being in a relationship. *Self not in a relationship* and *ideal self* are closer on the Principal Components Analysis and there are no *implicative dilemmas* relating to the elements *self not in a relationship* and *ideal self*.

3.5. Summary of main findings

Table 24 presents a summary of the findings relating to the hypotheses. Significant results are indicated with a number. There was no significant difference between correlation to average grid between pre-intervention and post-intervention. With regards to the grid of differential change some of the elements that changed the most between pre-intervention and post-intervention were related to the intervention. The exploration of participants' responses to the Helpful and Non-helpful Aspects of Therapy Questionnaire (Llewelyn, 1984)[58] that both Elliott and Yalom's Model were able to account for the majority, but not all, of the responses made. The responses unaccounted for mainly referred to difficulties talking within the group context and practical issues regarding the group.

58 For measures used please see Appendix 5

Table 24: Summary of significant findings

Hypothesis		GSI	ISA: NP	ISA: P	Less helpful coping	Problem Focused coping	Emotionally Focused Coping	Engage	Conflict	Avoid	Self to self	Extremity	Tight construing	IDs	Triadic Conflict
1	Self to Ideal Self distance						2								
2	Extremity														
3	Tightness of construing	1				2									
4	Triadic Conflict											1			
5	Implicative dilemmas														
6	Pre-intervention Global Severity Index				1										
7	Pre-intervention Brief Cope Index														
8	Grid Change												3		4
9	General Degree of Correlation (GDC)														
10	Sessions									1					
11	Post-intervention Global Severity Index	4													
12	Post-intervention Brief Cope Index				4		4								
13	Group Climate change														

1= significant positive correlation, 2= significant negative correlation, 3 = significant increase, 4= significant decrease

4. Discussion

The overall aim of the present research is to contribute to the Intimate Partner Violence literature base by investigating the construing of women who have experienced IPV. The research utilised Repertory Grid Technique (RGT) and questionnaire measures in order to obtain information regarding changes in construing, symptom severity, and the coping styles of the participants following a group intervention. The group intervention's theoretical approach is loosely based on the Duluth Model. Most of the previous literature used a range of measures to ascertain whether interventions were beneficial; however, to the author's knowledge, no study has examined the impact on construing and its correlation with other measures with women who have experienced IPV.

The discussion is separated into four sections. The first section presents the main findings of this study in response to the research hypotheses and questions, and links the findings to previous research. The second section assesses the strengths and limitations of the study. The third section considers the clinical implications of this study's findings. The fourth section outlines potential areas for future research.

4.1. Research findings

4.1.1. Participant Sample

The twenty-four participants came from a large age range (20-64), a variety of cultural and ethnic backgrounds and a range of educational backgrounds. All participants were no longer with their abusive partner. In terms of other support 14 participants were living in a refuge (58%) and 16 were having weekly sessions with a support worker (66%). At post-intervention only 18 participants completed measures, a 71% post-intervention response rate.

4.1.2. Severity of Spouse Abuse

Participants completed the Index of Spouse Abuse (ISA), which generates an abuse severity score for physical and non-physical abuse. Overall, this sample experienced higher levels of physical and non-physical abuse than the original ISA questionnaire sample who experienced IPV (Hudson & McIntosh, 1981). Neither physical nor non-physical abuse correlated with measures of *self* to *ideal self* distance, *extremity*, *tightness of construing*, *implicative dilemma*s, *triadic conflict*, symptom severity or coping style utilisation. This partly replicates the work of Aslan (2012) who found no relationship between severity of abuse in women who had experienced IPV and *self* to *ideal self* distance,

extremity and symptom severity. This also links to Erbes and Harter (1999), who did not find a relationship between severity of trauma and *tightness of construing*.

These findings contrast with some of the wider Personal Construct Psychology literature which indicates a relationship between traumatic experiences and *self* to *ideal self* distance (Freshwater, Leach and Aldridge, 2001; Sewell, 2005), *extremity* (Erbes & Harter, 1999; Sewell et al., 1996; Shafenberg, 2006), *tightness of construing* (Aslan, 2012) and symptom severity (Lacey et al., 2013; Machado et al., 2011; O'Donovan et al., 2012).

These findings do not support the dose-response literature regarding trauma (Kaysen et al., 2010; Lorant et al., 2003), where severity of abuse is related to severity of symptoms. One explanation for this may be that IPV impacts upon participants differently to other types of trauma. A Personal Construct Psychology interpretation of these results would suggest it is not the trauma itself which impacts upon the person and the outcome measures but the context of the trauma and how the individual made sense of the trauma in relation to their construct system. A similar finding was obtained in PCP research conducted with people who had experienced childhood sexual abuse (Bhandari et al., 2011).

4.1.3. Severity of Symptoms

Participants completed the Brief Symptom Inventory, generating a Global Severity Index score, as a measure of symptom severity. Overall the sample had higher levels of symptom severity than the original questionnaire sample[59] (Derogatis, 1993) and were in the 'dysfunctional range'. A significant positive relationship was found between symptom severity and *tightness of construing*, and this reflects the wider PCP literature, which links *tightness of construing* to psychological distress (Winter, 2003).

No other relationships were found between symptom severity and *self* to *ideal self* distance, *extremity*, *triadic conflict* and *implicative dilemma*s. This replicates the findings of Aslan (2012) but is contrary to the wider PCP literature, which suggests a link between psychological distress and *self* to *ideal self* distance (Higgins, 1987; Makhlouf-Norris & Jones, 1971; Ribeiro et al., 2012), *extremity* (O'Donovan, 1965; Arthur 1966; Hamilton 1968; Feixas-Viaplana et al., 2007), *implicative dilemma*s (Feixas et al., 2009; Dorough et al., 2007) and *triadic conflict* (Badzinski & Anderson, 2012; Feixas et

59 The participant sample in the research of Derogatis (1993) contained 423 adult psychiatric inpatients, 1002 adult psychiatric outpatients, 974 adult non-patients and 2408 adolescent non-patients.

al., 2009; Feixas-Viaplana et al., 2007; Melis et al., 2011). It is possible that the high incidence of symptom severity within this participant sample impacted on results with the effect that participant data was skewed towards higher symptom severity.

4.1.4. Coping Styles

4.1.4.1. Problem Focused Coping (PFC)

PFC is typically defined as managing stress by actively attempting to problem-solve (Carver et al., 1989). Overall, the participant sample were utilising PFC more than the other coping styles. This may represent a bias in that the participant sample was made up of women who were already out of their abusive relationships and accessing services, which means they may have needed PFC abilities to achieve this. It is possible that women still in their abusive relationships who were not accessing services may demonstrate a much lower PFC utilisation. PFC was found to be negatively correlated with *tightness of construing*; meaning higher utilisation of PFC was linked to looser construing. There has been no previous investigation of coping and IPV from a PCP perspective so this is a novel finding. There were no other relationships between PFC and *self* to *ideal self* distance, *extremity*, *implicative dilemma*s, *triadic conflict* or symptom severity.

4.1.4.2. Emotionally Focused Coping (EFC)

EFC is typically defined as managing stress through changing the emotional response (Carver et al., 1989). Overall, the sample were utilising EFC to a lesser extent than PFC. EFC negatively correlated with *self* to *ideal self* distance suggesting that participants who considered themselves closer to their *ideal self* utilised EFC the most. There has been no previous investigation of coping and IPV from a PCP perspective so this is a novel finding. EFC was not correlated with measures of *extremity*, *tightness of construing*, *implicative dilemma*s, *triadic conflict* or symptom severity.

4.1.4.3. Less Helpful Coping (LHC)

LHC is typically defined as avoiding dealing with the stressor (Carver et al., 1989). Overall, the sample were utilising LHC to a much lesser extent than PFC or EFC. However, there could be a bias within the current participant sample as research suggests there is an association between women who experience IPV and LHC utilisation (Calvete et al., 2007; 2008; Iverson et al., 2013; Sullivan et al., 2010). LHC was positively correlated with symptom severity, suggesting that participants who had higher symptom severity were utilising LHC to a greater extent than participants with lower symptom severity. This replicates findings from the IPV coping literature (Krause et al., 2008;

Littleton et al., 2007). LHC was not correlated with measures of *self* to *ideal self* distance, *extremity*, *tightness of construing*, *implicative dilemma*s or *triadic conflict*.

4.1.5. Triadic Conflict and Extremity

An additional finding at pre-intervention was a relationship between *triadic conflict* and *extremity*, suggesting that participants who thought in more extreme ways were also more conflicted, as measured by *triadic conflict*.

4.1.6. The Impact of the Intervention

4.1.6.1. The Impact on Symptom Severity and Coping

At post-intervention there was a significant decrease in symptom severity, EFC and LHC. There was a decrease in PFC, but this was not significant. It is, however, important to note that although symptom severity decreased participants were still in the 'dysfunctional range'. Nevertheless, it could be suggested that the intervention lowers symptom severity, which is a beneficial outcome. In terms of coping utilisation this is an interesting outcome. It would appear that at post-intervention participants were utilising all of the coping styles less often. A possible explanation for this is that over time participants had to cope with less stress and therefore utilised fewer coping strategies. An alternative explanation is that participants were becoming dependent upon services and having to cope on their own less often.

4.1.6.2. Impact on Repertory Grid Measures

It was predicted that the intervention would loosen construing but interestingly, at post-intervention construing became significantly tighter. At pre-intervention having a tighter construct system correlated with higher symptom severity yet at post-intervention the construct systems of participants were significantly tighter even though their symptom severity had significantly decreased.

We can only speculate about the construal process that may have occurred. One possible explanation is that construing loosened during the course of the intervention and then a new tighter configuration of constructs developed which were more adaptive than the first. Alternatively, having to consider what constitutes an abusive and non-abusive partner within the programme, made constructs more 'black and white', or concrete, and therefore tightened construing. Considering the chaotic circumstances that many of the participants were in, for example living temporarily in a refuge, one could suggest that a tightening of construing might be beneficial.

In relation to the wider PCP literature, Button (1980), whose research was with women with a diagnosis of anorexia, found that a tightening of construing following a group intervention was linked to more positive outcomes. Button (1980) considers this finding consistent with Kelly's (1955) suggestion that constructive change requires a process of tightening and loosening of construing.

At post-intervention there was also a significant decrease in *triadic conflict*. A possible explanation for this is provided by Winter (1983) who suggests that tighter construing is linked to low levels of logical inconsistency in construing.

