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# A Look at the Effectiveness of Outreach Programs for Victims of Domestic Violence: Outline of Preliminary Findings of a Small Scale Study

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## **Abstract**

Intimate-partner violence is an injustice imposed on both men and women; however, the vast majority of victims are women. Therefore, my study focuses solely on women. Moreover, abused women deal with an array of complexities in terms of their overall quality of life due to the abuse they suffer, and as a result a variety of outreach programs are being offered in hopes that these women will have a chance at a better living situation and better health outcomes. This paper will examine the psychological and physical symptoms experienced by battered women and the role of outreach programs to help them. My quantitative study will examine the efforts of one organization and its attempts to address the issue through the services offered to the victims of domestic violence in that particular area. The study consisted of a survey that revealed the benefits experienced by regularly attending the outreach program. In the study the participants overall reported the alleviation of symptoms thus actually benefitting from the program. The outreach program researched is Next Door Solutions, a program located in San Jose, CA, that has an ethnically diverse clientele. Furthermore, this study was a small scale study with 19 participants that was used to shed light on what is effective, what can be offered, and suggests that further research can be done to look into alternative approaches that can be implemented for a more effective outreach program.

## **Introduction**

Domestic violence is a traumatic experience for any victim that it affects since it not only leaves physical injuries which can linger but also leaves long-term psychological and emotional trauma that affects their overall mental health. Intimate-partner violence is defined as physical and emotional abuse, which includes the actual abuse or threats to the victim that come from a boyfriend/girlfriend, spouse, or dating partner whether current or former (Jaffe, 2011). Intimate-partner violence has reached such an extreme that it has been defined as a global health issue since 1994 by the world health organization, since victims are exposed to a variety of health issues that can leave long-term effects (Scheffer & Renck, 2008). The victim suffers both psychological and physical symptoms; each entails its own complexity of severity and combinations of symptoms leading to a low quality of well-being. In some cases we see that the psychological symptoms victims experience manifest themselves to become additional physical symptoms aside from what was already caused by the physical abuse. Crossing the boundaries of background, income, and educational attainment, women from all walks of life suffer from an array of health degradations (Ellsburg, Henrica, Heisa, Watts, & Moreno, 2008). While most shelters and domestic violence help centers focus on getting these women away from their abusers, one concern that does not receive enough attention is relieving the lingering psychological and physical symptoms of the victims (Ellsburg et al., 2008). Because these symptoms have not been treated, often abused women will not leave or do not have the necessary means to leave such abusive relationships. Due to this, outreach programs are now offering a way to address and treat the complex symptoms associated with being battered.

## Literature Review

### Psychological Symptoms

Victims of domestic-violence abuse suffer from a variety of psychological symptoms including many disorders related to mental health, stress, nervousness, anxiety, depression, low self-esteem and fear. While these are symptoms themselves, they can also be linked as the cause of physical symptoms in addition to the battering. Furthermore, it is symptoms such as these that cause long-term mental health issues. Women victims of intimate-partner violence have reported on various occasions that fear is a psychological symptom they live with even after leaving an abusive relationship. This fear creates a constant paranoia which can affect the way they go about their daily lives. Another major psychological symptom commonly found amongst victims of such abuse is post-traumatic stress disorder (PTSD), and many of the women unknowingly suffer from several of the symptoms that classify as PTSD. Along with this, in a study done on 14 women who experienced battering, a common theme found among them was that they had suicidal thoughts or feelings of low self-esteem. These women were compared to women who had never experienced any form of intimate-partner violence, and it was found that the degree of depression, suicidal thoughts, and lower self-esteem were significantly higher than that of their non-abused counterparts. This indicates that the violence is a significant factor in the mental health of women and their experience of feelings of depression (Scheffer, 2008). Not only are these feelings causing lower self-esteem, but it creates a lower quality of life for these women. Moreover, even if they are freed from their abusive situation, they still carry the burden of lasting effects and live their daily lives still suffering from anxiety, paranoia, fear, and other stressors. In a study on a Canadian population, it was found that abused women experienced significantly more anxiety, insomnia, and social dysfunction (Campbell, 2002). In addition, the severity of the violence was believed to be

