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Recovery from partner abuse: the application of the strengths perspective

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This study applied, and examined the effectiveness of, the strengths perspective on women who experienced partner abuse in Taiwan. Both quantitative and qualitative approaches were utilised. The findings from quantitative analysis show that the subjects experienced a significant decrease in depression, were positively empowered and had better life satisfaction. The results of the qualitative analysis further denote the functional components of recovery as the growth of sense of self, affirmation and action, or realisation of self. These results suggest that the strengths perspective could be a useful approach for case managers working with this population in helping the women to rediscover their own sense of self and reconstruct a productive life.

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Key words: partner abuse, recovery, strengths perspective, domestic violence, sense of self, Taiwan

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Introduction

Partner abuse is a devastating experience for the victims, one that not only poses unpredictable threats to their safety, but in the long run could also result in negative psychological effects such as self-blame, low self-esteem, depression and anxiety, post traumatic stress disorder and a fear of intimate relationships (Lundy & Grossman, 2001; Wiehe, 1998). Moreover, it could induce affective disorder and substance abuse. Thus, much attention has been given to providing services and protection for victims of partner abuse since the enactment of the Domestic Violence Acts (1975 in the USA and 1998 in Taiwan). The purpose behind the Acts was to ensure the safety of the victims and to help them reconstruct their lives. The protective services generally focus on ensuring personal safety and providing immediate assistance in legal, financial, occupational and psychological aspects. The outcome indicators for measuring the effectiveness of protective services among previous studies have included frequency of violence, whether the victim returned to the abuser, perceived level of internal control, depression and self-esteem and attitudes toward marriage and family. The literature suggests that both social services and counselling have contributed to the decrease in rates of depression and the increase in the victims self-esteem, personal mastery and the social support they receive (Greene & Bogo, 2002; Lundy & Grossman, 2001; Mears, 2003; Wiehe, 1998).

In the West, two major perspectives have been applied in the intervention for victims. One is the feminist approach and the other is the system perspective. The former views partner abuse as a structural problem influenced by a patriarchal culture and as a form of male dominance over women; therefore, the focus of the intervention is to protect the victims and require abusers to attend treatment for altering their cognition about intimate relationships. The latter perspective maintains that partner abuse is the result of marital or family conflict and that the solution is to have both partners receive conjoined treatment (Greene & Bogo, 2002; Lawson, 2003; Lundy & Grossman, 2001). Each perspective seems to explain part of the cause of the problem, but effectiveness of these two different interventions is inconclusive.

In recent decades the tendency has been toward an integrated model of intervention, such as those proposed by Dutton (1992) and Walker (1994) who used cognitive-behavioural treatment and intrapersonal theory within a feminist framework, the ecological framework developed by Heise (1998) and the multi-factors approach proposed by Foa, Cascardi, Zoeliner and Feeny (2000, cited in Lundy & Grossman, 2001).

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The multi-factors approach is especially comprehensive, including psychological factors (nature of abuse, psychological difficulties and resilience) and environmental factors (contact with the partner, tangible resources, interpersonal resources, legal resources and institutional resources). The distinguishing point of this approach is to treat women as effective and resilient change agents (Lundy & Grossman, 2001).

Such an integrated and positive approach to empowering the victims is noteworthy and concurs with the strengths perspective. The strengths perspective was developed in the 1980s as an approach to providing services to persons with mental illness, and has been applied in many other fields of social service programmes such as long-term care for the elderly, treatment for emotionally disturbed youth and their families, employment assistance programmes, rehabilitation of substance abusers and prisons, protective services for adults (Saleeby, 1997). In applying this perspective to persons with mental illness, eight studies showed positive outcomes on number of hospitalisations, quality of life, or social functioning and social supports. Research results have generally been positive across studies (Marty, Rapp & Carlson, 2001).

In the field of protective service, Andersen (1997) and Leung, Cheung and Stevenson (1994) found that the strengths perspective could enhance children's self-esteem and promote their recovery. Bell (2003) suggested that this perspective could prevent secondary trauma among victims of family violence. Lee, Uken and Sebold (2004) and Wormer and Bednar (2002) also showed that the strengths perspective had positive effects on domestic violence offenders in terms of self-esteem, interaction skills and recidivism of partner abuse. These results suggest that the strengths perspective could be an effective treatment approach yet no study in either Taiwan or the West has tested its applicability and effects on the victims of partner abuse.