There was also a non-significant decrease in *self* to *ideal self* distance, *extremity* and *implicative dilemma*s. This contrasts with the wider PCP literature, which suggests that undergoing an intervention can significantly impact upon these measures (Feixas & Saul, 2006; Feixas & Saul, 2004). However, Metcalfe et al. (2007) found that an intervention impacted on symptom severity measures to a greater extent than repertory grid measures.

At post-intervention there was no relationship between the degree of grid correlation (between pre-intervention and post-intervention) and change in symptom severity and coping style scores. The degree of correlation was also very high suggesting minimal changes in construing between pre-intervention and post-intervention. A possible explanation for this is that reconstruing, at least in the areas that were measured in the current research, is not the mechanism of change within the current intervention. Other measures, with a more explicit focus on relationships, may have been more appropriate; for example, Dyad Grids (Ryle & Lunghi, 1970; Fransella et al., 2004). Alternatively, as stated by the Modulation Corollary (Kelly, 1955), not all new experiences lead to a revision of personal constructs as some constructs are impermeable and resistant to modification regardless of our experiences.

4.1.6.3. Impact of Number of Sessions Attended

There was no correlation between number of sessions attended and change in symptom severity or coping styles. This could be due to the fact that only four participants (22%) completed the entire programme. From a Personal Construct Psychology perspective it could be suggested that it is not the number of sessions participants attended that was important but how they made sense of those sessions.

Additionally, a positive correlation was found between attendance and decrease in perceived group avoidance, suggesting that participants who attended more of the sessions felt that their fellow members were utilising less avoidance within the group. It could also be suggested that they themselves were also using less avoidance since they were not avoiding attending sessions.

4.1.6.4. Group Climate

At pre-intervention participants were asked to complete the Group Climate Questionnaire (Tschuschke et al., 1991) to indicate how they imagined the group climate. At post-intervention participants were asked to rate their actual experience of the group. There was no significant difference between imagined and perceived actual levels of Engagement, Avoidance and Conflict, with participants predicting and then experiencing high levels of engagement, some avoidance and low levels of Conflict. This finding suggests that the group behaved as participants expected it to.

4.1.6.5. Research Question 1: Are participants closer to the average grid at post-intervention?

At post-intervention there was no significant difference between pre-intervention and post-intervention correlations of the individual grids with the average grid. Suggesting participants are not closer to the average grid at post-intervention.

4.1.6.6. Research Question 2: What were the elements and constructs that changed the most from pre-intervention to post-intervention?

The elements which showed most differential change at post-intervention were: *man I don't like*, *fictional male character I like*, *mother*, *self in a relationship* and *ideal partner*. A possible explanation for change in some of these elements (*man I don't like*, *self in relationship* and *ideal partner*) is that they were considered during the intervention. An explanation for why the *mother* element changed most is perhaps that the participants were considering their role as mothers during the intervention which made them reconstrue their experiences of their own mothers. Interestingly, *ex-partner* was not an element which changed considerably. A possible explanation for this is that construal of this element was quite extreme at pre-intervention and remained extreme at post-intervention.

Constructs which showed the most change at post-intervention were: Sexual Controller, King of the Castle, Bad Parent and Bully. A possible explanation for this could be that these constructs were the most emotionally evocative to discuss. This suggestion is based on findings from the Helpful and Non-Helpful Aspects of Therapy Questionnaire (Llewelyn, 1984) in which five participants commented that 'The sessions about the Sexual Controller and the Bad Parent were

important but very upsetting'. This links to Kelly's (1955) theory that feeling emotional is linked to transitions in construing and reconstruing.

4.1.6.7. Research Question 3: What were the factors that participants found most helpful and non-helpful in relation to the intervention?

Overall, 17 of the 18 participants rated the intervention 'Very Helpful' and one rated the intervention as 'Fairly Helpful'. 114 factors were collated, of which 84 were helpful factors and 30 were unhelpful factors. The most reported helpful factors of the intervention were: not feeling alone, learning from the intervention, good facilitation and having a shared experience. The most frequently reported non-helpful factors were: wanting to talk more about themselves, some members talking too much, it being difficult to speak about personal experiences and that it was difficult for quieter group members to speak.

After categorisation of factors, 93 were accounted for by Elliott's (1985) model (82%) and 90 were accounted for by Yalom's (1970) model (80%). The factors with the highest number of responses were Yalom's (1970) 'Universality'[60] (24%) and Elliott's (1985) 'Personal Contact'[61] (33%), which suggests that the intervention provided these important aspects.

7 factors were not accounted for by either model (8%). These were: the flexibility of attendance, a suggestion that the group would be difficult with different women, that the group was geographically far from the participant, wanting more sessions, some women having ulterior motives (benefits) for attending, that group drop-outs were out of their control and not knowing what to do when participants saw people from the group outside the group. The researcher concluded that some of these factors related to difficulties with talking in the group context. Other factors were related to the practicalities of the group, which are not accounted for by either model. This replicates findings in the IPV literature that practical matters must be attended to in order to support women most effectively who have experienced IPV (Nabi & Horner, 2001; Postmus & Hahn, 2007). It is possible that Yalom and Elliott's models do not account for this component because they concentrate on factors within the therapy rather than practical and systemic factors. These findings suggest that groups for women who have experienced IPV have to take into consideration practical and emotional needs, as practical factors may impact on a woman's ability to make the best use of the intervention.

60For a detailed description of each factor please see Appendix 2.
61For a detailed description of each factor please see Appendix 3.

4.1.6.8. Exploration of Case Studies

In the first case considered, Pearl[62], is the participant who had the most grid change at post-intervention. Pearl's post-intervention measures suggested she had higher utilisation of PFC, a reduction in symptom severity and movement of the *self* closer to her *ideal self*. There was also a change in the construal of the male elements, suggesting that the intervention may have impacted upon Pearl's construal of men. At post-intervention Pearl's *ex-partner* element moved from being close to the King of the Castle and Persuader constructs poles to being closer to the Headworker construct poles suggesting that some elaboration about the ex-partner has occurred.

The second case, Ruby,[63] had ten *implicative dilemma*s at pre-intervention. For Ruby *self* was construed as Vulnerable, whereas the *ideal self* was construed as Less Vulnerable; however, being less vulnerable came at the cost of being closer to her construct poles. This may be a dilemma that many women who have experienced IPV face, due to their construal of vulnerability.

4.1.6.9. Summary of Findings

It was found that the severity of abuse did not correlate with other measures, which suggests that it is not the severity of the trauma which impacts on an individual but how the individual makes sense of the trauma. At post-intervention there were significant decreases in severity of symptoms, *triadic conflict* and utilisation of EFC and LHC. Also at post-intervention construing became significantly tighter. Some of the elements and constructs which had the most differential change at post-intervention were the focus of the intervention. Exploration of the helpful and non-helpful aspects of therapy mapped well onto models provided by Elliott (1985) and Yalom (1970). Unaccounted for aspects were related to difficulties with talking and practical issues. Participants reported that not being alone and good facilitation were helpful aspects, which links to research suggesting the importance of the therapeutic alliance in outcomes. Overall, seventeen participants rated the intervention 'Very Helpful' and one rated the intervention as 'Fairly Helpful'.

4.1.6.10. Dissemination of Findings

Following examiners' approval of the research, a summary of the research findings will be sent to participants via email, if this was consented to at the research interview. In this communication the researcher's contact details will again be given to participants, offering a meeting to discuss their individual outcomes if they wish. The organisations that took part in this research (Hertfordshire

62 Pseudonym used to ensure confidentiality
63 Pseudonym used to ensure confidentiality

County Council, Safer Places and Women's Aid) have requested a presentation of the findings and recommendations for their staff teams following examiner approval. The Hertfordshire Domestic Violence Forum has also requested a presentation of the findings and recommendations.

4.2. Strengths and Limitations of the Research

4.2.1. Participant Sample

A strength of the research is that the sample came from a diverse array of ages and cultures. A limitation is that due to the exclusion criteria of the current research there were no participants representing younger women (under 18), non-English speakers and no women with learning disabilities. These are all vulnerable subgroups of women who experience IPV but who were not considered by the current research. Another limitation is the small sample size. Shapiro et al. (1995) suggests that a sample size of twenty is generally considered necessary to provide sufficient statistical power to detect change during an intervention. As the current research had eighteen participants at post-intervention the findings therefore need to be treated with caution. In addition there were biases within the sample. Firstly, the majority of participants were residing in refuges and had already left their abusive partner, also the sample utilised high levels of PFC, which may have been related to how they managed to leave their abusive relationship. Secondly, research suggests that people who are willing to take part in research form a self-selection bias within the sample. These factors make the external validity of the research questionable (Grossman & Lundy, 2011).

4.2.2. Design and Analysis

It would not have been ethical, or within the researcher's power, to withhold services from participants; therefore, the study was unable to employ a control group. It was also not within the power of the researcher to ensure that participants attended every session and, therefore, only four participants completed all twelve sessions. In addition to this, twelve weeks is possibly a short period of time to capture change, which may account for the lack of significant findings regarding some of the RGT measures. It may have been more beneficial to have followed participants up at a later date and gather more longitudinal data; however, due to the timescale of the research this was not possible.

The data collected within the research did not form a normally distributed data set and therefore non-parametric tests were employed to conduct statistical analysis. These tests are not as powerful as parametric tests, which is another limitation of the research.

4.2.3. Questionnaire Measures

The questionnaire measures[64] used within the research are widely thought to be reliable and valid (Carver, 1997; Derogatis, 1993; Derogatis & Melisaratos, 1983; Hudson & McIntosh, 1981; Tschuschke, Hess, & Mackenzie, 1991). It is, however, important to note that all questionnaire measures utilise the subjective opinion of the participant and are, therefore, vulnerable to bias, which impacts upon outcomes. However, this is not necessarily a limitation, as Kelly (1969, p.150) suggests that: 'the avoidance of subjectivity is not the way to get down to hard realities. Subjective thinking is, rather, an essential step in the process the scientist must follow in grasping the nature of the universe'[65]. Subjectivity should be engaged with and thought about rather than dismissed.

4.2.4. Repertory Grid Technique (RGT)

A strength of the research is that the RGT allowed the male typographies, discussed during the intervention, to be rated. As these character types were the focus of the intervention, RGT allows us to directly measure change in construal based on the course content. Despite this, the results of the research found a non-significant decrease in the RGT measures of *self* to *ideal self* distance, *extremity* and *implicative dilemma*s at post-intervention. Possible explanations for this could be due to the small sample size or that the intervention did not greatly impact on participants' construct systems. An alternative explanation could be that the repertory grids used within this research were not sensitive enough to detect changes or that the wrong aspects of construing were being measured. The measures used do have limitations (discussed in section 2.4.1.), and the ratings used also suffer from subjectivity.

