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From Survival to Growth: A Pilot Evaluation of an Online Empowerment-Based Group Intervention for Women Survivors of Intimate Partner Violence

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Abstract

Background: Intimate partner violence (IPV) constitutes a major public health and human rights issue worldwide, with well-documented psychological consequences including posttraumatic stress, depression, and impaired interpersonal functioning. Despite increasing awareness of IPV in Greece, empirically evaluated psychosocial interventions for women survivors—particularly accessible online group programs—remain limited. Empowerment-oriented, trauma-informed interventions have been suggested as promising approaches for supporting survivors' recovery, enhancing self-efficacy, and fostering posttraumatic growth.

Methods: The present pilot study evaluated the preliminary effectiveness of A New Beginning – Learning to Care for Myself, a structured online psychoeducational group intervention developed by W.I.N. Hellas for women survivors of IPV. The program was delivered through 15 weekly sessions and was grounded in cognitive-behavioral, systemic, and trauma-informed principles aimed at increasing awareness of abusive dynamics, reducing self-blame, strengthening emotional regulation, and promoting empowerment. Twenty-one women survivors of domestic violence (aged 19–58 years; M = 41.81, SD = 9.84) participated in the study. Participants completed measures assessing posttraumatic stress symptoms (PCL-C), help-seeking attitudes and minimization of abuse (MHSS), and posttraumatic growth (PTGI-SF) before and after the intervention. Given the small sample size and non-normal distributions, nonparametric analyses were conducted, including chi-square tests and Wilcoxon signed-rank tests.

Results: The proportion of participants meeting the clinical cutoff for probable PTSD decreased from 28.6% pre-intervention to 14.3% post-intervention, although this change was not statistically significant. No significant differences were observed in most help-seeking attitudes. In contrast, significant improvements were observed in key domains of posttraumatic growth. Participants reported a significant increase in perceived personal strength ($z = -2.71$, $p = .007$) and relational intimacy with others ($z = -2.31$, $p = .021$). Trends toward improvement were also observed in appreciation of life and perceived ability to face difficulties. These findings suggest that participation in the intervention was associated with meaningful gains in psychological empowerment and relational functioning.

Conclusions: Although reductions in PTSD symptoms and changes in help-seeking attitudes were limited, the intervention demonstrated promising effects in enhancing posttraumatic growth among women survivors of IPV. The observed increases in personal strength and relational intimacy highlight the potential value of empowerment-focused psychoeducational group programs delivered in online formats. Given the exploratory nature of the study and its methodological limitations—including small sample size and absence of a control group—future research should employ larger samples, controlled designs, and longitudinal follow-ups to further examine the effectiveness and sustainability of such interventions. Nevertheless, the findings provide preliminary evidence supporting the feasibility and potential psychological benefits of structured online empowerment interventions for IPV survivors in the Greek context.

Keywords

intimate partner violence; empowerment; psychoeducational intervention; posttraumatic growth; PTSD; online group intervention; women survivors.

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Introduction

Intimate partner violence (IPV) represents a major global public health and human rights concern, with profound consequences for individuals, families, and societies. The World Health Organization defines IPV as any behavior within an intimate relationship that results in physical, psychological, or sexual harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors such as social isolation or the restriction of access to financial, social, or health-related resources [1]. IPV is a complex and multifaceted phenomenon that cannot be adequately explained by a single theoretical framework. Ecological models emphasize the interaction of individual, relational, community, and societal factors and highlight the role of gender inequality, patriarchal norms, and the social normalization of violence in shaping both perpetration and victimization [2].

The consequences of IPV extend well beyond immediate physical injury and are associated with enduring psychological, somatic, and behavioral outcomes. Empirical evidence consistently links IPV exposure to chronic pain, physical health conditions, and increased risk of long-term illness, as well as elevated rates of depression, anxiety, and posttraumatic stress disorder [3-4]. Higher levels of substance use and maladaptive coping strategies have also been documented among women exposed to physical and sexual IPV [5-6]. Prolonged exposure to abuse may further contribute to the normalization of violence, habituation, and concealment, processes that impede recognition of harm and delay help-seeking [7].