Given the fact that the development of interventions for the victims of partner abuse in Taiwan is still in the infancy stage, the purpose of this study is to apply the strengths perspective to the victims of partner abuse and to explore the changes on the outcome measures after intervention. Hopefully, the positive results obtained in this study could be used to advocate for further applications of the strengths perspective in other fields of social work practice.

Method

Sponsored by the National Committee on Domestic Violence and Sexual Assault in Taiwan, a two-year case management programme of protective service based on the strengths perspective for the victims of partner abuse was designed and implemented. To observe and capture the profound and multi-dimensional changes in the women who experienced partner abuse, both quantitative and qualitative approaches were adopted. First, through quasi-experimental design, the changes in the women after intervention were examined. Classical experimental design was not utilised because randomisation was not feasible and because of the inherent difficulties of controlling for group equivalence on the characteristics of both case managers and subjects. Quantitative data were collected at three points of time: the beginning of intervention, three months after intervention and nine months after the intervention or when intervention was about to be terminated. Second, the qualitative texts from in-depth interviews focused on the nature of change in self-experience by the victims and how the changes related to the components of the strengths model. The qualitative data served therefore as complements to the theme of self-recovery, upon which, hopefully, the complete profile of change in self could be derived and constructed.

The intervention upon the strengths perspective

Recovery as the outcome and process of the strengths perspective intervention

Recovery is treated as the final outcome in the Basic Training Manual of the strengths perspective. Recovery is defined as a journey of self-discovery (Mitchell, 2001), a unique personal process of changing one's attitudes, values, feelings and goals, and involves finding new meaning in life with or without the limitation caused by mental illness (Anthony et al., 2002). Thus, recovery as personal growth of inner self and adjustment to the outside world was proposed to be the aim of the strengths perspective for the victims of partner abuse. Also, in accordance with the literature, the quantitative outcome measures adopted in this study were depression, coping strategies, empowerment and life satisfaction, while the qualitative part would further explore the conceptual dimensions and components of recovery.

The principles and working procedure

Based on the writings of Saleeby (1997) and Rapp (1998), the fundamental belief and assumption of the strengths perspective is that people who can survive must possess some strengths and resources, and also have the potential to learn, grow and change. Thus, this perspective maintains that even for those people who are facing some adversities and limitations, their best strategy for initiating change is to explore and exploit their inherent strengths and aspirations. This is effective simply because people's actions are motivated by self-interest and what is meaningful to them. People tend to be successful by using what they are good at.

Furthermore, this perspective does not ignore all the existing problems around people. It believes in equal-finality (a major viewpoint in system theory) for the purpose of recovering of life. Let the client's aspirations lead the way, because even though the client's goal might not be directed toward solving the problems, the improvement in any aspect of life would create ripple effects on the other parts, indeed on the person's whole life. Often, the case manager has to help the client to either live with the problems or transcend them. For example, a client may need to learn to live with the symptoms of mental illness and then use his or her remaining function to find new meaning and enjoyment in life.

This perspective assumes that the client is an expert of his/her own life situations; he/she is thus the director of the working relationship. The primary role of the helping professional is to instil hope, facilitate change and provide information and support. In addition, the emphasis is on rebuilding the client's informal support system, since such a support network is more accessible and lasts longer with greater varieties and possibilities. Thus, the potential community resources that the client might have should be fully investigated and utilised.

Another related principle is that the case manager should reach out to the clients' habitat and be able to participate in their life world. In this way, the case manager can work with clients in such locations where they feel most comfortable; this could also help create a better understanding of the clients' strengths and resources in various life contexts.

Implementation of the programme

The intervention followed such programme protocols as training, implementation, supervision and evaluation. At the beginning, the investigators gave case managers a two-day basic training course on the strengths perspective. Regular internal group supervision was held within each agency approximately twice a month during the period of implementation. In addition, the investigators also provided regular external supervision for each agency to help case managers transform the principles of the strengths perspective into daily practice. For the first three months, the external supervision was held twice a month, afterwards once a month. Advance training sections were provided in accordance with the needs of case managers for promoting their operation on the strengths model. In addition, group activities were held with case managers to facilitate their mutual learning and sharing of positive work experiences.