Rizzo: A Look at the Effectiveness of Outreach Programs for Victims of DV the factor that correlated with the severity of the symptoms. However, in another study looking at ethnically diverse women in Chicago who had experienced abuse, minor physical assaults and even minor physical abuse psychological distress was still apparent (Hill, Schroeder, Bradley, Kaplan, & Angel, 2009). Moreover, in that particular case study it was found that women who endured minor physical assault were the ones who experienced the highest levels of psychological distress (Hill et al., 2009). Therefore, regardless of the level or length of the abuse, women suffer lasting symptoms. Victims are tormented by these psychological effects even long after the abuse has stopped. In addition, they deal with physical symptoms as a result of the direct abuse to the victim's body.

### **Physical Symptoms**

Furthermore, it is not just the psychological effects that can cause a lower quality of life, but the physical symptoms can deteriorate the health conditions of a victim. These physical symptoms can range from headaches, body aches, muscle tension, and other bodily injury. Battered women account for the majority of injured women in the healthcare system who report to the hospital. Along with this, there are particular areas of a woman's body that are affected most by the abuse, which include injuries to the head, face, neck, thorax, breasts, and abdomen. Although there are other areas that can be affected by the abuse, it is within these areas that women will experience the most health issues. A victim can experience chronic health problems related to headaches, back pain, even fainting and seizures. Abused women have also self-reported significantly higher gastrointestinal symptoms such as loss of appetite and eating disorders. Additionally, cardiac issues, such as hypertension, have also been found. Abused women find that the most common physical symptom of being in an abusive relationship is that of reoccurring headaches and migraines. The symptoms listed are those typical of physical abuse, yet these symptoms only worsen when sexual abuse is present. At that point, the health complications are only exacerbated and can range from sexually transmitted infections to several gynecological problems (Campbell, 2002). Lastly, victims who suffer from physical and mental abuse are more prone to also becoming substance abusers.

Living with the combination of psychological and physical abuse can lead the victims to feeling suicidal or to engaging in risky activities such as substance abuse to cope (Hill et al., 2009). Even among women experiencing minor physical abuse, the risk of intoxication increased in comparison to their non-abused counterparts (Hill et al., 2009). There is overwhelming evidence that women in abusive relationships will lead lives with poor health trajectories. Because it is such a recognized issue, it would be beneficial for outreach programs to treat both psychological and physical symptoms of abuse in improving the overall well-being of the victim. Looking at the detrimental physical and mental abuse, outreach programs are attempting to improve the unhealthy situation.

### **Outreach programs**

Outreach programs play a vital role in helping victims cope with symptoms and the overall well-being of the victim. Since it has been considered a health problem, the U.S congress has made funding available to aid and implement programs to prevent further abuse. Another form of support that aids such initiatives comes from the Center for Disease Control and Prevention. The CDC helps fund both primary and secondary initiatives. According to prior research conducted, it has

been found that outreach programs that include prevention and intervention are most effective when community-based as opposed to government-initiated (Post, Klevens, Maxwell, Shelley & Ingram, 2010). While the government has funded a variety of programs that include hotlines, shelters, support groups, group and individual counseling, legal and human services, housing, medical care, etc., it is important that communities take action to be the leaders in such program initiatives. The approach taken by the outreach programs plays a key role in how effectively the outcomes and benefits will be to the target population.

It is an appalling situation that is happening to women everywhere. This is a ubiquitous plight that has persisted over time and is causing low quality of life as well as a variety of health consequences. Such abuse does damage that affects mental health, quality of life, and the overall well-being of the person. Even more alarming, it has been found that women who are victims of intimate-partner violence between the ages of 15–44 years of age become 5–20% of fatal casualties (Lafta, 2008). Recognizing this as a global health problem, it is a necessity to address the issue with appropriate services. While it is ultimately up to the victim to seek help, making effective services accessible is a key component to helping these women. Services that address healthcare needs in addition to psychological and physical symptoms would be the most beneficial to increasing the quality of life for these women. It is generally discussion groups or counseling that are offered to these women to help them cope with these traumatic experiences. Furthermore, there are a wide range of services offered in an attempt to aid women in leaving the situation, such as shelters, legal help, and hotlines. In order to understand some of the benefits, it is important to examine the symptoms the victims are experiencing and whether those symptoms are being alleviated. My study takes a look at the common symptoms experienced by victims and investigates whether or not the outreach program is successfully alleviating symptoms.