Barriers to help-seeking following IPV have been widely documented and include limited awareness of available services, structural and access-related constraints, fear of negative consequences following disclosure, material dependence, self-blame, stigma, and institutional inadequacies [8]. These barriers underscore the need for interventions that extend beyond symptom reduction and address awareness, agency, and psychological empowerment. Psychoeducational and empowerment-oriented approaches have been identified as particularly relevant for supporting survivors' understanding of abusive dynamics, reducing internalized blame, and strengthening coping and decision-making capacities.

In Greece, recent national and European data indicate persistently high levels of IPV, particularly against women. Police and population-based survey data consistently identify psychological violence as the most frequently reported form of abuse, with intimate partner relationships accounting for the majority of incidents [9]. Reported cases of domestic violence have increased substantially in recent years, alongside rising demand for legal counseling and psychosocial support services. Greek empirical studies further point to gaps in coordinated prevention strategies, continuity of care, and the availability of structured psychosocial interventions, particularly during periods of social crisis such as the COVID-19 pandemic [10].

Qualitative research conducted in Greek counseling centers and shelter settings highlights the importance of empowerment, safety, and therapeutic relationships characterized by trust, validation, and emotional containment. Studies exploring survivors' experiences emphasize the role of supportive therapeutic environments in helping women recognize abusive dynamics, challenge internalized self-blame, and rebuild a sense of agency and personal control [11-12]. Complementary research focusing on professionals working in IPV services suggests that sustained engagement with survivors can also transform counselors' own understanding of violence. In a qualitative study of counselors working in Greek support services, Argyroudi and Flora [13] found that professional experience broadened counselors' conceptualizations of IPV—from a narrow focus on physical violence to a multidimensional understanding encompassing psychological abuse, coercive control, and power dynamics—while also emphasizing women's resilience and survival. Despite growing recognition of these needs, empirically evaluated, theory-driven psychosocial interventions for women survivors of IPV remain limited in the Greek context, particularly those delivered in accessible group-based or online formats.

To address this gap, W.I.N. Hellas developed A New Beginning – Learning to Care for Myself, a structured, trauma-informed, psychoeducational group intervention designed to support psychological empowerment among women with experiences of intimate partner and gender-based violence. Grounded in cognitive, systemic, and trauma-informed principles, the intervention conceptualizes abuse as a cumulative relational experience that affects self-concept, emotional regulation, and interpersonal functioning. Delivered online over 15 weekly group sessions, the program focuses on increasing awareness of abusive dynamics, reducing self-blame and shame, strengthening emotional regulation and boundary-setting skills, and supporting gradual movement toward autonomy and help-seeking. The present study examines the implementation and preliminary psychological outcomes of this intervention, contributing to the limited evidence base on empowerment-oriented IPV interventions in Greece.

The present study

Despite the increasing recognition of intimate partner violence (IPV) as a major public health concern in Greece, there remains a limited body of empirical research evaluating structured psychosocial interventions designed specifically for women survivors. While prior Greek studies have documented the prevalence, forensic characteristics, and therapeutic representations of IPV, systematic evaluations of trauma-informed, psychoeducational empowerment programs—particularly in online group formats—are scarce.

The present study seeks to address this gap by evaluating the preliminary effectiveness of the W.I.N. Hellas online intervention program "A New Beginning – Learning to Care for Myself." Grounded in cognitive-behavioral, systemic, and trauma-informed principles, the program aims to enhance empowerment, reduce self-blame, increase awareness of abusive dynamics, and strengthen adaptive coping capacities among women survivors of IPV.

Drawing on theoretical models of posttraumatic growth and recovery, we conceptualized healing not solely as symp-

tom reduction but also as the development of psychological strengths, relational capacity, and renewed life meaning following adversity. Accordingly, the study examined both distress-related and growth-related outcomes.

Specifically, the objectives of the study were:

To examine changes in posttraumatic stress symptomatology following participation in the intervention.

To assess potential shifts in help-seeking attitudes and minimization of abuse.

To investigate whether participation was associated with increases in posttraumatic growth, including domains such as personal strength, relational intimacy, appreciation of life, and perceived resilience.

Given the exploratory and pilot nature of the study and the relatively small sample size, we did not formulate strict directional hypotheses. However, it was expected that participants would demonstrate: a) reductions in PTSD symptom severity, b) increased readiness to seek support, and c) enhanced posttraumatic growth indicators following completion of the program.