With regards to the test-retest reliability of repertory grids, a study conducted by Feixas et al. (1992) has found a tightening effect at post-intervention, suggesting poor test-retest reliability. However, a number of studies, reviewed in Fransella et al. (2004), have found good test-retest reliability and validity.

Lastly, Kelly regarded the development of new constructs as one of the most fundamental changes occurring as a consequence of therapy (Kelly, 1955). In the current research new constructs were not elicited at post-intervention so that pre-intervention and post-intervention grids could be compared. This could have impacted upon capturing change within the construct systems of participants, as we can only see those changes closely related to issues that were reflected in the

64 Brief Symptom Inventory, Brief Cope Inventory and the Index of Spouse Abuse

pre-intervention grid. This means new structures created across the intervention were not captured in the post-intervention grid. Despite this, Winter (2003) suggests that using the same grid at pre and post-intervention is often the procedure employed by researchers.

4.2.5. The Freedom Programme

Because Intimate Partner Violence is considered a 'social problem' (Lawson, 2003; Morran, 2011) interventions for IPV are often held within the Social Care and charity sector. As discussed in the introduction this inherently leads to limitations in terms of interventions not being based upon empirical research, not regulated by a governing body and not routinely reviewed by outcome monitoring, which all impact on the legitimacy of the intervention used in the current research.

In line with the view of IPV as a 'social problem', women are often supported by a number of social services providing emotional and practical support. Because of this it is difficult to attribute changes at post-intervention entirely to the intervention, as participants were also accessing a cluster of other emotional and practical services. For example, 14 participants were residing within women's refuges (58%), and 16 participants were receiving one-on-one weekly sessions with a support worker (66%). Research suggests that it is packages of care that improve overall wellbeing, rather than individual services (Bennett et al., 2004).

Additionally, another limitation of the research is that it is difficult to isolate intervention components responsible for positive outcomes. There is some indication in the 'Helpful Factors' questionnaire responses, in which the most highly rated responses are 'Universality'[66] (24%) and 'Personal Contact'[67] (33%), suggesting social support was an important factor. Research suggests that social support is instrumental to participants' recovery, growth, and resilience (Anderson et al. 2012), and therefore it may be this which has impacted on measures as opposed to the content of the intervention; however, this judgement is speculative.

4.3. Clinical implications

4.3.1. Severity of Abuse

The findings of this research do not support the 'dose-response' theory, which suggests the severity of trauma relates to the severity of psychological distress. The findings do support the PCP view that it is not the experience itself that impacts upon the person but how they make sense of it. The

66For a detailed description of each factor please see Appendix 2.

67 For a detailed description of each factor please see Appendix 3.

current research adds to a growing research body that suggests that context and personal resilience also play an important role in how trauma impacts upon a person (Bhandari et al., 2011; Collishaw et al., 2007). This has implications for assessment and treatment of women who have experienced IPV in that clinicians must attempt to establish what sense the individual has made of her experiences.

4.3.2. Symptom Severity

At post-intervention there was a decrease in symptom severity which is a positive outcome. It is possible to suggest that if services are able to improve the wellbeing of women this will also improve the wellbeing of their children, due to the link made by research between maternal and child mental health (Miranda et al., 2013). Additionally, if women are able to use services in order to break the 'cycle of violence' then this would also be of benefit to their children, reducing their risk of being abused by their father / mother's partner.

4.3.3. Coping Styles

At post-intervention there was a decrease in the utilisation of coping strategies[68]. Ideally interventions for women who have experienced IPV would teach and encourage the use of Problem Focused Coping and Emotionally Focused Coping strategies to help empower women who are sometimes in a context of chaos, transition or dependence upon services (Abel, 2000).

4.3.4. Tightness of Construing

The current research found that women's construing was tighter at post-intervention. Kelly (1955) states that constructive change requires a process of tightening and loosening of construing. The current research provides evidence of the former but not the latter. If interventions are to achieve change then they must also ensure that conditions are available for loosening of construing to occur. It could be suggested that the loosening of constructs held about IPV may be difficult to achieve as in order for construing to loosen at an individual level it may also need to loosen at a community or societal level. This has implications for how IPV is 'treated'. Currently intervention funding is mainly directed towards interventions for the female 'victims' and male 'perpetrators' which gives no credence to the community in which the 'victim' and the 'perpetrator' are a part. The 'Bystander Approach' is a community model suggested by Jackson Katz in the United States of America (Katz, 2006; Katz, Heisterkamp & Fleming, 2011). The approach works on the premise that everyone in a community where IPV exists is a bystander, and colludes with it, and therefore should be part of the intervention. The programme aims to bring awareness and discussions about gender inequalities to

68 A significant decrease was found in Emotionally Focused Coping and Less Helpful Coping strategies. A non-significant decrease was found in Problem Focused Coping.

communities[69] (Katz, 2006; Katz et al., 2011). The World Report on Violence and Health states that how a community responds to IPV may affect the overall levels of abuse in that community (Heise & Garcia-Moreno, 2002). It is possible to suggest that community interventions utilising this approach could play an important role in helping loosen constructs held about gender issues.

4.3.5. Helpful and Non-Helpful Factors of the Intervention

Participants reported 'Universality'[70] and 'Personal Contact'[71] as the most helpful factors during the intervention; it is, therefore, important that group interventions for women who have experienced IPV aim to include these two components. To experience 'Universality'[72] and 'Personal Contact'[73], can lead to a positive help-seeking experience, which may help women see the benefits of seeking help. Following this experience it is more likely that women will be inclined to access further services (Dichter & Rhodes, 2011) or return to familiar services if needed.

The non-helpful factors reported in the current research suggested that some women found it difficult to talk in the group context; there is, therefore, a need for services to provide therapeutic alternatives to group interventions, namely individual therapy and expressive therapies, such as Art Therapy or Music Therapy. Additionally, other non-helpful factors reported related to the practical needs of women who have experienced IPV. The implications of this are that supportive services must continue to provide a service which reflects the array of emotional and practical needs that this client group may have, for example: individual therapy, housing, legal aid, links to education and employment (Gondolf, 2002).

4.3.6. Content of Intervention

The author continues to have concerns regarding the content of the intervention, which were stated in section 1.8. It remains unclear what the long term aims of the programme are and what lessons women are expected to take from the intervention. Additionally, it is possible that interventions focusing on the types of abusive men leave women dependent on factors outside of themselves and do not encourage them to think about their role within relationships and the constructs they hold about themselves and their relationships. There is a need to focus on change in the women themselves; namely, how can they construe and act differently so that they will be protected from

69 The Bystander Approach is also used to address issues of race and sexuality.
70 For a detailed description of each factor please see Appendix 2
71 For a detailed description of each factor please see Appendix 3
72 For a detailed description of each factor please see Appendix 2
73 For a detailed description of each factor please see Appendix 3

entering further abusive relationships. The use of Personal Construct Therapy may help women to think about how they construe themselves and their (ex) partners and how this is connected to their relationships (Wolf, 2001). In doing this women may be more empowered as they have an understanding of their role in the relationship (Procter, 2002).

Lastly, only four of the twenty-four women completed all twelve intervention sessions. A possible implication of this is that participants were 'voting with their feet' about the content of the intervention or theoretical approach used. This is only speculative and not proven within this research. If this was the case then it may be necessary to inquire what the members of the group wished it to be used for, or let them select from a range of topics. This would require a greater level of flexibility and skill in the facilitators as the topics they wanted to discuss may not be manualised. This has implications for the consideration of who is best qualified to facilitate these interventions.

4.3.7. Outcome Monitoring

Because of the severely limited evidence-base for effective or promising programmes it is important that the inclusion of outcome evaluation for interventions becomes standard practice (WHO, 2010). This is, however, a large undertaking and requires some technical capacity and scientific expertise. It is becoming more commonplace for academic or research institutions to collaborate with 'front line' services, as this research did. This relationship can take time to establish but can lead to important and necessary collaborations and should be encouraged as it could lead to the much needed development of this literature base (Home Office, 2005; WHO, 2010).

4.4. Future Research

The evaluation of interventions to improve the health and wellbeing of abused women remains a key research priority (Wathen & MacMillan, 2003), one that liaison between research institutions and 'front line' services could achieve. Within this research careful consideration will need to be given to the research design, measures and participants.

4.4.1. The Research Design

The main concern when designing an outcome evaluation is to ensure that any alternative explanations for the changes observed can be ruled out. Ideally, research should look at 'matched cases' experimental designs with adequate sample sizes, comparing participants who did and did not receive interventions. It is, however, unethical to deprive women of services they may need (Rubin, 1991). Even if ethically it were possible to have a control group of participants, there would still be

external influences that cannot be accounted for. Some women who have experienced IPV will access 'packages of care' which incorporate a variety of services. This makes it difficult to identify which service causes an 'improvement' in outcomes. A possible solution to this would be to compare 'care packages' or combinations of supportive services. This would ameliorate the difficulties around depriving women of any support. Additionally, women could be randomly assigned to different 'care packages' for comparison, except women who are in need of housing or refuge, which would create a bias in the findings. Research by Bennet et al., (2004) suggests that packages of care improve wellbeing; therefore packages of care should form the basis of an investigation rather than individual interventions.

Additionally, more longitudinal research is needed to investigate the long term impact of interventions. In a recent review (2013) by the Gender Violence and Health Organisation, who inform government policy, it was suggested that there is a need to lengthen the average timeline for research grants designed to generate evidence for informing policy and programmes on IPV as their preliminary findings indicate that change may not occur over short time periods. A difficulty regarding longitudinal research with this client group is that if a participant has returned to an abusive relationship it may be very difficult, perhaps even dangerous, for her to continue to take part in longitudinal research, which would create a bias in outcomes. Longitudinal research is also more costly.

4.4.2. Measures

Careful consideration needs to be given with regards to which measures relate well to the goal of an intervention for women who have experienced IPV (WHO, 2010). The ultimate goal is clearly to prevent IPV, however this does not easily break down into smaller outcomes. For individual interventions outcomes should be based upon the theory underlying the intervention's approach and objectives.

