Journal of Fundamentals of Mental Health

Mashhad University of Medical Sciences

Psychiatry and Behavioral Sciences Research Center

Original Article

The effectiveness of coping therapy on domestic violence and self-efficacy in abused women

Azade Darvishnia[1]; *Alireza Aghayousefi[2]; Naser Sobhi Gharamaleki[3]

[1]Ph.D. student in general psychology, Department of Psychology, Saveh Branch, Islamic Azad University, Saveh, Iran.
[2]Associate professor, Department of Psychology, Faculty of Psychology and Educational Sciences, Payame Noor University, Tehran, Iran.
[3]Associate professor, Department of Psychology, Faculty of Psychology and Educational Sciences, Allameh Tabatabai University, Tehran, Iran.

Abstract

Introduction: Domestic violence is still considered a global problem. The present study aims to investigate the effectiveness of coping therapy on domestic violence and the sense of self-efficacy in abused women.

Materials and Methods: Among the 115 women victims of violence in Tehran who were initially interviewed, 40 women who were victims of violence living in Ray city, Kahrizak district, who referred to Hazrat Abolfazl (AS) comprehensive health center during the months of September-October 2019, were randomly assigned to the coping therapy group (n= 20) and the control group (n= 20). All participants completed the demographic checklist, self-efficacy questionnaire, and standard questionnaire for measuring violence against women in three stages. We used analysis of variance with repeated measures. The data was analyzed with SPSS version 24 software.

Results: There was a significant difference between the groups in the post-test and follow-up stages. This can indicate the effectiveness of coping therapy on self-efficacy in victims of violence and the stability of the effectiveness in the follow-up stage ($P< 0.001$).

Conclusion: The results showed that coping therapy can be used as a psychological intervention to increase the sense of self-efficacy and reduce violence towards women. This intervention empowers women who have experienced violence.

Keywords: Coping therapy, Domestic violence, Self-efficacy

Please cite this paper as:
Darvishnia A, Aghayousefi A, Sobhi Gharamaleki N. The effectiveness of coping therapy on domestic violence and self-efficacy in abused women. Journal of Fundamentals of Mental Health 2023 Jul-Aug; 25(4): 245-251.

Introduction

Family is not always a place to satisfy various physical, intellectual, and emotional needs (1). Violence against women causes pain and suffering to victims and their families and burdens societies worldwide, often occurring in intimate relationships or between people known to each other (2). Based on the definition of the statement on the elimination of violence against women adopted by the United Nations in 1993, the term violence against women means any act of violence based on gender that causes physical, sexual, or psychological suffering or harm to women (or is likely to cause such harm). It includes the threat of such actions, pressure, and threat or arbitrary deprivation of liberty, whether

***Corresponding Author:**
Department of Psychology, Faculty of Psychology and Educational Sciences, Payame Noor University, Tehran, Iran.
arayeh1100@gmail.com
Received: Feb. 22, 2022
Accepted: May. 21, 2023

in public gatherings or private life (3). Thus, violence against women includes but is not limited to, physical, sexual, or psychological violence at the three levels of the family, society, or by the government, or is tolerated wherever it occurs (4).

Violence against women in its domestic and social dimensions, both in developed and developing societies, has always been a concern and harm, and its spectrum varies from industrial society to backward societies based on cultural and local factors (5). Throughout history and in many parts of the world, women have always been oppressed due to a misunderstanding of human rights and other reasons, and violence has been one of the closest tools to suppress them (6). Today, despite industrial advances, with the growth of civilization and culture and the development of science and technology, family violence is still considered a global problem. Until about two decades ago, it was believed that the family is the best place for adults to live because of the existence of close, loving relationships and emotions. However, studies and research related to the family have determined that a difference should be made between (ideal) and (real) families (7). Probably the ideal family is the best place for children and adults to live. Experimental studies have shown that the ideal family constitutes a small percentage of families. The family is often considered a haven of safety and happiness, but domestic violence is part of the experience of many family members, including women. Domestic violence is not a new social disaster (8). Taghdiri et al. showed that the prevalence of violence in Tehran is 36.35%, so women need empowerment. One of the concepts of the empowerment model is self-efficacy. Self-efficacy is a key clinical, educational, social, developmental, health, and behavioral psychology variable. Bandura defines automaticity as a person's perceived capacity to perform a behavior successfully. As a result, self-efficacy is a cognitive concept that compares behavioral needs with individual capacities (9). According to Bandura, these factors effectively create automaticity; 1- successful experiences, 2- vicarious experiences, 3- verbal or social persuasions, and 4- emotional and physiological states (10). Autonomy, the ability to successfully perform a task, is an important element that connects awareness and action. Autonomy affects the choice of behavior, the time and position of performing the behavior, and the amount of effort and persistence to perform a specific task (11).