By examining both vulnerability-related and strength-based outcomes, the present study aims to contribute to the growing literature on empowerment-oriented interventions for women survivors of IPV and to provide preliminary evidence regarding the feasibility and psychological impact of structured online group programs in the Greek context.

Method

Participants

A total of 21 women survivors of domestic violence participated in the intervention study. The participants' ages ranged from 19 to 58 years ($M = 41.81$, $SD = 9.84$, $N = 21$). With respect to marital status, 42.9% were married or in a civil partnership, 23.8% were in a relationship, 19.0% were not in a relationship, and 14.3% were widowed, divorced, or in another category. Regarding parental status, 11 participants (52.4%) reported having children, while 10 (47.6%) did not. Among those with children, 45.5% had one child, 36.4% had two children, and 18.2% reported having four children. The majority resided in urban areas (76.2%), while 23.8% lived in rural communities. More than half (57.1%) lived with their family of origin, 28.6% lived with a spouse or partner, and 14.3% lived alone. Educational attainment was high, with 52.4% holding a university or technical degree, 33.3% a postgraduate or doctoral degree, and 14.3% having completed secondary education (see Table 1).

Table 1. Sample Characteristics (N = 21)

	n	%
Marital status		
Married/civil partnership	9	42.9
In a relationship	5	23.8
Not in a relationship	4	19.0
Widowed/divorced/other	3	14.3
Children		
Has children	11	52.4
No children	10	47.6
Number of children (n = 11)		
One	5	45.5
Two	4	36.4
Four	2	18.2
Residence		
Urban	16	76.2
Rural	5	23.8
Living arrangement		
With family of origin	12	57.1
With spouse/partner	6	28.6
Alone	3	14.3
Educational attainment		
Secondary education	3	14.3
University/technical degree	11	52.4
Postgraduate/doctoral degree	7	33.3
Age	***M***	***SD***
	41.8	9.8

Note. Values are based on self-reported data from 21 women survivors of domestic violence who participated in the intervention study.

According to participants' responses, lifetime exposure to intimate partner violence reflected a wide range of experiences, including psychological, emotional, physical, and sexual abuse. Psychological and emotional forms of violence were pervasive and included being called offensive names, insulted, ridiculed, or demeaned. Many participants described situations in which their intelligence was questioned, their worth was belittled, or they were treated as inferior to their partners. Public humiliation was also commonly reported, highlighting the social dimension of abuse in addition to its private occurrence. Physical forms of violence emerged in various manifestations. Several women reported being slapped, shoved, pulled with force, or kicked, while others disclosed incidents of being struck with objects or even experiencing attempts at strangulation. These accounts indicate not only routine physical assaults but also episodes of severe and potentially life-threatening violence. Sexual victimization was also evident. Some women reported being coerced into sexual activity against their will or persuaded into acts they initially

did not consent to. These forms of coercion illustrate both direct sexual violence and more subtle manipulative dynamics that undermined their autonomy. In addition, a number of women described controlling behaviors that restricted their freedom, such as being told they could not meet with family or friends. These restrictions reinforced patterns of isolation and dependency that are characteristic of coercive control within abusive relationships.

Relational Conflict and Violence

Detailed descriptive data were collected on participants' experiences of conflict and violence within intimate relationships during the past year:

Explaining one's side or proposing a compromise: 19.0% reported this had never occurred, 4.8% reported it had occurred in the past but not the previous year, and 76.2% reported it occurred at least once in the past year. Specifically, 9.5% indicated twice, 33.3% three to five times, 14.3% six to ten times, and 19.0% more than 20 times.

Partner explained side or proposed compromise: 23.8% reported never, 9.5% in the past but not the previous year, and 66.7% in the past year. Rates included 9.5% once, 4.8% twice, 23.8% three to five times, 9.5% six to ten times, 4.8% eleven to twenty times, and 14.3% more than 20 times.

Insulted, swore, or yelled at partner: 23.8% never, 14.3% in the past but not the previous year, and 61.9% within the past year. Of these, 23.8% once, 19.0% twice, 14.3% three to five times, and 4.8% six to ten times.

Partner insulted, swore, or yelled: 23.8% never, 9.5% in the past but not the previous year, and 66.7% within the past year. Specifically, 14.3% once, 14.3% twice, 28.6% three to five times, 4.8% eleven to twenty times, and 4.8% more than 20 times.

