Continuous Intimate Partner Violence
Mental health consequences and feasibility of psychological interventions: the case of Iran

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<tr>
<td>IPV</td>
<td>Intimate Partner Violence</td>
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<tr>
<td>PTSD</td>
<td>Post-traumatic Stress Disorder</td>
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<tr>
<td>NET</td>
<td>Narrative Exposure Therapy</td>
</tr>
<tr>
<td>TAU</td>
<td>Treatment-As-Usual</td>
</tr>
<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders- 5th edition</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>BPD</td>
<td>Borderline Personality Disorder</td>
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<td>CBT</td>
<td>Cognitive Behavioral Therapy</td>
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<tr>
<td>CTT-BW</td>
<td>Cognitive Trauma Therapy for Battered Women</td>
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<tr>
<td>HOPE</td>
<td>Helping to Overcome PTSD through Empowerment</td>
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<td>EMDR</td>
<td>Eye Movement Desensitization and Reprocessing</td>
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<td>PE</td>
<td>Prolonged Exposure therapy</td>
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<tr>
<td>CS</td>
<td>Conditioned Stimulus</td>
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<tr>
<td>US</td>
<td>Unconditioned Stimulus</td>
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<tr>
<td>cPTSD</td>
<td>Complex PTSD</td>
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<td>IPT</td>
<td>Interpersonal therapy</td>
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<tr>
<td>TF-CBT</td>
<td>Trauma-Focused Cognitive Behavioral Therapy</td>
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<tr>
<td>PSS-I</td>
<td>Posttraumatic Stress Symptom Scale – Interview</td>
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<tr>
<td>PHQ</td>
<td>Patient Health Questionnaire</td>
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<tr>
<td>PSS</td>
<td>Perceived Stress Scale</td>
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<tr>
<td>WSAS</td>
<td>The Work and Social Adjustment Scale</td>
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<td>CAS</td>
<td>Composite Abuse Scale</td>
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<td>LEC</td>
<td>The Life Events Checklist</td>
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<tr>
<td>MACE</td>
<td>Modified Adverse Childhood Experiences</td>
</tr>
<tr>
<td>TUMS</td>
<td>Tehran University of Medical Sciences</td>
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<tr>
<td>BSL</td>
<td>Borderline Symptom List</td>
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<td>ACT</td>
<td>Acceptance and Commitment Therapy</td>
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<tr>
<td>ICD-10</td>
<td>International Classification of Diseases, 10th Revision</td>
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<tr>
<td>RCT</td>
<td>Randomized Controlled Trials</td>
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Summary

Intimate Partner Violence (IPV) against women is a pervasive worldwide phenomenon, with high prevalence in the patriarchal societies of the Middle East such as Iran. High incidence of IPV results in the high prevalence of mental health problems such as Post-traumatic Stress Disorder (PTSD) and depression. Not all women have the opportunity to escape violence, especially in low-to middle income countries, where lack of resources, social taboos, and fear of isolation and rejection lead abused women to keep silent and acquiesce to violence. Refusal to leave an abusive relationship is also frequent in modern societies and high-income countries, where social support and legal intervention are more widely available. The women affected might hope their partner will change or are constrained by their abusive partner's controlling tactics. Accordingly, a huge number of abused women remain unable to seek help and live under ongoing IPV for a prolonged period of time. The present thesis was developed to evaluate the feasibility and effectiveness of a culturally sensitive trauma-focused therapy, Narrative Exposure Therapy (NET), to meet the mental health needs of abused women with current experiences of ongoing IPV.

We believe that individual psychotherapy is a feasible means of providing help within patriarchal societies. It has advantages over legal interventions and social support, in that it does not require structural reforms and fundamental sociopolitical changes, which take time and provokes resistance within a society. Psychotherapeutic interventions are not only capable of reducing pain and suffering among victims of ongoing IPV, but also might decrease violent occurrences within private households, raise awareness, and increase general public knowledge of IPV and its causes and effects. NET is an evidence-based therapeutic method that is capable of delivering exposure-based treatments to people from different cultural backgrounds. It is especially well-suited to the treatment of trauma-related symptoms among victims of chronic violence, which, at the same time, helps the patient to develop a testimony against human right violations in war-affected societies.