### **Methodology**

To observe the effects of Next Door Solution's programs, I examined discussion groups to assess their role in alleviating psychological and physical symptoms. The program is located in San Jose, California. It is an outreach program whose sole purpose is to offer resources to victims of intimate-partner violence. Furthermore, Next Door Solutions serves a racially and ethnically diverse clientele consisting of women with low educational attainment. The two forms of outreach groups offered at Next Door Solutions and presented to me as appropriate for the project were quilt groups and discussion groups. Both were initially considered in this study, but due to time constraints, only the discussion groups' participants were considered. A discussion group is a support group for victims of intimate-partner violence. These groups are offered to the victims to discuss their experiences, their feelings, and how they are coping with their situations; they share openly amongst other women who are enduring abusive relationships. Groups are offered in both Spanish and English. The participants targeted for this study were the core members of the discussion group. Core members were identified as the ones who attended the group more than five times. Focusing on core group members allowed me to get a better sense of the impact of the groups on the clients. I was granted permission by the directors and facilitators of the discussion groups to distribute my survey. In total I had 19 respondents.

I chose to work with Next Door Solutions because of their need for research assistance in evaluating their programs. After discussing with the directors their assessment goals, we found we

Rizzo: A Look at the Effectiveness of Outreach Programs for Victims of DV had similar research interests and began to work on this project. One of the first steps we took was deciding that we wanted to evaluate the programs using a quantitative approach. We then conceptualized the specific criteria we wanted to evaluate and developed questions that would offer insight on the alleviation of physical and psychological symptoms. Working closely with one of the directors, I was guided in accessing their clientele and also the facilitators. The role of the facilitators was to oversee the discussion groups and lead the discussion as well as to help these women interpret the occurrences of their abuse. With their help, I was able to come in on several occasions to pass out the survey instrument. The facilitators were notified in advance that I would be coming, thus allowing them time to notify their clientele as well. This process allowed everyone involved to understand that the survey would be taking place and that it was solely on a volunteer basis. The particular organization was not assigned a pseudonym and was willing to disclose the name of the organization.

### **Participants**

I surveyed the clients to assess the impact of the group on physical and psychological symptoms. I distributed a self-administered questionnaire during a group meeting. The questionnaire was in both English and Spanish and surveyed several different issues relating directly to the psychological and physical alleviation of symptoms through the discussion group. Lastly, participants were given time to provide feedback about the services received at the outreach program they attended with a qualitative section at the end. The survey was handed out on a volunteer basis; those who willingly participated signed a consent form informing them of the confidentiality of their responses, that no service would be jeopardized with their participation, and the right to withdraw at any time during the survey.

All the participants were recruited from the biweekly discussion groups. While both quilt and discussion groups were initially to be part of this study, the quilt group was excluded due to time constraints. From the discussion group, I was able to collect 19 surveys from both the Spanish and English groups. The majority of the participants were from the Spanish discussion group, since that group was the larger of the two as well as more willing to participate in the survey.

### **Instrument**

The questionnaire was divided into four different sections: demographic information, psychological symptoms, physical symptoms, and an open ended question section. In total, there were 22 questions in the questionnaire; six questions were on background information, six questions related to psychological symptoms, six questions related to physical symptoms, and four open ended questions related to services being received. Both the psychological and physical symptom portions used an index that asked the respondent to choose from strongly agree, agree, disagree, strongly disagree, and don't know.

The first section consisted of basic background information such as age, educational attainment, sex, ethnicity, which group the respondent attended, and whether they had attended over five times. This basic information was asked in order to classify women into different categories and also analyze the results based on these different groupings.