Sustained minor physical injury (e.g., sprain, bruise, small cut, pain the next day): 90.5% reported never, and 9.5% reported this occurred in the past but not the previous year.

Partner sustained minor physical injury: 100% reported never.

Showed respect or care for partner's feelings during disagreement: 9.5% never, 4.8% in the past but not the previous year, and 85.7% in the past year. Among the latter, 4.8% once, 9.5% twice, 9.5% three to five times, 23.8% six to ten times, 14.3% eleven to twenty times, and 23.8% more than 20 times.

Partner showed respect or care for participant's feelings during disagreement: 19.0% never, 9.5% once, 14.3% twice, 19.0% three to five times, 19.0% six to ten times, and 19.0% more than 20 times.

Pushed, shoved, or slapped partner: 81.0% never, 14.3% in the past but not the previous year, and 4.8% once in the past year.

Partner pushed, shoved, or slapped participant: 85.7% never, 9.5% in the past but not the previous year, and 4.8% twice in the past year.

Hit partner with fist, kicked, or beat up: 100% never.

Partner hit participant with fist, kicked, or beat up: 90.5% never, 9.5% in the past but not the previous year.

Destroyed partner's belongings or threatened to hit partner: 100% never.

Partner destroyed belongings or threatened to hit participant: 81.0% never, 9.5% in the past but not the previous year, 4.8% once in the past year, and 4.8% six to ten times in the past year.

Required medical attention after a fight: 95.2% never, 4.8% in the past but not the previous year.

Partner required medical attention after a fight: 100% never.

Used violence to force partner into sex: 100% never.

Partner used violence to force participant into sex: 95.2% never, 4.8% in the past but not the previous year.

Insisted on sex when partner did not want (without physical force): 95.2% never, 4.8% in the past but not the previous year.

Partner insisted on sex when participant did not want (without physical force): 66.7% never, 28.6% in the past but not the previous year, and 4.8% three to five times in the past year.

Overall, the data suggest that while severe forms of physical and sexual violence were uncommon in the sample, verbal aggression, emotional disrespect, and non-physically coercive sexual pressure were more prevalent. Constructive conflict behaviors (e.g., compromise, showing respect) were also reported with regularity, highlighting the complexity of relational dynamics within this group of women survivors of domestic violence.

Measures

Revised Conflict Tactics Scale – Short Form (CTS2-S; 20 items). Intimate partner violence was assessed using the 20-item short form of the Revised Conflict Tactics Scale (CTS2-S) [14]. The CTS2 measures the frequency of negotiation, psychological aggression, physical assault, sexual coercion, and injury within intimate relationships. The short form reduces participant burden while maintaining good psychometric properties [15]. Respondents indicated how often each behavior occurred during the past year using a Likert-type scale ranging from 0 (never) to 6 (more than 20 times). The scale was adapted into Greek from the original English version by two bilingual researchers using standard back-translation procedures [16]. Frequencies of the answers were provided as indices of prevalence and incidence of intimate partner violence in the sample.

Minimization and Help-Seeking Scale (MHSS). The Minimization and Help-Seeking Scale (MHSS) [17] was used to evaluate participants' tendencies to downplay experiences of abuse (Minimization subscale) and their willingness to seek help (Help-Seeking subscale). Part A of the MHSS assesses which behaviors respondents consider abusive, while Part B measures beliefs and attitudes toward conflict and help-seeking using Likert-type items. Subscale scores are computed separately, with higher Minimization scores indicating greater denial or normalization of abuse, and higher Help-Seeking scores reflecting stronger intentions to access support. The scales adapted to Greek from their original English version by two bilingual researchers following back translation procedures [16]. Previous studies have demonstrated satisfactory internal reliability [17]. In the present study, Cronbach's α values were .77 for Minimization and .56 for Help-Seeking.

PTSD Checklist – Civilian Version (PCL-C; 17 items). Posttraumatic stress symptoms were assessed using the PTSD Checklist – Civilian Version (PCL-C) [18]. The 17 items correspond to DSM-IV criteria for PTSD, including symptoms of re-experiencing, avoidance, and hyperarousal. Respondents rated how much they were bothered by each symptom over the past month using a 5-point scale ranging from 1 (not at all) to 5 (extremely). Total scores range from 17 to 85, with higher scores indicating greater PTSD symptom severity. A cutoff score of 44 was used to indicate probable PTSD, consistent with prior validation research. The PCL-C has demonstrated good psychometric properties across different cultural contexts, including in the Greek population [19], supporting its use in civilian samples of trauma survivors. Internal consistency in our sample was excellent (Cronbach's α = .93).