To observe the process and ensure the fidelity of programme implementation, for the first year a check form was designed to log the contacts made between case managers and clients, including the purpose of the contact, the location of the meeting, the principles utilised and the level of accomplishment of the service goals. Various implementation issues were discussed during supervision. There was no required intensity of services in the programme since that depends on each client's situation and needs, and on each case manager's caseload. However, to establish a trusting relationship, intensive contacts and services were expected, especially in the beginning stage of the intervention.

Table 1. Output of services during the first 13 months.

Descriptions	*n*	Mean	SD	Range
Total no. of services	68	16.07	12.32	3–55
Duration of services for terminated cases				
For the subjects in the community	8	8.88	3.31	5–13
For the subjects in the shelter	16	3.31	1.78	2–9
Total no. of services for the terminated cases				
For the subjects in the community	8	15.13	11.46	8–42
For the subjects in the shelter	16	10.69	4.78	3–19

During the first 13 months, data were logged on 68 subjects. The average total number of services was 16.07 (see Table 1). For the 24 subjects whose cases were terminated, the duration of services was 8.88 months for those who were living in the community and 3.31 months for those living in the shelter. As for the total number of services, the subjects who were living in the community received an average of 15.13 times of services, while the average number of services for the subjects in the shelter was 10.69. The data (n = 68) showed that the case manager did visit the clients and key members in their network (m = 1.20 times per month), although more services were provided by telephone (m = 1.47 times) and by meeting in the agency (m = 1.53 times). The major areas in which case managers worked with clients were daily living issues such as self-protection, finance, legal affairs, job search, social support, health and recreation. In addition, case managers also worked on empowering the clients and tackled family issues, for example family relationships and communications, and child-raising.

The sources of the clients' network included relatives, friends, children's school teachers, local police, leaders of community organisations and religious groups. A few case managers worked with the key members in the clients' informal support system by deliberately engaging them as the change agents. However, since some clients either did not want to reveal their status as a victim of violence or had exhausted almost every possible supporter in their network, they might have little interest in further exploring or using their natural support system.

Participants and procedures

The women who experienced partner abuse were referred to the service agencies mainly by the police,

via hot line and hospitals. The strengths model was applied to seventy-two women in the service system who were invited to participate in this study based on two criteria: willingness to work with a case manager and having at least one source of personal social support. Since the strengths model was relatively new and quite demanding to most case managers, the above criteria were chosen to ensure positive experiences for case managers and to help them remain interested in employing this model.

Thirty-two case managers and five supervisors from eight agencies in four cities and counties were invited and agreed to apply this model. They all held either a bachelor or a master's degree in social work, and most of them had been working in the field of domestic violence, with an average experience base of three years. Over the two-year period, a total of 72 subjects received the service based on the strengths model. Of these, 65 joined the first assessment, 26 completed the second assessment and 6 finished the third assessment. Nineteen of the initial 65 subjects received shelter services while the remaining 46 had services in the community. Very few completed the third assessment, which was due in part to the fact that subjects in shelters are entitled to a maximum of three months of short-term service, so the persons staying in a shelter were able to complete only two assessments. By the end of the second year of the programme evaluation, 35 cases of the 72 subjects were closed with positive results.

The assessments were introduced to and completed by each subject upon their informed consent and with the assistance of their case managers. The data were collected either by in-person interview by case managers or self-report by the subjects, depending on their own choice. In terms of the qualitative part, case managers further conducted an in-depth interview with the subjects based on a semi-structured interview guide and then complete a subjective evaluation on changes in the subjects after case termination. The interviews were tape-recorded with the permission of the subjects. Although data collection conducted by case managers might induce an element of social desirability and compromise the credibility of the results, this method was chosen to maintain client confidentiality and for the comfort of the clients; a second consideration was the authors' intention to build upon the evaluation as part of the regular service model.

Data collection

Quantitative data

Depression. The Center for Epidemiologic Depressive Mood Scale (CES-D; Radloff, 1977) was utilised to measure the negative psychological status of the subjects. The subjects were asked to indicate on a 4-point scale (0 to 3) the level of their experience on each item during the past week. CES-D has very good internal consistency (0.90) (Corcoran & Fischer, 1994). For the present study, the alpha level (0.92) was also satisfactory. The higher the score, the higher the level of depression indicated. The cut-off score is 16, with 16 and above indicating the possibility of clinical depression.