The current research has shown the application of a small number of analyses available to conduct on repertory grid data. These and other analyses have the potential to provide a greater understanding of women who have experienced IPV and provide a means of investigating changes in the construct systems of women post-intervention. Additionally other PCP methodology, such as dyad grids, could provide an understanding of the construal of the abusive relationship itself, which may help women to recognise the role they have played within a relationship (Fransella et al., 2004).

4.4.3. Participants

As discussed previously, there are certain subgroups of women who have experienced IPV who were not accounted for by the current research and are also neglected in the wider research. These women are; women still in abusive relationships (Abel, 2000), older women (Vinton et al., 1997), women with learning disabilities (Healey et al., 2013), women in same sex relationships (Ard & Makadon, 2011) and the wives of military personnel (Williamson, 2012). Accessing 'harder to reach' subgroups of women needs to become a key research priority so that theories can be developed and inform interventions. There is a need for an increase in awareness of these subgroups so services can meet their needs. The author has no clear recommendations regarding the most appropriate method of accessing these subgroups for research purposes or supporting this subgroup, as this was not the focus of the research.

4.5. Conclusions

The findings of the current research suggest that at post-intervention participants had a lower symptom severity, lower utilisation of less helpful coping strategies lower utilisation of emotionally focussed coping strategies, tighter construing and less conflict as measured by *triadic conflict*. Responses on The Helpful and Non-helpful Aspects of Therapy Questionnaire (Llewellyn, 1984) suggested that the most beneficial components were 'Universality'[74] and 'Personal Contact'[75]. Caution regarding the general reliability of the results was discussed, due to the small sample size of the research and a sample bias. The programme provides a valuable first step into services for women who have experienced IPV. Development of services which follow on from the intervention need to be able to assist change in the way women construe themselves and their relationships while additionally supporting the practical needs of this client group.

Recommendations for future research include the comparison of different combinations of care packages over longer periods of time. Consideration should also be given to what constitutes an intervention goal and how this is measured. Lastly, the investigation of the needs of subgroups of women who have experienced IPV is needed.

74 For a detailed description of each factor please see Appendix 2
75 For a detailed description of each factor please see Appendix 3

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Appendix 1: Literature Review Search Strategy

Stage 1: Initial Exploratory Search

- An initial search began with a review of relevant books within the Learning Resource Centre at the University of Hertfordshire, The British Library and database searches using Web of Knowledge and Google Scholar. The search terms used at this stage were:
    - 'Intimate Partner Violence'
    - 'Domestic Violence'
    - 'Group Interventions'
    - 'Personal Construct Psychology'
    - 'Coping Styles'
    - 'Historical Perspectives'

Stage 2: Following up references

- From relevant articles, key references were identified and followed up. At this time, key authors were also identified and relevant papers obtained.

Stage 3: Contacting Researchers in the Field

- From the list of key authors, several were contacted to obtain copies of papers that were not available through the University. In addition to this I joined the Research Gate Network.

Stage 4: Detailed Review of the Literature over 12 months

- Informed by my previous searches, I went on to conduct a detailed review of the literature according to the criteria outlined below:

Inclusion Criteria:

- Papers published in English
- Peer reviewed Journals
- Papers related to Intimate Partner Violence / Domestic Violence

Exclusion Criteria:

- Research regarding male victims of Intimate Partner Violence / Domestic Violence
- Research regarding male victims of Intimate Partner Violence / Domestic Violence in same sex relationships

Dates of Search: *1950s-2013*

- Domestic Violence became the focus of national attention in Great Britain in the 1970s arising from the women's movement within the contexts of feminism and women's rights. Texts pre-dating this period helped the author to consider the historical context.

Search Terms

- Using Boolean operators and truncation options to ensure all relevant papers were retrieved, the following search terms were employed:
    - Intimate Partner Violence
    - Domestic Violence
    - Dating Violence
    - Stalking
    - Sexual Violence
    - Emotional Abuse
    - Psychological Abuse
    - Physical Abuse
    - Women
    - Young Women
    - Psychosocial adjustment
    - Psychological affects
    - Psychological impact
    - Psychological wellbeing
    - Resilience
    - Interventions
    - Programmes
    - Group interventions
    - Supportive groups
    - Cognitive Behavioural Groups

- Older Women
- Identity
- Relationships
- Consequences of
- Experience of
- Living with
- Impact of
- Adjustment
- Coping Styles
- Coping Strategies
- Categorisation of Coping Strategies
- Coping Measures
- Criticism of X Measure
- Symptom Measures
- Group Dynamics Measures
- Group Climate Measures
- Social Construction
- Social Constructionist
- Constructivism
- Feminism
- Social Learning Theory
- Duluth Model
- Interventions for perpetrators of IPV
- Interventions for victims of IPV
- Interventions for survivors of IPV
- World Health Organisation
- Home Office Guidelines / Strategies / policies
- Personal Construct Psychology
- Personal Construct Theory
- Personal construct Psychology Interventions
- Personal Construct Psychology Measurement
    - Repertory Grid Technique
    - Self to Ideal Self distance
    - Tightness of Construing
    - Extremity
    - Conflict
    - Implicative Dilemmas
    - Dyads
    - Case Study

Search Engines

- Citation alerts were set up associated with key papers identified through the search. The following search engines were used:
    - Web of Knowledge
    - Google Scholar
    - Scopus
    - Psyc Info
    - Pubmed
    - The Pro quest Theses & Theses database

General Web Searches

- More generic sources were needed to inform certain aspects of the study. These were obtained through World Wide Web searches to locate the following:
    - Home Office
    - Department of Health
    - Women's Aid
    - Gender Violence and Health Centre
    - World Health Organisation
    - Safer Places

Ongoing Search of Specific Journals

- The following journals were continually reviewed during the study to ensure that the most up-to-date research was referenced:
    - Journal of Family Violence
    - Violence Against Women
    - Journal of Interpersonal Violence
    - Trauma Violence Abuse
    - International Journal of Personal Construct Psychology

Appendix 2: Yalom's Curative Factors of Group Treatment (1971)

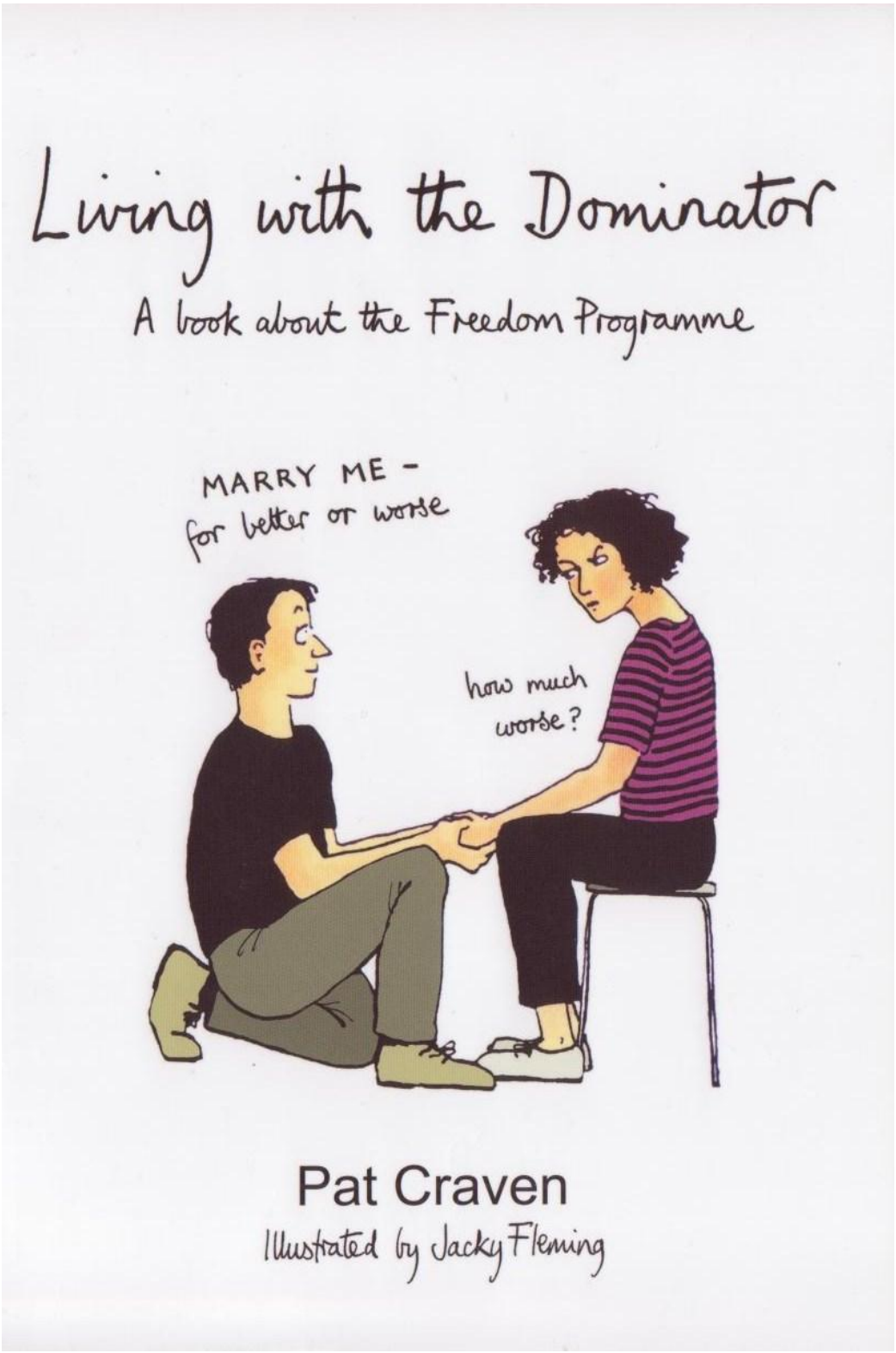
Instillation of Hope	Faith that the treatment mode can and will be effective.
Universality	Demonstration that we are not alone in our misery or our "problems".
Imparting of information	Didactic instruction about mental health, mental illness, psychodynamics or whatever else might be the focal problem of the group. (Ex. learning about the illness process itself).
Altruism	Opportunity to rise out of oneself and help somebody else; the feeling of usefulness.
Corrective recapitulation of primary family group	Experiencing transference relationships growing out of primary family experiences providing the opportunity to relearn and clarify distortions.
Development of socializing techniques	Social learning or development of interpersonal skills.
Imitative behaviour	Taking on the manner of group members who function more adequately.
Catharsis	Opportunity for expression of strong affect.
Existential factors	Recognition of the basic features of existence through sharing with others (e.g. ultimate aloneness, ultimate death, ultimate responsibility for our own actions).
Direct Advice	Receiving and giving suggestions for strategies for handling problems.
Interpersonal learning	Receiving feedback from others and experimenting with new ways of relating.