Posttraumatic Growth Inventory – Short Form (PTGI-SF; 10 items). Posttraumatic growth was measured using the 10-item short form of the Posttraumatic Growth Inventory (PTGI-SF) [20]. The PTGI-SF includes two items for each of the five original domains: Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. Items are rated on a 6-point scale ranging from 0 (did not experience this change) to 5 (experienced this change to a very great degree). The total score represents the overall degree of posttraumatic growth, with higher scores reflecting greater perceived positive change following trauma. The Greek version of the full PTGI was translated and back-translated following standard cross-cultural adaptation procedures by Kalaitzaki, Tamiolaki, and Tsouvelas [21]. Their work confirmed the linguistic and conceptual equivalence of the Greek version, as well as its excellent internal consistency and factorial validity among Greek health care workers. The current study used the corresponding Greek short form (PTGI-SF) derived from that validated adaptation. In our sample, internal consistency was high (Cronbach's α = .95).

Ethical Considerations

Although formal approval from an institutional ethics committee was not obtained prior to the implementation of the intervention, all procedures were conducted in accordance with internationally recognized ethical standards for research with human participants. The study adhered to the ethical principles outlined in the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct [22] and the Declaration of Helsinki [23]. Participation in the study was entirely voluntary. All participants were fully informed about the study's aims, procedures, potential risks, and benefits before enrollment. Written informed consent was obtained from each participant, ensuring that they understood their right to decline or withdraw from the study at any time without penalty or loss of benefits. Given the sensitivity of the topic—intimate partner violence—special care was taken to protect participants' psychological well-being and confidentiality. Data collection took place in a safe and supportive environment, and participants were assured that all information would remain strictly confidential and used solely for research purposes. Identifying information was removed from the dataset prior to analysis. During and after the intervention, participants were provided with information about local counseling and victim support services should they experience distress or wish to seek additional assistance. The research team was trained in trauma-informed and gender-sensitive practices to ensure the respectful and ethical treatment of survivors throughout the study. In summary, although formal institutional ethics approval was not obtained, the study was designed and conducted in accordance with the core ethical principles of respect for persons, beneficence, and justice. Every effort was made to safeguard participants' dignity, autonomy, and emotional safety in accordance with established international ethical standards.

Data Analysis

Data were analyzed using IBM SPSS Statistics version 20. Prior to conducting the main analyses, data were screened for accuracy, missing values, and violations of statistical assumptions. Descriptive statistics (means, standard deviations, and frequencies) were calculated to summarize participants' sociodemographic characteristics and patterns of intimate partner violence. Internal consistency for all scales was evaluated using Cronbach's alpha coefficients. Given the small sample size (N = 21) and non-normal distribution of several variables, nonparametric statistical tests were employed. To examine changes in posttraumatic stress symptomatology, a chi-square (χ^2) test of independence was used to compare the proportion of participants meeting clinical cutoff criteria for PTSD before and after the intervention. To assess pre- to post-intervention differences in continuous outcome measures—namely help-seeking attitudes and posttraumatic growth (PTG)—Wilcoxon signed-rank tests were conducted. This test was chosen as the nonparametric equivalent of the paired-samples t test and is appropriate for ordinal data and small sample sizes. Median values and corresponding Z statistics were reported for each variable, along with p values. For all analyses, statistical significance was set at $p < .05$ (two-tailed). Trends approaching significance ($p < .10$) were also noted given the exploratory nature of the study and limited statistical power. Results were interpreted in light of both statistical significance and the magnitude and direction of observed changes to provide a comprehensive understanding of the intervention's effects.

Results

Regarding clinical symptomatology pre intervention, 6 participants (28.6%) met cutoff criteria for post-traumatic stress disorder (PTSD), while post intervention 3 (14.3%) participants 14.3% met clinical criteria. However, the χ^2 test did not reveal statistically significant differences between pre- and post-intervention assessments ($\chi^2(1) = 1.27$, $p = .259$).

The Wilcoxon signed-rank tests were conducted to compare participants' responses before and after the intervention

across measures of help-seeking attitudes and posttraumatic growth (PTG).