Coping method. This variable was measured by an 18-item scale developed by Bell (1977). This scale taps two types of coping methods: (i) emotional (11 items) and (ii) problem coping (7 items). Each item was rated on three response categories: never (0), once in a while (1) and often (2). The scale has been used previously in Taiwan (Chen & Song, 2000) and the Cronbach's alpha was satisfactory (0.93).

Empowerment. The scale developed by Rogers, Chamberlin, Ellison and Crean (1997) was used to tap the variance of this outcome measure. It is a 28-item scale with five conceptual dimensions: (i) self-esteem and self-efficacy, (ii) power or powerlessness, (iii) optimism and control over the future, (iv) community activism and autonomy and (v) righteous anger. The scale items have acceptable internal consistency (0.86) and also good discriminatory validity. The differences in scale scores between mentally ill persons (n = 56) and college students (n = 200) were significant. A higher score indicates better empowerment for this scale.

Life satisfaction. The authors developed a scale of seven items to capture the level of satisfaction of various life aspects of the subjects: (i) living status, (ii) work, (iii) finance, (iv) interpersonal relations, (v) children's status, (vi) self-competence and (vii) external environment. Items were phrased in ways such as: 'I am satisfied with my living status'. The subjects rated each item among four categories: strongly disagree (1), disagree (2), agree (3) and strongly agree (4).

In data analysis, the summative score for depression was created to compare with the cut-off score. Comparatively, the mean score was calculated for coping method, empowerment and life satisfaction to reveal its extent by comparing the score with the range of the response categories.

Qualitative data

An interview guide was outlined for case managers to explore the subject's perception and feelings on their current life situation, desires and plans for the future, changes after receiving service, attribution of the changes, reflection on the process and continuity of such changes, the process of changes, comments on how the services contributed to the changes, and how the strengths assessment and personal work plan related

Table 2. Descriptive data of outcome measures.

Measures	Time 1 ($n = 65$)			Time 2 ($n = 26$)			Time 3 ($n = 6$)		
	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range
Depression	25.30	14.22	0–57	15.69	11.64	1–40	14.83	9.20	3–28
Coping									
Emotional	0.77	0.28	0–1.45	0.81	0.31	0.18–1.45	0.79	0.20	0.45–1.00
Behavioural	1.10	0.43	0–2.43	1.24	0.37	0.14–1.86	1.38	0.35	1.00–2.00
Empowerment	2.67	0.27	2.04–3.18	2.83	0.31	2.32–3.57	3.02	0.61	2.50–4.19
Life satisfaction	2.53	0.48	1.29–3.57	2.69	0.47	1.71–3.71	2.93	0.59	2.29–4.00

to the changes. In addition, case managers were asked to write an evaluative summary of their clients along these dimensions after the clients' cases were terminated.

Data analysis

Paired-*t* tests were conducted to examine if the changes between the first and second assessments reached significance. Since only six subjects completed the third assessment, Mann–Whitney U test was used to examine the differences between the first and third as well as the second and third assessments. Given the small sample size, the analysis is for preliminary examination only, and for the purpose of suggestion rather than conclusion.

The script of each interview was transcribed into a dialogic text. The procedure of data analysis began with open coding and conceptual labelling. The initial open coding was held by research assistants and then further revised by the authors to ensure inter-rater reliability. The open coding was then compared across subjects for extracting similar and different properties and themes.

Results

Sample characteristics

The 65 subjects participating in this study were victims of partner violence; 78.5 per cent of them were abused by their current spouse, 15.4 per cent by their former spouse, 3.1 per cent by their cohabiting partner and 3.1 per cent by others. Their mean age was 38.91 (median = 38.50; SD = 8.53), with a range of 22–59 years. The majority were educated to either senior high (42.2 per cent) or junior high school (31.3 per cent) level. Eight (12.5 per cent) held a college or masters degree. Most of them had either two (37.1 per cent) or four children (22.6 per cent). Just over a third (34.9 per cent) lived in their own house, 20.6 per cent lived in a rented place, 30.2 per cent stayed in a shelter and 14.3 per cent in other facilities. Twenty per cent worked full-time, 29.2 per cent did not work, 10.8 per cent held a part-time job, 9.2 per cent worked irregularly and 6.2 per cent were housewives. Just over a third (36.7 per cent) had no income, 25 per cent had a monthly income of less than US$468 and 28.3 per cent had monthly income between US$469 and US$937. In terms of sample characteristics, the 26 subjects who completed the second assessment were not significantly different from those who did not ($n = 39$). Among these 26 subjects, seven (26.9 per cent) were living in a shelter at the first assessment while the rest lived in the community.