Appendix 3: Elliott's Helpful and Non-Helpful Aspects of Therapy Taxonomy (1985)

Helpful Factors	
New Perspective- insight	Client realises something about self or self in relation to others that they had not previously considered.
Problem Solution	Client describes progression towards a plan of action to cope with problems.
Clarification of Problem	Client describes becoming clearer about the definition of his or her problems, tasks, or goals for therapy.
Focusing Awareness	Client describes the reduction in, or overcoming, uncomfortable thoughts, feelings and perceptions.
Understanding	Client describes being accurately or deeply understood by the therapist, in relation to the clients' experiences or as a person.
Client Involvement	Client describes being cognitively stimulated or working hard or becoming more involved or invested in the tasks of therapy.
Reassurance	Client describes experiences either a sense of relief from painful feelings, or the enhancement of positive feelings.
Personal Contact	Client describes a sense of the therapist as a fellow human being. This includes perception of positive characteristics of therapist as a fellow human being and as a person, and the experience of mutually or shared view with the best therapist.

Non-helpful Factors	
Misperception:	Client describes feeling misunderstood or inaccurately perceived.
Negative Counsellor Reaction	Client describes feeling that the counsellor was either uninvolved or critical.
Unwanted Responsibility	Client describes being burdened with more responsibility than he or she thought was comfortable or reasonable from an: Inadequate Counselor Response (failing to provide a desired response) or Counselor Pressure (for client to talk in session or take some action outside session).
Repetition	Client describes the counselor going over old ground, dwelling on the obvious, or merely reemphasizing problems.
Misdirection events	Client describes the counselor interrupting or interfering with the student's disclosure and exploration.
Unwanted Thoughts	Client describes discomfort caused by the counselor presenting unpleasant thoughts or feelings that the client felt unprepared to deal with.

Appendix 4 The Freedom Programme Terminology



THE DOMINATOR IS HIS NAME
CONTROLLING WOMEN IS HIS GAME

THE SEXUAL CONTROLLER
- Rapes you.
- Won't accept no for an answer.
- Keeps you pregnant OR
- Rejects your advances.

KING OF THE CASTLE
- Treats you as a servant/slave.
- Says women are for sex, cooking and housework.
- Expects sex on demand.
- Controls all the money.

The Dominator

THE BULLY
- Glares.
- Shouts.
- Smashes things.
- Sulks.

THE JAILER
- Stops you from working and seeing friends.
- Tells you what to wear.
- Keeps you in the house.
- Seduces your friends/family.

THE BADFATHER
- Says you are a bad mother.
- Turns the children against you.
- Uses access to harass you.
- Threatens to take the children away.
- Persuades you to have 'his' baby, and then refuses to help you care for it.

THE LIAR
- Denies any abuse.
- Says it was 'only' a slap.
- Blames drink, drugs, stress, over-work, you, unemployment etc.

THE PERSUADER
- Threatens to hurt or kill you or the children.
- Cries.
- Says he loves you.
- Threatens to kill himself.
- Threatens to report you to Social Services, DSS etc.

THE HEADWORKER
- Puts you down.
- Tells you you're too fat, too thin, ugly, stupid, useless etc.

NOT A SAINT THAT WE ARE SEEING
JUST A DECENT HUMAN BEING

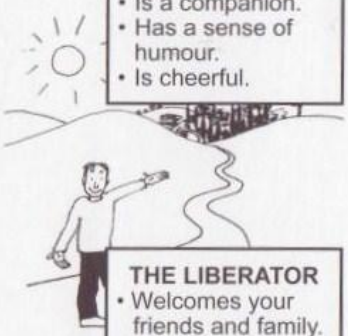
THE LOVER
- Shows you physical affection without assuming it will lead to sex.
- Accepts your right to say no to sex.
- Shares responsibility for contraception etc.

THE PARTNER
- Does his share of the housework.
- Shares financial responsibility.
- Treats you as an equal.

THE GOODFATHER
- Is a responsible parent.
- Is an equal parent.
- Supports your dealings with the children.

The Friend

THE FRIEND
- Talks to you.
- Listens to you.
- Is a companion.
- Has a sense of humour.
- Is cheerful.



THE LIBERATOR
- Welcomes your friends and family.
- Encourages you to have outside interests.
- Encourages you to develop your skills at work or at college..

THE TRUTHTELLER
- Accepts responsibility.
- Admits to being wrong.

THE NEGOTIATOR
- Takes responsibility for his own well-being and happiness.
- Behaves like a reasonable human being.

THE CONFIDENCE BOOSTER
- Says you look good.
- Values your opinions.
- Supports your ambitions.
- Says you are competent.
- Values you.

Appendix 5: Measures

Part 1: Pre-Intervention Measures

University of Hertfordshire

School of Psychology

INFORMATION SHEET

Research Title: The Impact of The Freedom Programme on Construing, Coping and Symptomology in Women who have Experienced Intimate Partner Violence: a Personal Construct Approach

Introduction

You are invited to take part in a research study exploring the personal experiences of women who have experienced abuse from their partner. Before you decide whether you would like to give consent to take part, please take the time to read the following information which I have written to help you understand why the research is being carried out and what it will involve.

The researchers

The study is being carried out by Sarah Clarke, who is a Doctoral student at the University of Hertfordshire, and supervised by Professor David Winter, Director of the Doctorate Programme in Clinical Psychology at the School of Psychology (University of Hertfordshire).

How can I contact the researchers?

You can contact Sarah Clarke by telephone on 077636 94839 or by email s.clarke7@herts.ac.uk. You can contact Professor David Winter by email on d.winter@herts.ac.uk.

What is the purpose of the study?

This research is focused on the experiences of women who have experienced abuse by their partners. The aim is to measure the impact of The Freedom Programme on the way women think about themselves, others and their relationships with others. This understanding will inform psychological treatment recommendations for women who have experienced abuse by their partners.

What is involved?

The research will involve you being asked questions about yourself, your partner, and other significant people in your life, as well as completing five questionnaires. The questionnaires involve questions about you, your relationship with your partner, your relationship with The Freedom Programme group members, and the type of abuse that you have experienced. This should take between 60 and 120 minutes, and you could be seen either at the children's centre, Safer Places refuge or the University of Hertfordshire.

Do I have to take part?

Participation in this research is completely voluntary and you may withdraw at any time with no consequences to the assistance provided to you by The Freedom Programme. Your participation in the project will remain confidential.

What is going to be done with the questionnaires?

The collected data will be analyzed and the results could be published in articles or presented at conferences. However, no information from participants that could allow them to be identified will appear in any publications or presentations.

What are the potential difficulties that taking part may cause?

I am aware from my clinical experience that this topic can be very emotive. If at any point during the interview, you feel you want to stop or take a break, we will do so. Despite these potential difficulties, some researchers suggest that people taking part in research interviews can find the process of talking through their experiences therapeutic and beneficial.

Who has reviewed this study?

This study was reviewed by the University of Hertfordshire's Research Ethics Committee and was given ethical approval. The Registration Protocol Number is: PSY/08/12/SC

Thank you for taking time to read this.

University of Hertfordshire

School of Psychology

PARTICIPANT CONSENT FORM

Research Title: The Impact of The Freedom Programme on Construing, Coping and Symptomology in Women who have Experienced Intimate Partner Violence: a Personal Construct Approach.

Researcher: Sarah Clarke: Doctoral student; **Supervisor**: Professor David Winter

Please initial box

1) I confirm that I have read and understand the information sheet relating to the above study. ☐

2) I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

Having read the information sheet, I have decided to participate in this research and I agree to my results being used for clinical and research interests.

Name:

Address or telephone number where I may be contacted:

Preferred location for seeing a researcher:

Date:

Sign:

DEMOGRAPHIC INFORAMTION

AGE BAND			
Under 19 ☐	20 - 24 ☐	25 -29 ☐	30 - 34 ☐
35 - 39 ☐	40 - 44 ☐	45 - 49 ☐	50 - 54 ☐
55 - 59 ☐	60 - 64 ☐	Over 65 ☐	Prefer not to say ☐
MARITAL STATUS			
Single ☐	In a relationship ☐	Living with partner ☐	Married ☐
Remarried ☐	Separated ☐	Divorced ☐	Widowed ☐
Civil Partnership ☐	Other ☐	Prefer not to say ☐	
SEXUAL ORIENTATION			
Heterosexual ☐	Homosexual ☐	Bisexual ☐	Transsexual ☐
Prefer not to say ☐			

RACE/NATIONALITY/ETHNIC ORIGIN				
White	English ☐	Scottish ☐	Welsh ☐	Irish ☐
	British ☐☐	Other white background ☐ (please specify) …….		
Mixed	White and Black Carribean ☐		White and Black African ☐	
	White and Black British ☐		White and Asian ☐	
	Other mixed background ☐ (please specify) ……			
Asian	Indian ☐	Pakistani ☐	Bangladeshi ☐	British ☐
	Other Asian background ☐ (please specify) ……			
Black	Black Carribean ☐		Black African ☐	
	Black British ☐		Other Black background ☐ (please specify) …….	
Chinese ☐				
Other ethnic group ☐				
Prefer not to say ☐				

RELIGION			
Buddhist ☐	Catholic ☐	Christian ☐	Hindu ☐
Jewish ☐	Muslim ☐	Rastafarian ☐	Sikh ☐
None ☐	Other ☐ (please specify) ……..	Prefer not to say ☐	

DISABILITY			
None ☐	Physical disability ☐	Other disability ☐	Prefer not to say ☐

HIGHEST LEVEL OF EDUCATION COMPLETED		
Primary School ☐	Some Secondary School ☐	Completed Secondary School ☐
Some additional training (apprenticeship, TAFE course, etc. ☐	College ☐	Undergraduate university ☐
Postgraduate university ☐	Other _____☐ (please specify)	Prefer not to say ☐

NUMBER OF DEPENDENTS			
1 ☐	2 ☐	3 ☐	4 ☐
5 ☐	6 ☐	Other ☐	Prefer not to say ☐

FREEDOM PROGRAMME SESSIONS ATTENDED			
1 ☐	2 ☐	3 ☐	4 ☐
5 ☐	6 ☐	7 ☐	8 ☐
9 ☐	10 ☐	11 ☐	12 ☐
13 ☐	14 ☐	Unsure ☐	Course via book ☐