Beliefs related to automaticity affect goals and aspirations and form the consequences of human behavior. People who have more self-efficacy consider more important goals, are more committed, and, as a result, show more favorable behavior. At the same time, people who have little self-efficacy do not show proper behavior (12). Coping therapy technique is used as a method to correct ineffective coping skills (13). This technique is based on the type and severity of tensions and individual's ways of coping based on the reciprocal tension theory of Folkman-Lazarus (14). Coping therapy reveals its usefulness by making a person aware of the type of life stresses, the person's coping possibilities, and searching and finding suitable coping methods for each situation (15). Based on the implementation package of this intervention method of coping therapy, the eight ways of coping with stress that people use in incorrect and inappropriate ways (during the coping therapy sessions are set up in a useful way, and the clients use their coping ways with the discussions that took place in the therapy sessions and the assignments related to the session intervals are modified and deal with a compromise with stressful events (16). The main question of the current research is whether coping therapy affects women's sense of self-efficacy and empowerment. Is it effective against domestic violence of abused women?

Materials and Methods

The statistical community of this clinical trial included abused women who referred to Hazrat Abulfazl (AS) Comprehensive Health Center, Ray City, and Kahrizak District-Iran. Among 115 women who referred, 40 women were selected using the purposeful and convenient sampling method and randomly (using a random number table) assigned in the experimental group (20 cases) and the control group (20 cases). After random replacement, in order to comply with the principle of random application, one of the groups was selected again by chance as the intervention group (the group that received the therapy intervention) and the control group (the group that did not receive the intervention). The inclusion criteria included women aged 30-45 years, not having mental illness and history of hospitalization in the psychiatric ward, not having a history of neurological and history of hospitalization,

ability to participate in group therapy sessions, and willingness to cooperate. The exclusion criteria included not attending intervention sessions for more than two sessions and unwillingness to continue the intervention. After obtaining approval from Islamic Azad University, Saveh Branch, we went to Hazrat Abulfazl (AS) Comprehensive Health Center, Ray City, Kahrizak District, and submitted a letter of introduction to work in the research environment and after introducing to the relevant officials, the objectives of the research and told them the steps to do the work. To conduct the present research, firstly, the educational content based on the therapeutic approach (counter-therapy) of the intervention using scientific and reliable sources and according to the model structures, including the sense of self-efficacy and empowerment of abused women against domestic violence. Then, to determine the validity of the educational content, the content was given to two experts. After summarizing the comments, the necessary changes were made to the educational content. Prior to intervention, the research objectives, steps, the confidentiality of information, and the right to withdraw from the study were explained to women. All the participants completed the demographic profile questionnaires, the Sherer self-efficacy questionnaire, and the standard questionnaire scale for measuring violence against women in the pre-test stage. The experimental group underwent the mentioned intervention. According to the research objectives, three months after the last session of intervention therapy, a post-test was conducted and all cases completed the questionnaires again. Morally, there was no relationship between the control group and the experimental group during the study.

Research instruments

A) Demographic Checklist: It included basic information such as age, educational level, and number of children.