Changes over time

Quantitative outcomes. Generally, the subjects had positive changes over time. More changes occurred between the first and second assessments, and less between the second and third assessments (see Table 2). The data showed that the depression level decreased, while behavioural coping, level of empowerment and life satisfaction increased. The group means on emotional coping revealed tiny changes over time.

The paired-*t* test further revealed the aggregate results of individual changes between the first and second assessments (see Table 3). Significant changes occurred in level of depression, empowerment and life satisfaction ($P < 0.05$). The group mean (25.47) of the first assessment was far more than the cut-off score (16) of clinical depression, whereas the group mean (15.69) of the second assessment was less than the cut-off score. The subjects not only experienced a decrease in depression, but also had significant elevation of empowerment and higher satisfaction with their life. On the other hand, the changes in two coping methods were not significant ($P > 0.05$).

The results of the Mann–Whitney U tests also revealed that most subjects changed in the direction that the investigators expected, although none of the changes were of statistical significance ($P > 0.05$) (see Table 4 and Table 5). For example, four subjects' depression scores decreased, one increased and one did not change between the first and third assessments. Nevertheless, it is possible that the insignificance could be due to too few cases. The comparisons showed that, for the six cases that reached the third assessment, there were more positive changes between the first and second assessments, but fewer between the second and third assessments (see Table 5). In sum, the results suggest

Table 3. Changes on outcome measures between time 1 and time 2 ($n = 26$).

Measures		Mean	SD	*t* value	*P*
Depression	T1	25.57	11.53	3.79	0.001
	T2	15.69	11.64		
Emotional coping	T1	0.87	0.28	1.22	0.23
	T2	0.80	0.31		
Behavioural coping	T1	1.19	0.47	–0.57	0.58
	T2	1.24	0.37		
Empowerment	T1	2.69	0.27	–2.96	0.007
	T2	2.83	0.31		
Life satisfaction	T1	2.49	0.54	–2.54	0.018
	T2	2.71	0.47		

Table 4. Changes on outcome measures between time 1 and time 3 ($n = 6$).

Measures	T3 > T1	T3 < T1	T3 = T1	Z	*P*
Depression	1	4	1	–1.753	0.080
Emotional coping	2	4	0	–0.638	0.524
Behavioural coping	3	1	2	–1.134	0.257
Empowerment	3	3	0	–0.420	0.674
Life satisfaction	4	1	1	–0.948	0.343

Table 5. Changes on outcome measures between time 2 and time 3 ($n = 6$).

Measures	T3 > T2	T3 < T2	T3 = T2	Z	*P*
Depression	3	3	0	–0.425	0.671
Emotional coping	2	3	1	–0.135	0.892
Behavioural coping	3	2	1	0.000	1.000
Empowerment	3	3	0	–0.105	0.917
Life satisfaction	3	3	0	–0.106	0.915

that significant positive changes occurred between the first and second assessments; the long-term effects were also promising, but not yet definite.

Qualitative analysis. Both the subjects' personal accounts and the case managers' evaluation summaries revealed bountiful internal growth and external adjustment as positive changes brought about by intervention. Most subjects recovered from their adverse situation and survived to reconstruct a new life based on their aspirations. These outcomes had been abstracted into three layers of the recovery of self, from the core of awareness of the existence of self (*sense of self*) to the external layer of the affirmation of capacity and potential of self (*affirmation of self*), and further to the outside layer of the demonstration of the strengths of self to enjoy a better life world (*action* or *realisation of self*). These three layers in the recovery of self pertain to the intrapersonal, interpersonal and transpersonal levels, respectively. Under each layer, there were few sub-constructs extracted from the subjects' life experience. They are presented as follows.