SUPPORT BEING RECIEVED CURRENTLY			
The Freedom Programme ☐	Weekly sessions with a charity worker ☐	Weekly sessions with a support worker ☐	Weekly sessions with a refuge worker ☐
College Course ☐	Living in a refuge ☐	Parenting Course ☐	Therapy ☐
Therapy in the past ☐	Happy and Healthy ☐	Drop in service ☐	Solace Workshop ☐
Social Group ☐	Cognitive Behavioural Therapy ☐	Personal Development Programme ☐	Health Visitor ☐
Waiting List for Therapy ☐	Freedom Programme book ☐	Brighter Futures ☐	Life Coach ☐
Other _____☐	Other _____☐	Other _____☐	Other _____☐

SUPPORT RECIEVED HISTORICALLY			
The Freedom Programme ☐	Weekly sessions with a charity worker ☐	Weekly sessions with a support worker ☐	Weekly sessions with a refuge worker ☐
College Course ☐	Living in a refuge ☐	Parenting Course ☐	Therapy ☐
Therapy in the past ☐	Happy and Healthy ☐	Drop in service ☐	Solace Workshop ☐
Social Group ☐	Cognitive Behavioural Therapy ☐	Personal Development Programme ☐	Health Visitor ☐
Waiting List for Therapy ☐	Freedom Programme book ☐	Brighter Futures ☐	Life Coach ☐
Community Mental Health Team ☐	Inpatient Care ☐	Crisis Team ☐	CBT _____ ☐
Other _____☐	Other _____☐	Other _____☐	Other _____☐

Name: Date:

Repertory Grid

In which important way are any two of them similar to each other and different from the third?

	Self	Mother	Father	(Ex)Partner	Self in Romantic Relationship	Self not in Romantic Relationship	Ideal Self	Ideal Partner	Woman I like	Man I Like	Woman I don't like	Man I don't Like	Fictional male character I like	
Bully														Friend
Bad Parent														Good Parent
Headworker														Confidence booster
Jailer														Liberator
Sexual controller														Lover
King / Queen of the castle														Partner
Liar														Truthteller
Persuader														Negotiator

Brief COPE

These items deal with ways you cope with the stress in your life which has occurred as a result of the domestic violence that you have experienced. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says by answering how much or how frequently you have been doing it. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it.

Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1. I've been turning to work or other activities to take my mind off things.				
2. I've been concentrating my efforts on doing something about the situation I'm in.				
3. I've been saying to myself "this isn't real."				
4. I've been using alcohol or other drugs to make myself feel better.				
5. I've been getting emotional support from others.				
6. I've been giving up trying to deal with it.				
7. I've been taking action to try to make the situation better.				
8. I've been refusing to believe that it has happened.				
9. I've been saying things to let my unpleasant feelings escape.				
10. I've been getting help and advice from other people.				
11. I've been using alcohol or other drugs to help me get through it.				
12. I've been trying to see it in a different light, to make it seem more positive.				
13. I've been criticizing myself.				
14. I've been trying to come up with a strategy about what to do.				
15. I've been getting comfort and understanding from someone.				

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
16. I've been giving up the attempt to cope				
17. I've been looking for something good in what is happening.				
18. I've been making jokes about it.				
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20. I've been accepting the reality of the fact that it has happened.				
21. I've been expressing my negative feelings.				
22. I've been trying to find comfort in my religion or spiritual beliefs.				
23. I've been trying to get advice or help from other people about what to do.				
24. I've been learning to live with it.				
25. I've been thinking hard about what steps to take.				
26. I've been blaming myself for things that happened.				
27. I've been praying or meditating.				
28. I've been making fun of the situation.				

Brief Symptom Inventory

Here is a list of problems people sometimes have. Please record HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY**.**

DURING THE PAST 7 DAYS, how much were you distressed by:

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)	Refused (R)
1.Nervousness or shakiness inside						
2. Faintness or dizziness						
3. The idea that someone else can control your thoughts						
4. Feeling others are to blame for most of your troubles						
5. Trouble remembering things						
6. Feeling easily annoyed or irritated						
7. Pains in the heart or chest						
8. Feeling afraid in open spaces						
9. Thoughts of ending your life						
10. Feeling that most people cannot be trusted						
11. Poor appetite						
12. Suddenly scared for no reason						
13. Temper outbursts that you could not control						
14. Feeling lonely even when you are with people						
15. Feeling blocked in getting things done						
16. Feeling lonely						
17. Feeling blue						
18. Feeling no interest in things						
19. Feeling fearful						
20. Your feelings being easily hurt						
21. Feeling that people are unfriendly or dislike you						
22. Feeling inferior to others						
23. Nausea or upset stomach						
24. Feeling that you are watched or talked about by others						
25. Trouble falling asleep						
26. Having to check and double check what you do						
27. Difficulty making decisions						

Please Turn Over

DURING THE PAST 7 DAYS, how much were you distressed by:						
	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)	Refused (R)
28. Feeling afraid to travel on buses, subways, or trains						
29. Trouble getting your breath						
30. Hot or cold spells						
31. Having to avoid certain things, places, or activities because they frighten you						
32. Your mind going blank						
33. Numbness or tingling in parts of your body						
34. The idea that you should be punished for your sins						
35. Feeling hopeless about the future						
36. Trouble concentrating						
37. Feeling weak in parts of your body						
38. Feeling tense or keyed up						
39. Thoughts of death or dying						
40. Having urges to beat, injure, or harm someone						
41. Having urges to break or smash things						
42. Feeling very self-conscious with others						
43. Feeling uneasy in crowds						
44. Never feeling close to another person						
45. Spells of terror or panic						
46. Getting into frequent arguments						
47. Feeling nervous when you are left alone						
48. Others not giving you proper credit for your achievements						
49. Feeling so restless you couldn't sit still						
50. Feelings of worthlessness						
51. Feeling that people will take advantage of you if you let them						
52. Feeling of guilt						
53. The idea that something is wrong with your mind						

GROUP QUESTIONNAIRE

HOW I IMAGINE THE GROUP WILL BE

Read each statement carefully
As you answer the questions think of HOW YOU IMAGINE THE GROUP WILL BE
For each statement fill in the box under the MOST APPROPRIATE heading that best describes how you imagine the group will be
Please mark only ONE box for each statement.

	Not at all (0)	A Little Bit (1)	Somewhat (2)	Moderately (3)	Quite a bit (4)	A Great Deal (5)	Extremely (6)
1. The members liked and cared about each other							
2. The members tried to understand why they do the things they do, tried to reason it out							
3. The members avoided looking at important issues going on between themselves							
4. The members felt what was happening was important and there was a sense of participation							
5. The members depended upon the group leader(s) for direction							
6. There was friction and anger between the members							
7. The members were distant and withdrawn from each other							
8. The members challenged and confronted each other in their efforts to sort things out							
9. The members appeared to do things the way they thought would be acceptable to the group							
10. The members rejected and distrusted each other							
11. The members revealed sensitive personal information or feelings							
12. The members appeared tense and anxious							

Index of Spouse Abuse

Please indicate how often each one of these acts has happened in the last 12 months rating it from 1 (*never*) to 5 (*very frequently*).

	Never (1)	Rarely (2)	Occasionally (3)	Frequently (4)	Very Frequently (5)
1. Belittles me					
2. Demands obedience to his whims					
3. Becomes surly and angry if I tell him he is drinking too much					
4. Makes me perform sex acts that I do not enjoy or like					
5. Becomes very upset if dinner, housework or laundry is not done when he thinks it should be					
6. Is jealous and suspicious of my friends					
7. Punches me with his fists					
8. Tells me I am ugly and unattractive					
9. Tells me I really couldn't manage or take care of myself without him					
10. Acts like I am his personal servant					
11. Insults or shames me in front of others					
12. Becomes very angry if I disagree with his point of view					
13. Threatens me with a weapon					
14. Is stingy in giving me enough money to run our home					
Extra. Controls my expenses and often complains because I expend too much (i.e. clothes, telephone, etc.)a					
15. Belittles me intellectually					
16. Demands that I stay home to take care of the children					
17. Beats me so badly that I must seek medical help					
18. Feels that I should not work or go to college					
19. Is not a kind person					
20. Does not want me to socialize with my female friends					
21. Demands sex whether I want it or not					
22. Screams and yells at me					
23. Slaps me around my face and head					
24. Becomes abusive when he drinks					
25. Orders me around					
26. Has no respect for my feelings					
27. Acts like a bully toward to me					
28. Frightens me					
29. Treats me like a dunce					
30. Acts like he would like to kill me					

University of Hertfordshire

School of Psychology

DEBRIEFING INFORMATION SHEET

This research is being conducted in order to obtain information about the experiences of women who have experienced abuse by their partners. The aim is to measure the impact of The Freedom Programme on the way women think about themselves, others and their relationships with others. Your responses to the various measures will be included with those obtained from other participants, and statistical analyses will then be conducted.

Thank you very much for your collaboration.

Talking about your experiences may have left you feeling low or upset. This is quite normal and often passes after a few days. However, if these feelings persist there are local sources of support available to you:

Hertfordshire Domestic Violence Helpline: 08 088 088 088
Women's Aid: 0808 2000 247

If you wish to receive a report of the overall results of the research, please mark in the corresponding box:

□ Yes, I wish to be informed of the results of this research.
□ No, I am not interested in being informed of the results.

Name:

Date:

Sign:

Address to which I wish results to be sent:

Appendix 5: Measures

Part 2: Post-Intervention Measures

University of Hertfordshire

School of Psychology

INFORMATION SHEET

Research Title: The Impact of The Freedom Programme on Construing, Coping and Symptomology in Women who have Experienced Intimate Partner Violence: a Personal Construct Approach

Introduction

You are invited to take part in a research study exploring the personal experiences of women who have experienced abuse from their partner. Before you decide whether you would like to give consent to take part, please take the time to read the following information which I have written to help you understand why the research is being carried out and what it will involve.

The researchers

The study is being carried out by Sarah Clarke, who is a Doctoral student at the University of Hertfordshire, and supervised by Professor David Winter, Director of the Doctorate Programme in Clinical Psychology at the School of Psychology (University of Hertfordshire).

How can I contact the researchers?

You can contact Sarah Clarke by telephone on 077636 94839 or by email s.clarke7@herts.ac.uk. You can contact Professor David Winter by email on d.winter@herts.ac.uk.

What is the purpose of the study?