B) General Self-Efficacy Questionnaire: This scale, which was created by Sherer et al. (1982), has 17 items, which scored on a 5-point Likert scale from agree to completely disagree (1= completely agree, 5= completely disagree). Sherer et al. reported the reliability coefficient equal to 0.86 (17,18). In another study the internal consistency of the total questionnaire was reported 0.86 (19). Also, using Cronbach's alpha coefficient, the Persian version had the internal consistency of the subscales and the total scale as 0.78, 0.76, 0.66, 0.70, and 0.86, respectively (20). The reliability coefficients of the entire questionnaire in this research have been estimated at 0.89, which is acceptable.

C) The Standard Questionnaire for Measuring Violence against Women: This tool was developed by Haj-Yahia in 1999 (21). This questionnaire has 32 questions. The validity of the standard questionnaire for measuring violence against women was confirmed by its creators. Its validity was also obtained by Amiri by calculating the validity of the questionnaire through face validity in such a way that the researcher translated the questionnaire measuring violence against women, and its validity was confirmed by several expert professors (22). In this research, the internal consistency of this questionnaire was 0.69. It shows acceptable reliability.

Table 1 presents the content of coping therapy protocol.

Table 1. The content of coping therapy protocol

Session	Content
First	We ask the members to introduce themselves and tell the positive and negative characteristics they know about themselves against stressful events, that is, to explain their usual coping methods. This allows us to see how much ability a person has to face a stressful event. We ask the members what things have made the person tense in the last year? What things have upset them? We briefly introduce the methods of dealing with stress. Regarding the effect of stress on biological and psychological health, we explain that this work motivates the references to cooperate more. We ask the members to write down and bring the most important stress they have now and want to be solved these days for the next meeting. For this, it is necessary first to describe the event, explain their thoughts and feelings, and then write which part of the situation is stressful for them.
Second	We want the members to present the task of the previous session, in which we asked each of them to bring up the stressful situation they are involved in and would like to solve soon. The thoughts they had and the Expression of feelings, the members analyze the conditions together with the help of a consultant. They find the ineffective coping methods, highlight the positive aspects, and identify the efficient ones. We ask the person to test this new method until the next meeting, take notes, write down the events, and express his feelings. In each session, we focus on one of the techniques to deal with stress, and we use real and tangible examples from the members' notes. When the members feel a positive effect in the subsequent sessions, they learn to change their methods with the stressful event in a completely conscious way.
Third	We evaluate the stress-causing event that the person noted and brought to herself in the second session and evaluate the person's coping methods. We change the places where the person encountered the problem; we strengthen the place that was beneficial and helped the person to solve this problem. In contrast to material therapy, we change the person's coping methods to useful methods. If the person's problem is solved soon but the treatment period is not yet completed, we ask that person to write down another stressful event that the person wants to be solved soon and bring it to the meeting.

Results

In term of demographic variables, the means of age in the experimental group and the control group were 43.92 ± 5.09 years and 45.53 ± 4.77 years, respectively (P> 0.05). In both groups, most cases had diploma. Also, the majority of the participants in both group, had three children. Table 2 shows the descriptive statistics of the violence and self-efficacy in pre-test and post-test stages. Table 3 presents the results of Kolmogorov-Smirnov test and Shapiro-Wilk test to check the normal distribution of data.

Table 2. The descriptive statistics of the variables in pre-test, post-test, and follow-up stages

Variable	Group	Pre-test		Post-test		Follow-up	
		Mean	SD	Mean	SD	Mean	SD
Psychological violence	Experimental	12.50	2.70	4.15	1.14	4.25	1.16
Physical violence		14.80	1.76	6.70	1.80	7.05	1.66
Sexual violence		13.40	2.32	7.05	1.73	7.40	1.60
Psychological violence	Control	12.60	2.70	13.01	2.61	12.75	2.48
Physical violence		13.85	2.07	13.95	1.76	13.95	1.90
Sexual violence		13.30	2.34	13.50	2.21	13.75	2.02
Self-efficacy	Experimental	29.01	5.12	52.53	6.53	48.93	6.46
	Control	25.73	6.25	25.47	5.24	25.37	5.31

Table 3. The Kolmogorov-Smirnov test and Shapiro-Wilk test to check the normal distribution of data