Despite the urgent needs of continuously abused women, first-line IPV intervention programs have mostly been conducted in abused women who have taken refuge in domestic violence shelters or at least a temporary leave of their abusive partner. Therefore, mental health needs of abused women suffering from ongoing IPV has been neglected. To fill this gap in the literature, the present thesis investigates whether psychotherapy, particularly the exposure-based method of NET, in comparison to treatment-as-usual (TAU) interventions, reduces mental health problems and IPV occurrences in women living in a context of ongoing threat and violence in a Middle Eastern country such as Iran. In addition, there are questions of how abused women perceive IPV-related traumatic stressors, and whether IPV-affected women with mental health problems caused by continuous violence, show specific demographic and psychopathological characteristics. Therefore, we interviewed 47 married Iranian women currently suffering from threatening and violent living circumstances, of which 34 completed therapy sessions and 3- and 6-month follow-up diagnostic interviews.

The results in the first article, which are in line with previous research, showed comorbidity of PTSD and depression, and a significant degree of relationship between PTSD and daily
functioning impairment. Further, we found that only IPV experiences in the last year, rather than childhood abuse, IPV in past years of marriage, and additional lifetime traumatic events, significantly predicted PTSD variance among abused women living with an abusive partner. Further analysis of relationships between demographics and mental health symptoms revealed that a) abused women with higher PTSD symptoms used more psychopharmaceutical drugs, b) socially empowered women with high education and high financial competence suffered from high PTSD and depressive symptoms, and c) women with a non-drug-addicted abusive partner showed high symptoms of depression. Accordingly, in the first article we discuss the contribution of psychosocial factors to the expression of IPV consequences in abused women living in a context of continuous domestic violence in Iran. It is of particular interest to contrast these factors as they play out in a strongly patriarchal society with similar cases in less oppressive societies.

The second article demonstrates the feasibility and effectiveness of NET in the reductions of PTSD, depression and perceived stress symptoms, in a comparison against TAU, in the context of ongoing IPV. These results, consistent with the previous results of exposure-based interventions among IPV-affected women, reveal that trauma-focused therapeutic methods not only enable abused women to distinguish between real dangers and overgeneralized trauma reminders to appropriately apply specific skills to each condition, but also reduce symptoms of numbing and avoidance, which, in turn might decrease the likelihood of re-victimization. Results showed that NET and TAU performed similarly in the reductions of IPV occurrences and daily functioning impairment, participants showed significant reductions in IPV experiences and disturbed functionality in 3- and 6-month follow-ups, regardless of the type of treatment. This finding fills the gap in the literature regarding the effectiveness of psychotherapy interventions in reduction of IPV experiences.

The third article explores the hypothesis that abused women's subjective perceptions of most disturbing adversities do not precisely correspond to the current definition of traumatic stressors described in standard diagnostic categorizations such as DSM-5. The abused women investigated in the present study considered psychological abuse, continuity, and chronicity of IPV experiences as well as physical abuse as the most severe stressors leading them to develop PTSD symptomology. This is important because international standard diagnostic assessments have neglected these common sources of pain and suffering as traumatic stressors among victims of chronic violence. In addition, further exploratory examination of women's experience of psychotherapy under ongoing IPV reveals that psychotherapy even under unsafe condition of living with an abusive partner, is a pathway to self-growth, self-confidence, new life skills, and an integrated self.