This research is focused on the experiences of women who have experienced abuse by their partners. The aim is to measure the impact of The Freedom Programme on the way women think about themselves, others and their relationships with others. This understanding will inform psychological treatment recommendations for women who have experienced abuse by their partners.

What is involved?

The research will involve you being asked questions about yourself, your partner, and other significant people in your life, as well as completing five questionnaires. The questionnaires involve questions about you, your relationship with your partner, your relationship with The Freedom Programme group members, and the type of abuse that you have experienced. This should take between 60 and 120 minutes, and you could be seen either at the children's centre, Safer Places refuge or the University of Hertfordshire.

Do I have to take part?

Participation in this research is completely voluntary and you may withdraw at any time with no consequences to the assistance provided to you by The Freedom Programme. Your participation in the project will remain confidential.

What is going to be done with the questionnaires?

The collected data will be analyzed and the results could be published in articles or presented at conferences. However, no information from participants that could allow them to be identified will appear in any publications or presentations.

What are the potential difficulties that taking part may cause?

I am aware from my clinical experience that this topic can be very emotive. If at any point during the interview, you feel you want to stop or take a break, we will do so. Despite these potential difficulties, some researchers suggest that people taking part in research interviews can find the process of talking through their experiences therapeutic and beneficial.

Who has reviewed this study?

This study was reviewed by the University of Hertfordshire's Research Ethics Committee and was given ethical approval. The Registration Protocol Number is: PSY/08/12/SC

Thank you for taking time to read this.

University of Hertfordshire

School of Psychology

PARTICIPANT CONSENT FORM

Research Title: The Impact of The Freedom Programme on Construing, Coping and Symptomology in Women who have Experienced Intimate Partner Violence: a Personal Construct Approach.

Researcher: Sarah Clarke: Doctoral student; **Supervisor**: Professor David Winter

Please initial box

3) I confirm that I have read and understand the information sheet relating to the above study. ☐

4) I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

Having read the information sheet, I have decided to participate in this research and I agree to my results being used for clinical and research interests.

Name:

Address or telephone number where I may be contacted:

Preferred location for seeing a researcher:

Date:

Sign:

DEMOGRAPHIC INFORAMTION

AGE BAND			
Under 19 ☐	20 - 24 ☐	25 -29 ☐	30 - 34 ☐
35 - 39 ☐	40 - 44 ☐	45 - 49 ☐	50 - 54 ☐
55 - 59 ☐	60 - 64 ☐	Over 65 ☐	Prefer not to say ☐
MARITAL STATUS			
Single ☐	In a relationship ☐	Living with partner ☐	Married ☐
Remarried ☐	Separated ☐	Divorced ☐	Widowed ☐
Civil Partnership ☐	Other ☐	Prefer not to say ☐	
SEXUAL ORIENTATION			
Heterosexual ☐	Homosexual ☐	Bisexual ☐	Transsexual ☐
Prefer not to say ☐			

RACE/NATIONALITY/ETHNIC ORIGIN				
White	English ☐	Scottish ☐	Welsh ☐	Irish ☐
	British ☐☐	Other white background ☐ (please specify) …….		
Mixed	White and Black Carribean ☐		White and Black African ☐	
	White and Black British ☐		White and Asian ☐	
	Other mixed background ☐ (please specify) ……			
Asian	Indian ☐	Pakistani ☐	Bangladeshi ☐	British ☐
	Other Asian background ☐ (please specify) ……			
Black	Black Carribean ☐		Black African ☐	
	Black British ☐		Other Black background ☐ (please specify) …….	
Chinese ☐				
Other ethnic group ☐				
Prefer not to say ☐				

RELIGION			
Buddhist ☐	Catholic ☐	Christian ☐	Hindu ☐
Jewish ☐	Muslim ☐	Rastafarian ☐	Sikh ☐
None ☐	Other ☐ (please specify) ……..	Prefer not to say ☐	

DISABILITY			
None ☐	Physical disability ☐	Other disability ☐	Prefer not to say ☐

HIGHEST LEVEL OF EDUCATION COMPLETED		
Primary School ☐	Some Secondary School ☐	Completed Secondary School ☐
Some additional training (apprenticeship, TAFE course, etc. ☐	College ☐	Undergraduate university ☐
Postgraduate university ☐	Other _____☐ (please specify)	Prefer not to say ☐

NUMBER OF DEPENDENTS			
1 ☐	2 ☐	3 ☐	4 ☐
5 ☐	6 ☐	Other ☐	Prefer not to say ☐

FREEDOM PROGRAMME SESSIONS ATTENDED			
1 ☐	2 ☐	3 ☐	4 ☐
5 ☐	6 ☐	7 ☐	8 ☐
9 ☐	10 ☐	11 ☐	12 ☐
13 ☐	14 ☐	Unsure ☐	Course via book ☐

SUPPORT BEING RECIEVED CURRENTLY			
The Freedom Programme ☐	Weekly sessions with a charity worker ☐	Weekly sessions with a support worker ☐	Weekly sessions with a refuge worker ☐
College Course ☐	Living in a refuge ☐	Parenting Course ☐	Therapy ☐
Therapy in the past ☐	Happy and Healthy ☐	Drop in service ☐	Solace Workshop ☐
Social Group ☐	Cognitive Behavioural Therapy ☐	Personal Development Programme ☐	Health Visitor ☐
Waiting List for Therapy ☐	Freedom Programme book ☐	Brighter Futures ☐	Life Coach ☐
Other _____☐	Other _____☐	Other _____☐	Other _____☐

SUPPORT RECIEVED HISTORICALLY			
The Freedom Programme ☐	Weekly sessions with a charity worker ☐	Weekly sessions with a support worker ☐	Weekly sessions with a refuge worker ☐
College Course ☐	Living in a refuge ☐	Parenting Course ☐	Therapy ☐
Therapy in the past ☐	Happy and Healthy ☐	Drop in service ☐	Solace Workshop ☐
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Waiting List for Therapy ☐	Freedom Programme book ☐	Brighter Futures ☐	Life Coach ☐
Community Mental Health Team ☐	Inpatient Care ☐	Crisis Team ☐	CBT _____ ☐
Other _____☐	Other _____☐	Other _____☐	Other _____☐

Name: Date:

Repertory Grid

In which important way are any two of them similar to each other and different from the third?

	Self	Mother	Father	(Ex)Partner	Self in Romantic Relationship	Self not in Romantic Relationship	Ideal Self	Ideal Partner	Woman I like	Man I Like	Woman I don't like	Man I don't Like	Fictional male character I like	
Bully														Friend
Bad Parent														Good Parent
Headworker														Confidence booster
Jailer														Liberator
Sexual controller														Lover
King / Queen of the castle														Partner
Liar														Truthteller
Persuader														Negotiator

Brief COPE

These items deal with ways you cope with the stress in your life which has occurred as a result of the domestic violence that you have experienced. There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says by answering how much or how frequently you have been doing it. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it.

Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1. I've been turning to work or other activities to take my mind off things.				
2. I've been concentrating my efforts on doing something about the situation I'm in.				
3. I've been saying to myself "this isn't real."				
4. I've been using alcohol or other drugs to make myself feel better.				
5. I've been getting emotional support from others.				
6. I've been giving up trying to deal with it.				
7. I've been taking action to try to make the situation better.				
8. I've been refusing to believe that it has happened.				
9. I've been saying things to let my unpleasant feelings escape.				
10. I've been getting help and advice from other people.				
11. I've been using alcohol or other drugs to help me get through it.				
12. I've been trying to see it in a different light, to make it seem more positive.				
13. I've been criticizing myself.				
14. I've been trying to come up with a strategy about what to do.				
15. I've been getting comfort and understanding from someone.				

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
16. I've been giving up the attempt to cope				
17. I've been looking for something good in what is happening.				
18. I've been making jokes about it.				
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20. I've been accepting the reality of the fact that it has happened.				
21. I've been expressing my negative feelings.				
22. I've been trying to find comfort in my religion or spiritual beliefs.				
23. I've been trying to get advice or help from other people about what to do.				
24. I've been learning to live with it.				
25. I've been thinking hard about what steps to take.				
26. I've been blaming myself for things that happened.				
27. I've been praying or meditating.				
28. I've been making fun of the situation.				

Brief Symptom Inventory

Here is a list of problems people sometimes have. Please record HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY**.**

DURING THE PAST 7 DAYS, how much were you distressed by:

	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)	Refused (R)
1.Nervousness or shakiness inside						
2. Faintness or dizziness						
3. The idea that someone else can control your thoughts						
4. Feeling others are to blame for most of your troubles						
5. Trouble remembering things						
6. Feeling easily annoyed or irritated						
7. Pains in the heart or chest						
8. Feeling afraid in open spaces						
9. Thoughts of ending your life						
10. Feeling that most people cannot be trusted						
11. Poor appetite						
12. Suddenly scared for no reason						
13. Temper outbursts that you could not control						
14. Feeling lonely even when you are with people						
15. Feeling blocked in getting things done						
16. Feeling lonely						
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20. Your feelings being easily hurt						
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23. Nausea or upset stomach						
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26. Having to check and double check what you do						
27. Difficulty making decisions						

Please Turn Over

DURING THE PAST 7 DAYS, how much were you distressed by:						
	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)	Refused (R)
28. Feeling afraid to travel on buses, subways, or trains						
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31. Having to avoid certain things, places, or activities because they frighten you						
32. Your mind going blank						
33. Numbness or tingling in parts of your body						
34. The idea that you should be punished for your sins						
35. Feeling hopeless about the future						
36. Trouble concentrating						
37. Feeling weak in parts of your body						
38. Feeling tense or keyed up						
39. Thoughts of death or dying						
40. Having urges to beat, injure, or harm someone						
41. Having urges to break or smash things						
42. Feeling very self-conscious with others						
43. Feeling uneasy in crowds						
44. Never feeling close to another person						
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46. Getting into frequent arguments						
47. Feeling nervous when you are left alone						
48. Others not giving you proper credit for your achievements						
49. Feeling so restless you couldn't sit still						
50. Feelings of worthlessness						
51. Feeling that people will take advantage of you if you let them						
52. Feeling of guilt						
53. The idea that something is wrong with your mind						

GROUP QUESTIONNAIRE

WHAT WAS YOUR EXPERIENCE OF THE GROUP

Read each statement carefully
As you answer the questions think of YOUR EXPERIENCE OF THE GROUP
For each statement fill in the box under the MOST APPROPRIATE heading that best describes how you would like the group to be.
Please mark only ONE box for each statement.