The second section was the psychological symptoms portion. Respondents were asked a series of questions regarding the alleviation of symptoms through the discussion groups. They were asked if they experienced less anxiety, tension, whether they felt safe at the program, about their mood, and whether they could relate to other women in the group. These questions were asked to establish whether these women experience any psychological benefits in attending the groups and whether the symptoms were alleviated after attending the discussion group.

The third section looked at physical symptoms. Respondents were asked whether they experienced fewer headaches, body aches, soreness, reduced muscle tension, whether the group offered activities that helped relieve headaches, and whether attending the group improved overall health. These questions were asked in order to get a sense of the health benefits and whether the discussion group helped relieve the common physical symptoms of battered women.

The last section consisted of four open-ended questions inquiring about the satisfaction of the services provided at Next Door Solutions. Participants were asked to provide feedback on the benefits they felt they gained from attending the group, what aspects of the program they would change if any and why or why not, their favorite program offered, and any other services they would like to see implemented. These questions were the qualitative portion of my study and were asked in hopes of providing insight on the level of satisfaction of the program and whether there are other services they could benefit from receiving at Next Door Solutions.

## Results

General Information Table (*Table 1*)

	Mean Score
Age	36.4
Physical benefit index	3.50
Psychological benefit index	3.67

Physical Benefit Table (*Table 2*)

	Mean score
Non-Latino	3.62
Latino	3.45

Age: 18-35	3.58
Age: 36-52	3.38
Education: Less than high school	3.54
Education: High school graduate	3.22
Education: more than high school	3.66

Psychological benefit Table (*Table 3*)

	Mean score
Non-Latino	3.71
Latino	3.62
Age: 18-35	3.78
Age: 36-52	3.47
Education: less than high school	3.72
Education: High school graduate	3.44
Education: more than high school	3.70

The results listed in the table are organized into three categories, general information, the mean for the physical benefits, and the means for the psychological benefits. Within these categories, the factors examined were ethnicity (non-Latino vs. Latino), age, and educational attainment. Ethnicity was divided into non-Latino vs. Latino because the majority of the respondents were Latino, and the rest were simply grouped together. The tables are separated by the different factors looked at and the average response of the respondents in that particular category. In the physical and psychological section, the scale ranged from 1 = strongly disagree to 4 = strongly



agree. Data from the tables indicate the overall average for each group within each category of the survey. The results indicate a generally high sense of satisfaction, but within the categories there are some minor differences in terms of who reports receiving more benefits from the program.

In Table 1, the general information table, respondents' mean age ranged from 18–35. In the physical benefit section, the respondents reported a high sense of physical benefits, with a mean of 3.50. Furthermore, participants felt an even higher satisfaction with psychological benefits received at the program, with the average response 3.66.

In Table 2, the responses of the physical benefit section are examined. One finding is that between non-Latino and Latinos, Latinos reported less satisfaction with the program than their non-Latino counterparts. Those between the ages 18–35 reported a higher satisfaction than those who were in the age range of 36–52. Between the different levels of educational attainment, we find that the most satisfied clients were those who had an education beyond high school. These respondents reported an average of 3.66, indicating that they were highly satisfied with the program. Furthermore, those with less than a high school education were nearly as satisfied with the program, reporting an average of 3.54. The least satisfied amongst this category were those who were high school graduates, reporting their satisfaction level at 3.22.

Table 3, the final category of responses, examines the psychological benefits experienced. Latinos reported a lower sense of satisfaction with the psychological benefits that the program offered. On average, Latinos reported a response of 3.62 and non-Latinos reported an average response of 3.71. The age group 18–35 reported a higher satisfaction with the psychological benefits they received at the program. There is a similar pattern with the responses in this section as with the average of responses to the physical benefits. Within the educational attainment category, the results show that the respondents with more than a high school education report receiving more psychological benefits from the program, with their average response being 3.72. Those with less than a high school diploma reported a similar response, with their average response being a 3.70. These two groups are almost the same in the level of satisfaction with the psychological benefits they receive with the program. The last group, high school graduates, reported the lowest in the benefits received at the program, with their average response being 3.44.