Sense of self

Most of the subjects had sacrificed their personal identity to the family or to a relationship, and they easily lost their sense of self once they became victims of violence. Under the traditional Chinese patriarchal cultural expectation, since they could neither denounce the family nor hate their loved ones, they could only either blame themselves or deny the reality of the violence. Inevitably, they became powerless and depressed. In addition, they lost self-esteem and were trapped in hopelessness and helplessness. In the subjects' journey toward recovery, the turning point for critical thinking in order to escape the trap of hopelessness was their becoming aware of the value or importance of their own existence; they could then begin to see themselves as having a newly born life. Simultaneously, they were able to stop self-blaming and were able to accept themselves.

(i) Value one's own existence. Clients were used to avoidance coping strategies, such as drinking and contemplating suicide when encountering adversities in life. But now they learned to value their own existence; once that realisation was in place they could begin to change the way they lived their lives. As subject 3 said,

> *I used to think that since there was no way out of the problem, I just drank and went to the top of the mountains or the sea shore, and tried to jump and kill myself. Now I don't think that way, I can see the importance of my life, and I know my children need me.*

(ii) No more self-blame. Low self-esteem and self-blame go hand in hand, and often the victims saw the violence as being their own fault. As one case manager commented on subject 11; '. . . *as I constantly reminded and reflected the strengths of the client, they began to stop self-blaming and negative self-appraisal*.' In addition, the clients were no longer easily or negatively influenced by others.

(iii) Self-acceptance. Case managers frequently demonstrated genuine acceptance of the clients and positive recognition of their strengths. On the basis of such helping relationships, the clients gradually accepted who they were and became more assertive about themselves. They were also able to confront the negative criticism from their ex-husband or other people in their life world. As subject 10 reflected,

> *I had been a person of suppressed type and always worried about how others would think of me. But my case manager very often recognised my strengths. Then I told myself that I had to accept the suffering and recognise my own potential.*

Affirmation of self

Once the subjects had a sense of self, they began to enjoy their internal growth and development of self. They were now able to express themselves and care for themselves in ways that helped them recognise their capacity and potential. On the basis of that realisation, they could further learn to let go or live with the problem and to enhance their coping ability under stress. After being more assertive and confident in themselves, and having better knowledge and skills in problem solving or asking for help, most of the subjects were apparently able to decrease the frequency of violence that happened to them.

(i) Being able to express oneself. As the case manager of subject 3 remarked, the client was not used to expressing her own opinions, even for the seemingly simple task of choosing the time and place to meet with the case manager. However, through the empowerment by the case manager, one month later the client was able to actively discuss the proper date for their meeting.

(ii) Starting to care for the self. Upon the strengths perspective, the clients were empowered to seriously think about their wants in every life aspect, including daily living, financial insurance, occupation, recreation etc. Case managers demonstrated unconditional acceptance and positive regard for the clients, by which the clients gradually learned to care for themselves in the endeavour to fulfil their goals. For example, subject 5 was a caregiver for her father-in-law and was burdened by his over-demanding personal care. Through the intervention, she began to let go of the constraints of her family role and tried to participate in the recreational and philanthropic activities of the company she worked for. After all, for her, life was not just about making it through the day.

(iii) Recognising self-capacity and potentials. Through helping relationships and strengths assessment, case managers facilitated the clients' ability to recognise their capacities and to explore potentials that they had long forgotten. As fulfilling their aspirations became their goal in life, the clients committed themselves to actions that gradually helped them to regain self-assertiveness. As the case manager remarked about subject 4,

> *At the beginning, the client did not see her computer skills or past work experiences as her strengths and capacity. Later on the client realised that she could use these skills and experiences in accomplishing her personal plan. She finally recognised her own potential.*

(iv) Learning to let go or live with the problem: The clients gained a true and profound understanding that recovery does not mean there would be no more struggling in life or the problem of partner abuse would be resolved entirely. They understood that it simply meant that one can adopt a positive and proactive attitude toward the problem or just let go of it, or even transcend over its limits and find a way to live with it. As subject 10 remarked,

> *I understand that my life can go on even though I am still facing these problems. . . . Though I am still not confident in establishing new interpersonal relationships, at least I try to make contacts with old friends. The major difference is that now I don't hate myself anymore.*

(v) Enhancing stress-coping ability. The clients were able to adopt more effective coping strategies to deal with their problems, such as searching for comfort from prayer, consulting with family members and friends or asking someone else for help. As subject 1 remarked,