	Not at all (0)	A Little Bit (1)	Somewhat (2)	Moderately (3)	Quite a bit (4)	A Great Deal (5)	Extremely (6)
1. The members liked and cared about each other							
2. The members tried to understand why they do the things they do, tried to reason it out							
3. The members avoided looking at important issues going on between themselves							
4. The members felt what was happening was important and there was a sense of participation							
5. The members depended upon the group leader(s) for direction							
6. There was friction and anger between the members							
7. The members were distant and withdrawn from each other							
8. The members challenged and confronted each other in their efforts to sort things out							
9. The members appeared to do things the way they thought would be acceptable to the group							
10. The members rejected and distrusted each other							
11. The members revealed sensitive personal information or feelings							
12. The members appeared tense and anxious							

Helpful and Unhelpful aspects of The Freedom Programme Questionnaire

1) Of the events that occurred during the course of The Freedom Programme, which events do you feel were the *most helpful* for you personally? They may be things you said or did, or things the facilitator or other group members said or did. Can you say why they were helpful? Please list the events below (for additional space to write comments please turn over the page):

2) Of the events that occurred during the course of The Freedom Programme, which events do you feel were the *most unhelpful* for you personally? They may be things you said or did, or things the facilitator or other group members said or did. Can you say why they were unhelpful? Please list the events below (for additional space to write comments please turn over the page):

2) Can you rate how helpful The Freedom Programme was overall? (Please tick one)

Very Helpful	
Fairly Helpful	
Neither Helpful or Unhelpful	
Fairly Unhelpful	
Very Unhelpful	

3) Has anything particularly important happened in your life since you started The Freedom Programme? (For additional space to write comments PTO):

Thank you very much for completing this questionnaire

CONTINUATION SHEET FOR FURTHER COMMENTS

University of Hertfordshire

School of Psychology

DEBRIEFING INFORMATION SHEET

This research is being conducted in order to obtain information about the experiences of women who have experienced abuse by their partners. The aim is to measure the impact of The Freedom Programme on the way women think about themselves, others and their relationships with others. Your responses to the various measures will be included with those obtained from other participants, and statistical analyses will then be conducted.

Thank you very much for your collaboration.

Talking about your experiences may have left you feeling low or upset. This is quite normal and often passes after a few days. However, if these feelings persist there are local sources of support available to you:

Hertfordshire Domestic Violence Helpline: 08 088 088 088
Women's Aid: 0808 2000 247

If you wish to receive a report of the overall results of the research, please mark in the corresponding box:

□ Yes, I wish to be informed of the results of this research.
□ No, I am not interested in being informed of the results.

Name:

Date:

Sign:

Address to which I wish results to be sent:

Appendix 6: University of Hertfordshire Ethical Approval

Original Application Approval

Revised (September 2006)

SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE APPROVAL

Student Investigator: Sarah Clarke

Title of project: The impact of The Freedom Programme on construing of self, others, romantic relationships and attachment patterns in women who have suffered intimate partner violence: a personal construct approach.

Supervisor: David Winter

Registration Protocol Number: PSY/08/12/SC

The approval for the above research project was granted on 20 August 2012 by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire.
The end date of your study is 30 April 2013.

Signed:  Date: 20 August 2012

Professor Lia Kvavilashvili
Chair
Psychology Ethics Committee

STATEMENT OF THE SUPERVISOR:

From my discussions with the above student, as far as I can ascertain, s/he has followed the ethics protocol approved for this project.

Signed (supervisor): ……

Date: ……

Appendix 6: University of Hertfordshire Ethical Approval – Modifications Approval

PSC Form Version 2008

SCHOOL OF PSYCHOLOGY ETHICS APPLICATION FORM - 3
For minor modifications to an existing protocol approval

Status: Doctorate

Course code (if student): DClinPSyc

Title of project: The impact of The Freedom Programme on construing of self, others, romantic relationships and group cohesion in women who have suffered intimate partner violence: a personal construct approach.

Name of researcher(s): Sarah Clarke

Contact Tel. no: 077 636 94839
Contact Email: s.clarke7@herts.ac.uk

Name of supervisors: David Winter and Claire Norris
(for undergraduate and postgraduate research)

Start Date of Study (if the end date of the existing approval has expired): July 2012

End Date of Study: April 2013

Details of modification:

The study (Registration Protocol Number: PSY/08/12/SC) gave the following questionnaires to participants before they took part in a group intervention called The Freedom Programme.

Measures which have been completed by participants before undertaking group intervention:
Personal Information Questionnaire
Repertory Grid Technique
The Group Climate Questionnaire
The Brief COPE
The Brief Symptom Inventory
Index of Spouse Abuse

Proposed Changes
Following completion of the intervention I propose that the participants complete the following measures:
Demographic Questionnaire (modified Personal Information Questionnaire to gather better demographic information)
Repertory Grid Technique (modified with one extra element: favourite group member)
The Group Climate Questionnaire (modified from expectations of group to actual experience of group)
The Brief COPE (same)
The Brief Symptom Inventory (same)
Helpful and Unhelpful Aspects of Supportive Services Questionnaire (new measure)
Helpful and Unhelpful Aspects of The Freedom Programme Questionnaire (new measure)

Appendix 1 :Full Assessment Pack including pre and post new and modified measures that I am requesting ethical approval for.

Does the modification present additional hazards to the participant/investigator? *(delete as inappropriate option category)*	*NO*
If yes, please provide a clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them.	YES

This form should be submitted (via your Supervisor for MSc/ESc students) to the Psychology Ethics Committee, psyethics@herts.ac.uk where it will be reviewed before being approved by chair's action.

PLEASE ATTACH COPY OF ORIGINAL PROTOCOL APPLICATION

Name …Sarah Clarke……Date…14.12.12…
(Researcher(s))

Name…Professor David Winter……Date…14.12.12…
(Supervisor)

APPROVAL OF PROTOCOL APPLICATION FOR MODIFICATION

We support the approval of modification of the above protocol	Yes
We **do not** support the modification of the above protocol for the following reasons:	

Signature ……. **Date 16.01.13**

Acting Chair of Psychology Ethics Committee

Ethics LK/CH/2006 Created: 19/09/06

Appendix 7: Helpful and Non-Helpful Questionnaire Responses

Table 1: Frequency of 'helpful aspects' responses

Frequency of response	Response
13	'I learnt a lot from the Freedom Programme'
13	'I don't feel alone'
10	'The Facilitators were very good'
6	'We had a shared experience'
5	'The sessions about the Sexual Controller and the Bad Parent were important but very upsetting'
4	'I felt understood'
3	'I didn't feel judged by anyone'
3	'I think we gave each other strength'
3	'I didn't feel judged by anyone'
3	'We were able to use humour at times'
3	'It gave me hope'
2	'I felt connected to the group'
2	'I don't feel it was my fault'
2	'The group had a good atmosphere'
1	'I felt acknowledged'
1	'I felt listened to'
1	'It was very supportive'
1	'I found it reassuring'
1	'going through the different characters, like The Bully and The Headworker, helped me to recognise it'
1	'I feel like it opened my eyes'
1	'I had never really realised it was abuse because I hadn't talked about it to anyone'
1	'I made friends'
1	'I made contacts'
1	'It was good that it was a flexible group and you could attend sessions when you could'
1	'I got information about other services that I could access'
1	'I found it Inspiring'

Table 2: Frequency of 'non-helpful aspects' responses

Frequency of response	Responses
2	'I find it difficult to talk about me'
2	'It's difficult for quiet ones to speak'
2	'I wanted to talk more about my experience'
2	'Some members talked too much'
1	'We were all very different'
1	'We didn't really have things in common'
1	'So many women act like victims'
1	'The facilitator hadn't experienced domestic violence, I think this made a difference'

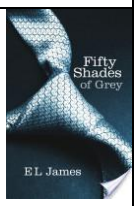
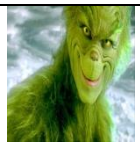
1	‘I wanted the facilitators to talk more’
1	‘Some people aren’t ready to be there’
1	‘I’m a private person’
1	‘We talked about things that were of no interest to me’
1	‘I just wanted to put it behind me’
1	‘It drags it all up’
1	‘I came away upset’
1	‘I felt old in comparison’
1	‘I worried I talked too much’
1	‘I think that some women had ulterior motives for attending the group, I think they had to come to get their benefits’
1	‘We didn’t talk about how men came to be that way’
1	‘Group drop-outs were out of my control’
1	‘I wanted to do it alone’
1	‘I wanted more sessions’
1	‘the group was [sic]too far away from where I live’ (geographically)
1	‘I was angry by some of the women’s stories, I don’t know why they let it [sic] go on (the abusive relationship)’
1	‘I can imagine that if a group had different women it could be difficult, everyone in our group was so nice.’
1	‘when you see people outside of the group and you don’t know what to do’

Total 114 Factors

Appendix 8: Fictional Male / Famous Male I like

During the repertory grid interview participants were asked to give a name for the element: Fictional Male Character or Famous Male that participants liked from books, television, film etc. Table 25 presents the males that participants chose to use within their repertory grids. Of the men, 18 were actors from film and television. The remaining men were a political leader, a singer, a book character a puppet and professional coach for 'The Secret' (a technique for acquiring how to get what you want).

Table 25: Fictional Male/ Famous Male I like

1	Mark (Polish TV Actor)	Unable to find image	9	Hawk – Character: Law enforcement (Actor)		17	Lenard Hofstadter - Character: Physicist (Actor)	
2	Richard Gere: Actor		10	Mr Darcy - Character: Wealthy aristocrat (Actor)		18	Denzel Washington: Actor	
3	Jack Branning - Character: Nightclub owner (Actor)		11	Wentworth Miller - Character: Prisoner (Actor)		19	Mr Grey - Character: Successful business man with niche sexual preferences	
4	Clive Owen: Actor		12	Alfie Moon - Character: Publican (Actor)		20	Johnny Depp: Actor	
5	Harrison Ford: Actor		13	Bob Proctor: Professional Life Coach		21	George Clooney: Actor	
6	Nelson Mandela: Political Leader		14	Bill Cosby: Actor and Comedian		22	The Grinch – Character: Goblin who tried to stop Christmas	
7	James Cordon: Actor and Comedian		15	Anthony Hopkins: Actor		23	Colin Firth: Actor	
8	Captain Jack Sparrow - Character: Pirate (Actor)		16	Will Smith: Actor, Comedian and Singer		24	Peter Andre: Singer and Reality TV star