Help-Seeking Attitudes

Overall, participants did not report significant changes in most measures of help-seeking intentions following the intervention. Median scores for seeking help from victim support organizations remained relatively stable (pre-intervention *Mdn* = 7.00, post-intervention *Mdn* = 6.00), and median values for seeking support from friends or family did not change (*Mdn* = 2.00 both pre- and post-intervention). Similarly, willingness to give a partner another chance remained stable (*Mdn* = 2.00 pre- and post-intervention), as did feelings of fear of blame (*Mdn* = 1.00 pre- and post-intervention) or shame (*Mdn* = 1.00 pre- and post-intervention) associated with disclosure. A trend was observed in participants' belief that organizations exist which could support them in situations of partner violence, $z = -1.73$, $p = .083$. Although the median response did not change (pre-intervention *Mdn* = 7.00, post-intervention *Mdn* = 7.00), the distribution of responses indicated a movement toward stronger endorsement of the availability of support services (see Table 2).

Posttraumatic Growth (PTG)

Significant and near-significant changes were observed across several domains of PTG. Participants reported a significant increase in the sense of intimacy with others, $z = -2.31$, $p = .021$. Median scores increased from 1.50 pre-intervention to 3.00 post-intervention, indicating a marked strengthening of relational closeness following the program. Similarly, participants reported a significant enhancement in the recognition of personal strength, $z = -2.71$, $p = .007$, with median scores increasing from 1.00 to 3.00. These findings suggest that the intervention contributed to survivors' perceptions of resilience and self-efficacy. Trends were also identified in several PTG domains. Specifically, participants showed a tendency toward greater appreciation of life, $z = -1.71$, $p = .088$, with median scores rising from 2.00 to 4.00. Similarly, a positive shift was observed in participants' belief that they can face difficulties, $z = -1.71$, $p = .088$, with medians increasing from 3.00 to 4.00. Together, these results indicate movement in the expected direction. Participants may have begun to reframe their experiences in ways that foster positive psychological change; however, these effects were marginal (see Table 2).

In summary, the findings suggest that while direct changes in help-seeking behaviors were limited, participants demonstrated meaningful gains in posttraumatic growth following the intervention. Median scores indicated significant improvements in relational intimacy and personal strength, and trends toward enhanced appreciation of life and resilience. These findings point to the potential of the intervention to foster psychological growth and resource awareness among women survivors of intimate partner violence.

Table 2. Pre- and Post-Intervention Median Scores on Help-Seeking Attitudes and Posttraumatic Growth (PTG)

Measures	Mdn Pre	Mdn Post	z	p
Help-Seeking Attitudes				
Seek help from victim support organizations	7.00	6.00	–0.73	.465
Not seek help from family/friends	2.00	2.00	0.00	1.000
Give partner another chance before leaving	2.00	2.00	–0.22	.824
Fear disclosure due to potential blame	1.00	1.00	–0.31	.755
Shame preventing disclosure	1.00	1.00	–0.05	.958
Believe organizations exist that could help	7.00	7.00	–1.73	.083†
Minimize severity of incident if police were involved	1.00	1.00	–1.20	.230
Tell friends or family about what happened	6.00	6.00	–0.41	.679
Posttraumatic Growth (PTG)				
PTG score	2.40	2.90	–1.49	.136
1. Changed priorities in life	2.00	3.00	–0.78	.438
2. Greater appreciation of life	2.00	4.00	–1.71	.088†
3. Sense of better future possibilities	2.00	4.00	–1.10	.272
4. Increased spiritual/religious understanding	3.00	4.00	–0.72	.475
5. Stronger sense of intimacy with others	1.50	3.00	–2.31	.021*
6. Made a new start in life	0.50	3.00	–1.17	.242
7. Awareness of ability to face difficulties	3.00	4.00	–1.71	.088†
8. Strengthened religious faith	0.50	2.00	–0.67	.502
9. Realized personal strength	1.00	3.00	–2.71	.007**
10. Learned about the goodness of people	3.50	4.00	–0.67	.502

Note. Wilcoxon signed-rank test. † $p < .10$ (trend). $p < .05$. *$p < .01$.