> *Whenever I feel stressed, I adopt a relatively proactive attitude now. I consult with my family and friends. I try to calm myself down and think about the solutions. In the past, I could only get panicked and did not know what to do. I know that my problem-solving skills have been improved.*

(vi) Decreasing frequency of violence. The assurance of personal safety for each client is the basic requirement of the intervention; however, this does not necessarily mean that the clients would have to leave their relationships. Some clients did make a choice of staying in the relationship with an abusive partner. Nevertheless, through the helping process they could still regain autonomy and acquire self-protection, with the result that the frequency of the violence decreased. For example, subject 3 was battered about once every 10 days before the intervention of the strengths model, after which it had been 4 months since her husband had resorted to violence.

Action and realisation of self

Having an affirmative recognition of the capacity and potential of themselves, the subjects determined their life goals, gained access to available resources and began to establish a recovered life domain and meaningful interpersonal relationships. Moreover, they took a brand new attitude of proactivity toward their life world, and further transcended their own personal suffering and became helpers for other abused women.

(i) Will to change and recover. Deegan (1988) mentioned that there are three cornerstones of recovery:

hope, willingness and responsible action. Thus, the key facilitator to recovery is the willingness and motivation to change. For example, subject 11 was not used to visiting the hospital before, but then she realised that the hospital could help her. Although often she still felt pain whenever she thought about the trauma of being abused, she knew that what she wanted most was to keep herself sober and happy.

(ii) Plan to fulfil one's life goals. Case managers helped the clients to reorganise their past experiences and their embedded strengths, to clarify their current life situations and to explore what they want for the future. Some clients appreciated that the assessment and planning process had contributed to greater awareness and recovery of self, and the exact tasks of the plan were helpful in setting concrete steps toward their life goals. For example, subject 10 commented,

> *The plan surely made my life more focused and instilled self-confidence, and helped me re-enter the job market. I did sincerely enact my personal plan.*

(iii) Access to resources. During the entire service process, case managers encouraged the clients to utilise community resources in accordance with their goals. The clients gradually developed an awareness and concern for their own needs. Some of them began to attend community activities, to engage in contact with neighbours and to explore their own personal interests. As subject 1 commented,

> *I know where I can find resources now. And I also know whom I can ask for help. In addition, I am willing to get help from neighbours.*

(iv) Establishment of a life domain and interpersonal relationships. The strengths perspective emphasises exploring the clients' natural resources and support for them to reconstruct a new life world. This seemed to be difficult in the beginning of the service since most victims had been deliberately isolated from outside contacts by their abusive partners. However, some clients realised this need and found ways to expand their life domain and interpersonal relationships. Especially, they started to reach out and make new friends. As subject 2 reflected,

> *Right now I am gradually establishing my autonomy by advancing my own knowledge and trying to improve my skills of interpersonal communication.*

(v) Proactivity toward life. Whether the clients could fight against or protect themselves from partner abuse and further reconstruct a new life surely depends on what kind of life perspectives they hold for themselves. The focus of the strengths perspective is to empower clients to transform their sense of self from that of a victim to a survivor and to a self-valued and recovered person. As subject 3 remarked: '*Nothing is impossible, as long as I make an effort*'. Subject 11 thought that she could do something to ease the pain of physical illness: '*. . . after I was discharged from the hospital, I exercised more and tried to find a job*.'

(vi) Transcendence of self and becoming a helper. Some clients expressed the will to live beyond their own suffering and trauma and became helpers for other victims. Through their recovered life experiences, these clients were able to show deep empathy for other women's adversity and became role models and sources of hope for them. As subject 9 said,

> *I won't waste my time and energy on fighting with him anymore. It's wise for me to take care of my health . . . I want to live my own life and help others as much as possible.*

Discussion

The effects of the strengths perspective

This is the first study to examine the effectiveness of the service based on the strengths perspective for the victims of partner abuse in Taiwan. The results revealed positive effects of strengths perspective intervention on both intrapersonal and interpersonal functional indicators such as depression, self-efficacy and social support for the subjects, which concurs with the results of previous studies on general protective services (Greene & Bogo, 2001; Lundy & Grossman, 2001; Mears, 2003; Wiehe, 1998). The subjects' personal accounts revealed in the qualitative part of the study further denote the functional components of recovery as sense of self, affirmation of self and action or realisation of self. The functional levels of recovery extracted from this study as intrapersonal, interpersonal and transpersonal also correspond to the three outcome levels of empowerment proposed by Parsons (1995) (cited in Gutiérrez, Parson & Cox, 1998), except that the transpersonal level of self in this study focused on a generally proactive attitude and a willingness to help other people in adversity, while the political/community level of empowerment appealed to the ultimate goal of advocacy for social reform.