## Discussion

Through this study I found that the women attending the discussion groups did benefit from the program substantially through the alleviation of some of their symptoms. In the survey, I found that the level of agreement with the statements revealed that the clients were satisfied and were in fact experiencing alleviation of both physical and psychological symptoms. Despite some slight variations in the responses, both Latino and non-Latino participants experienced similarly high levels of satisfaction with the program, and in addition, they reported having some relief from their symptoms as a result of attending the group. When referring to high levels of satisfaction this is referring to the average of respondents reporting that they agreed or strongly agreed with receiving benefits from the program. The difference across particular categories compared was slight, and overall there was a high level of satisfaction amongst the participants who were surveyed. This slight difference is not deemed statistically significant to be considered a notable difference amongst categories. Moreover, in the qualitative section there were some insightful

Rizzo: A Look at the Effectiveness of Outreach Programs for Victims of D comments that shed light on the specific aspects of the program that clients liked, what could be added, and what programs at Next Door Solutions were most helpful to them. The first common theme found in this section was the benefit of being able to share, listen, and relate to other women in the group; in fact, participants noted this as the most beneficial part of attending the discussion group. The opportunity to share provided the women with a chance to share their stories, hear other stories, and relate to other women. They reported that this was a way that they could relieve their anger as well as share their stories, which would either help other women or make them feel as if they were not the only ones alone in an abusive relationship. Such feelings are summed up in this woman's response: "I feel that I benefit because I can learn from other women who have been through the same violence that I have lived and the girls gives us advice and make us feel better about ourselves."

The majority of responses mentioned feeling higher self-esteem as a result of the group discussions. Being able to learn from others and share allowed these women to feel better about themselves and boosted their self-esteem. Amongst such responses, women also reported feeling less stressed, being able to give and receive advice, and receiving emotional support. One participant stated: "I don't feel alone. Being able to talk to someone, to listen, makes me less stressed and relieved."

The last question on the survey was open-ended to allow women to say in their own words what they would want to change or see implemented. The majority of participants expressed that they wanted to receive individual counseling. While many women expressed satisfaction with the discussion group, many of them felt they would like to receive individual counseling for themselves and their children. Along with this, childcare and child counseling was also noted as an important factor that these participants felt would be beneficial to see more of in the program. The program does offer limited childcare, but the participants reported they would like to see services available to their children. Lastly, I also found that these women reported that the current childcare, the 24-hour crisis line, and the legal help were the most appreciated programs offered at Next Door Solutions. I feel that through the array of programs being offered, the victims can benefit from choosing which service is suitable for them. The current programs are showing efficiency, but independent counseling can be even more beneficial to these women. In addition, these women are also concerned about their children; therefore, more programs should have childcare and programs to address the children who have also been victims of the abuse.

I acknowledge that there were some limitations to my study that affect the analysis of the results. Moreover, it would have been ideal to include the quilt group in order to compare which method of outreach program yields better results as it relates to the symptoms experienced. Looking at one support group only sheds light on one aspect of the outreach programs offered at the organization; examining more forms of therapy will create an overall picture of what structure can best help these women. Another limitation was that the facilitator was present for the Spanish group, which could have placed pressure on the participants to answer in a certain manner. Moreover, a more private setting for the participants could have been beneficial to avoid influencing the responses in any manner. Because I had a particularly small population, my findings cannot be utilized to make any generalizable comments on the overall issues. They can only offer insight on programs that have shown a degree of success and indicate that such programs can be an approach taken by other resource centers. Lastly, in the future, I would like to examine more confounding factors that

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could have contributed to these women's overall health improvement such as their own living situations or other programs they were involved in.

Not much research has been done on evaluating the efficacy of outreach programs; however, analyzing these programs can help promote activities and counseling that will serve as a way to cope with such harsh conditions as well as providing the support to overcome such traumatic events in their lives. Further studies can look into what works best to address the constant need of support and alleviation of the array of symptoms experienced in addition to ways to help the families of these women and children. Not only this, but due to the hardships it can cause the family, examining the effects and trauma it causes the children involved in abusive relationships can also better help address the damaging effects of intimate-partner violence on its victims.

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