Discussion

The present pilot study evaluated the preliminary effectiveness of a structured, trauma-informed, psychoeducational online group intervention for women survivors of intimate partner violence (IPV) in Greece. Although reductions in PTSD symptomatology did not reach statistical significance, the proportion of participants meeting the clinical cutoff for probable PTSD decreased following the intervention. More robust findings were observed in strength-based domains, including significant increases in perceived personal strength

and relational intimacy, alongside trends toward greater appreciation of life and enhanced perceived ability to face difficulties. Help-seeking attitudes did not significantly change, except for a marginal trend toward stronger endorsement of the availability of supportive organizations. It is also noteworthy that the median values for this item were already high at both assessment points, indicating that participants strongly endorsed the belief that supportive organizations exist even prior to participation in the program. Consequently, the observed trend should not be interpreted as a shift from low to high awareness but rather as a subtle strengthening of an already strongly held belief. The Wilcoxon signed-rank test captures changes in the distribution of responses rather than solely changes in central tendency, suggesting that a greater proportion of participants reported stronger endorsement of service availability following the intervention. These findings are broadly consistent with existing literature on trauma-informed psychoeducational interventions for IPV survivors.

Meta-analytic evidence indicates that structured psychological interventions, particularly cognitive-behavioral and trauma-focused approaches, are associated with significant reductions in PTSD severity among women survivors of IPV [24-25]. Psychoeducation is a core component across effective interventions, helping normalize trauma responses and provide coping strategies [26-27].

However, some pilot and feasibility studies report improvements that do not reach statistical significance, particularly in small samples [24, 28]. The current findings align with this pattern. The intervention emphasized empowerment, awareness, and coping rather than direct trauma exposure or intensive trauma processing. Realist reviews suggest that trauma-informed interventions may initially enhance safety, stabilization, and empowerment, with symptom remission potentially emerging more gradually [29].

Therefore, the observed non-significant reduction in PTSD symptoms should be interpreted with caution, given the small sample size and the intervention's primary emphasis on psychoeducation and empowerment rather than intensive trauma processing.

One of the most salient findings was the significant increase in perceived personal strength. Empowerment and self-efficacy are consistently identified as critical outcomes for IPV survivors [30]. Survivors participating in trauma-informed group interventions frequently report feeling stronger, more capable, and more self-aware following participation [31].

Strengths-based and peer-supported group interventions enhance agency, self-expression, and self-empowerment while reducing isolation [32]. Digital trauma-informed interventions have similarly demonstrated improvements in empowerment, stress management, and coping self-efficacy [33]. The observed increase in personal strength in the present study aligns closely with these findings, suggesting that psychoeducational group formats may facilitate identity reconstruction and resilience-building even when symptom reduction is modest.

Participants also demonstrated significant increases in relational intimacy. Trauma exposure is known to affect relational functioning, yet research indicates bidirectional associations between psychological distress and relational intimacy [34]. Psychoeducational interventions that address the impact of trauma on relationships may facilitate improvements in intimacy and interpersonal functioning. Group-based trauma-informed programs have been shown to improve social relations and reduce mental health difficulties [27]. Creating safe spaces where women can share experiences and receive validation may foster relational trust and reconnection [32]. The improvement in relational intimacy observed in this study supports the role of group-based psychoeducation in restoring interpersonal capacities disrupted by IPV.

Limitations and Future Directions

Several limitations should be considered when interpreting the findings of the present pilot study. First, the small sample size limits its statistical power and restricts the generalizability of the results to broader populations of women survivors of intimate partner violence. Second, the absence of a control or comparison group precludes causal inferences regarding the effectiveness of the intervention, as observed changes cannot be conclusively attributed to program participation alone. Third, the reliance on voluntary participation introduces the possibility of self-selection bias, as women who chose to engage in the program may have been more motivated, psychologically resourced, or open to change than survivors who did not participate. In addition, outcomes were assessed only immediately following the intervention, preventing evaluation of the durability of effects over time and limiting conclusions regarding longer-term impact. Measurement-related limitations should also be acknowledged, particularly the low internal consistency observed for the Help-Seeking subscale, which may have reduced sensitivity to change in this domain. Future research should address these limitations by employing larger and more diverse samples, incorporating randomized or controlled designs, extending follow-up assessments to examine maintenance of gains, and refining or supplementing measures of help-seeking to ensure adequate reliability and construct validity.

Conflict of Interest, The authors declare no conflict of interest.
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