The strengths perspective seems to be effective in enhancing clients' self-discovery and empowerment by carefully exploring, recognising and mobilising their strengths. In addition, based on the insights and wisdom derived from the helping process, some subjects could live with or let go of their problems and continue to pursue their life goals. Moreover, some could even transcend their own personal suffering and dedicate themselves to making a contribution as a helper for

other victims. The altruistic intention derived from self-adversity is regarded as a higher functional level of recovery. Thus, it seems that the strengths perspective has significantly contributed to both the process and outcome of self-recovery. In particular, the tools of the strengths assessment and personal plan could effectively enhance the subjects' self-efficacy and motivate their actions for better life satisfaction. Besides, case managers also indicated the effective components of the helping process as: intensive contacts, genuine concerns, establishing trust, instilling hope, helping clients see that there are alternatives and choices in life, emphasising positive experiences and bracketing those problems that could not be solved right away, which had made the strengths perspective especially acceptable and accountable to the clients in Taiwan.

The insignificance of changes in coping strategies could be either due to case managers not paying enough attention to this topic during intervention, or simply because it might take a longer time to reveal larger changes. However, some of the subjects did adopt effective problem-solving oriented coping strategies and were less trapped by helplessness and powerlessness after service. Moreover, the functional core of self had been generally strengthened, although the behavioural dimension of coping had not yet fully been learned or developed.

Under the cultural expectations and constraints, some women did choose to stay in the marital relationship for the best interest of themselves and their children. To follow the clients' wishes, case managers respected their decisions and helped them work through such issues as self-protection, effective communication and rewarding interaction in the relationship with no more or less violence along the journey of recovery. This intervention strategy challenged the personal values of some case managers. According to their viewpoint, the abused women should simply leave the relationship. Nevertheless, despite the fact that the case managers would personally advocate for the woman abandoning the relationship, they had learned to set aside their philosophical differences, feeling it was better to give these women the tools necessary to empower themselves in their current situation if they were not willing to remove themselves from the abuser. The results indicated that the programme helped the case managers apply a relatively new model in their practice. As David Kolb (cited in Thompson, 2000) pointed out, the full learning process includes concrete experience, reflective observation, abstract conceptualisation and active experimentation. Practitioners need continuous supervision and support after training to transform their knowledge and skills into daily practice. A particularly important standpoint of the strengths perspective is that case managers have to reach out and work with the clients' social network and deal with the clients' personal goals. Of course, creativity and flexibility of service definitely play a great part in the process of recovery for the clients. The supervision style that fosters brainstorming ideas and positive experiences is also essential to the success of this model. However, structural changes and support are needed to decrease the caseload and administrative responsibilities for the case manager to fully implement the strengths model. Before this happens, partial implementation on selective clients with multiple needs who are willing to work on reconstructing their lives would be a good approach toward developing effective practice both now and in the future.

The limitations and contributions of the study

Initially, this study started with a quasi-experimental design with three rounds of measurements. However, there were barriers for this type of practice research in Taiwan. Usually, high caseloads and other administrative commitments deterred case managers from cooperating in the data collection and applying the strengths model to other clients. As a result, very few subjects completed the third assessment. Furthermore, the pre- and post-design and potential social desirability induced by the fact that data collection was conducted by case managers might have lessened the internal validity of this study. Nevertheless, the qualitative interviews documented the subjects' voices, and their narratives explicitly revealed the positive changes that the strengths model had brought about for them. The findings are preliminary and inconclusive, and future studies are needed to expand the scope and length of service in order to collect data at different points of time and thereby test the internal validity of this model.

Moreover, this study did not use a control group; thus, the findings suggest only that the strengths perspective might be useful for victims of partner abuse, not that it is necessarily more effective than other approaches. Moreover, as proposed by Foa et al. (2000), this perspective could be used as part of an integrated model to enable case managers to help victims of partner abuse rediscover their own sense of self and reconstruct a productive life.

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