Group	Variable	Stage	K-S			Shapiro-Wilk		
			F	DF	P	F	DF	P
Experimental	Self-efficacy	Pre-test	0.133	26	0.200	0.966	26	0.525
		Post-test	0.220	26	0.002	0.865	26	0.003
		Follow-up	0.313	26	0.001	0.853	26	0.002
	Violence	Pre-test	0.155	26	0.108	0.936	26	0.108
		Post-test	0.159	26	0.092	0.917	26	0.039
		Follow-up	0.229	26	0.001	0.802	26	0.001
Control	Self-efficacy	Pre-test	0.218	26	0.003	0.702	26	0.001
		Post-test	0.319	26	0.001	0.489	26	0.001
		Follow-up	0.358	26	0.001	0.452	26	0.001
	Violence	Pre-test	0.167	26	0.060	0.917	26	0.038
		Post-test	0.170	26	0.050	0.939	26	0.124
		Follow-up	0.165	26	0.068	0.922	26	0.050

As shown in Table 2, the scores of violence and self-efficacy were not different significantly in two groups (P> 0.05). Also, the three dimensions of violence in the experimental group decreased in post-test compared to the pre-test, and this effect was stable in the follow-up stage. The differences between the groups in the post-test and follow-up stages were significant, which indicate the effectiveness of the coping therapy on violence and self-efficacy. The results of Levene's test, showed the assumption of the equality of variances (P> 0.05). The results of Shapiro and Wilk's normal distribution test in the experimental group showed that normal distribution of self-efficacy and violence in the pre-test stage (P> 0.05). Table 3 presents the scores of the dimension of violence and self-efficacy. Table 4 presents the MANCOVA results related to the violence in the post-test stage.

Table 4. The MANCOVA results related to the variable of violence in the post-test stage

Source of changes	SS	df	MS	F	P	Eta squared
Psychological violence	830.100	2	415.050	93.602	0.001	0.767
Physical violence	588.700	2	294.350	110.600	0.001	0.795
Sexual violence	559.033	2	279.517	77.361	0.001	0.731
Self-efficacy	5494.533	1	5494.533	156.533	0.001	0.848

According to Table 4, the significance level in psychological, physical, and sexual violence is less than 0.01. The difference between the two groups in these components is confirmed. Therefore, it can be said that coping therapy significantly changes these components of violence in abused women. Also, the significance level in the self-efficacy variable is lower than 0.01; the difference between the two groups in these components is confirmed. Therefore, 0.84 of the change in the variable of self-efficacy is due to the coping therapy.

Discussion

The present study aimed to assess the effectiveness of coping therapy on domestic violence and self-efficacy in abused women. Based on the findings, coping therapy is effective in self-efficacy and improving women's empowerment (reducing violence) in abused women. It has a lasting effect over time. This finding is consistent with the results of the studies by Ryff and Singer (23), Connor and Davidson (24), and Hyun, Chung, Lee (25).

Ryff and Singer investigated the effectiveness of coping therapy on 50 women with domestic violence experience, showed that coping therapy has a positive and significant effect on increasing the self-efficacy and self-esteem of the women (23). The results of the present study showed the significant differences between the two groups in the post-test and follow-up stages. This finding is in line with the results of the studies by Taghdiri et al. (9) and Tasi et al. (19). In the explanation of the present finding and consistent with the study by Alkan et al. (4) and Harvey (6), and Hammer et al. (13), it can be said that coping therapy is a non-directive client-centered method that through discovery and solution of the client's doubt increases internal motivation in the direction of change. Therefore, clients' ambivalence plays a central role in coping with therapy and unlike other treatments it directly raises resistance and ambivalence against change and resolves it (17). This is a problem in women who have been involved with domestic violence for a long time, and its complications, such as a decrease in self-confidence, depression, anxiety, and thoughts due to the reduction of resistance and the strengthening of documents and internal motivations, capacity and talent, increasing knowledge, creating skills. Motivation is very effective in starting and maintaining change, and strengthening treatment results in problems related to women who have suffered violence. It can be considered that coping therapy increases participation and success of subsequent pragmatic treatment methods, strengthening coping strategies in these women (17). In line with the present study and the study by Agha Yousofi (20), it can be said that coping therapy relies on principles such as expressing empathy, avoiding verbal discussion, supporting the client's efficiency, and moving with resistances. Orientation reduces the doubt and fear of abused women from facing anxiety-provoking situations (including inappropriate behaviors to control stress, including smoking and emotional eating) in abused women. Coping therapy is a combination of principles and techniques taken from a set of very wide models of psychotherapy and behavior change, which is useful in changing the lifestyle and dealing with spousal violence in abused women (20). Also, one of the important principles of coping therapy is strengthening positive points and helping women affected by domestic violence to discover what things in them will increase their empowerment. Due to reducing resistance and strengthening internal documents and motivations, coping therapy helps women deal with violence. It helps women identify and manage situations that lead to violence in marital relationships. Coping therapy increases women's self-efficacy. The results of the present study showed that the coping therapy improved self-efficacy in abused women and it had a lasting effect (20).

In line with Rai and Choi's study (8), it can be said that high self-efficacy creates a feeling of empowerment in individual tasks and reduces a person's fear of performing a certain behavior regularly. Self-efficacy directly affects health-related behaviors and other cognitive determinants. People with higher self-efficacy set higher goals for themselves, expect better outcomes, and see obstacles and problems in self-management as surmountable challenges and, therefore, more self-management (11). This point is very important for women who have experienced violence because people's self-esteem has decreased during periods of frustration caused by violence (26).

Self-efficacy is one of the richest resources within an individual that empowers a person to perform individual tasks. In general, it can be concluded that raising the self-efficacy of women affected by violence can make them self-confident. It is also argued that people's beliefs affect their behaviors, and people act in harmony with their inner beliefs, not based on existing facts. In the current explanation, self-efficacy refers to a person's beliefs or judgments about his/her abilities in performing duties and responsibilities. Also, striving for perfection is to realize one's real potential abilities. In another explanation, it was stated that in the perspective of coping therapy, it is the acceptance of a designed and daring state on the part of the individual and helps him/her without defense aspects of his/her

psychological experiences (bad, good, and ugly). So, our goal is to create a self-efficacious human being who is sincerely connected with his/her experiential world (27). In this line, Hyun, Chung, Lee studied 150 teenagers who experienced domestic violence (25). Coping therapy by focusing on inadequate coping methods of the affected women can improve their coping strategies—adapted practices change, which in turn increases self-efficacy. Coping therapy or creating the ability to be effective, overcome the problem, plan, behave purposefully and follow the problem, and significantly increase self-efficacy. In general, coping therapy reveals its usefulness by making the person aware of the coping possibilities of the person searching for and finding suitable countermeasures for each situation (25). The present study has some limitations such as the sample limited to a specific geographical area, with a limited number, and the voluntary and purposeful sampling method. Using a therapist and his help in the initial evaluation, providing the intervention carried out in this research, and the secondary evaluation, can create biases and limitations. Another limitation of this research is the COVID-19 pandemic. It caused the impossibility of access to abused women who did not want to participate in the meetings, as well as the prolongation of sampling and the implementation of protocols due to the unavailability of abused women and the risk of disease.

The practical suggestions of the research include screening and identifying abused women in the early stages and referring them to a psychologist can also effectively prevent and reduce the psychological problems. Practical suggestions for women's rights protection organizations by psychologists to increase resilience in this group of women can be useful. Implementation of group training and interventions in such a way as to enable the exchange of experiences of the participants to increase social support, both emotional and informational, should be put on the agenda.

Conclusion

In general, the results of the present study showed that coping therapy has a positive and significant effect on reducing domestic violence and increasing the level of self-efficacy.

Acknowledgments

The authors thank the officials of Hazrat Abulfazl (AS) Comprehensive Health Center. This article is resulted from the Ph.D. dissertation of the Islamic Azad University, Saveh Branch, which has been approved by Iran Doc Code 5269847 and Ethics Code IR.IAU.ARAK.REC.1400.016. In addition, this study was registered in the clinical trial center with code IRCT20110913007529N29. The authors declare no conflict of interest or financial support.

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