In sum, the present thesis shows that psychotherapy in general, and an exposure-based method such as NET in particular, can result in a reduction of psychological symptoms in victims living in a context of ongoing threat and violence. In addition, the present thesis emphasizes the need for reconsideration of current definitions of traumatic stressors in standardized diagnostic categorizations in order to include actual sources of pain and suffering among victims of chronic, intimate violence such as IPV.
Zusammenfassung


Trotz der dringenden Bedürfnisse von Frauen, die anhaltender Gewalt ausgesetzt sind, wurden Primärinterventionen bei IPV meist bei misshandelten Frauen durchgeführt, die bereits in Frauenhäusern Zuflucht gefunden hatten, oder zumindest vorübergehend ihren misshandelnden Partner verlassen hatten. Daher wurden die psychischen Bedürfnisse misshandelter Frauen, die unter anhaltender IPV leiden, bislang vernachlässigt. Um diese Lücke in der Literatur zu schließen, wird in der vorliegenden Arbeit untersucht, ob Psychotherapie, insbesondere die expositions basierte Methode der NET, im Vergleich zur üblichen Behandlung (TAU), psychische Probleme und IPV-Vorkommnisse bei solchen Frauen reduziert, die in einem Kontext andauernder
Bedrohung und Gewalt im Iran leben. Darüber hinaus wird untersucht, wie misshandelte Frauen \textit{IPV}-bezogene traumatische Stressoren wahrnehmen, und ob von \textit{IPV} betroffene Frauen mit psychischen Problemen, die aus der anhaltenden Gewalt resultieren, spezifische demographische und psychopathologische Merkmale aufweisen. Wir haben 47 verheiratete, iranische Frauen, die zum Zeitpunkt des Interviews unter bedrohlichen und gewalttätigen Lebensumständen litten, in die Untersuchung miterfasst; von diesen schlossen 34 Frauen die Therapiesitzungen sowie die Nachuntersuchungen in Form psychodiagnostischer Interviews nach 3 und 6 Monaten ab.


Der dritte Artikel untersuchte die Hypothese, ob die subjektive Wahrnehmung misshandelter Frauen hinsichtlich der belastendsten Ereignisse der derzeitigen Definition von traumatischen Stressoren entspricht, wie sie in standardisierten diagnostischen Kategorien wie dem DSM-5 beschrieben werden. Die in der vorliegenden Studie untersuchten misshandelten Frauen

Zusammenfassend zeigt die vorliegende Arbeit, dass Psychotherapie im Allgemeinen, und eine expositionsbasierte Methode wie die NET im Besonderen, zur Minderung einer psychologischen Symptomatik bei Opfern anhaltender *IPV* führen kann. Darüber hinaus betont die vorliegende Arbeit die Notwendigkeit die aktuellen traumatischen Stressoren in standardisierten, diagnostischen Kategorisierungen zu überdenken, um die tatsächlichen Schmerz- und Leidensquellen von Opfern andauernder, intimer Gewalt wie *IPV* zu berücksichtigen.
Record of achievement

The articles in the present dissertation were accomplished with the help and support of a number of colleagues. In the following, my independent contributions are listed per article.

**Article 1:** Trauma-Related Suffering in Women Exposed to Continuous Intimate Partner Violence in Tehran, Iran (Submitted for publication in *BMC Psychiatry*, 2017).

Tahereh Orang, Sarah Ayoughi, James K. Moran, Thomas Elbert

**My Contributions:**
- Obtained ethical approval
- Designed the study
- Coordinated logistics
- Carried out the whole process of recruitment
- Carried out all the clinical interviews
- Conducted the statistical analysis
- Drafted and revised the manuscript

**Article 2:** The Efficacy of Narrative Exposure Therapy (NET) in a Sample of Iranian Women Exposed to Ongoing Intimate Partner Violence (IPV) - A Randomized Controlled Trial (Published in *Clinical Psychology and Psychotherapy*, 2018)

Tahereh Orang, Sarah Ayoughi, James K. Moran, Hakimeh Ghaffari, Saeedeh Mostafavi, Maryam Rasoulian, Thomas Elbert

**My Contributions:**
- Obtained Ethical approval
- Designed the study
- Translated the instruments into Farsi
- Translated the NET manual into Farsi
- Conducted the interviewer training workshop
- Conducted the NET therapist training workshop
- Carried out the whole process of recruitment
- Coordinated logistics and the collaboration with partners in the field
- Carried out all the pre-treatment clinical interviews
- Supervised the follow-up clinical interviews
- Supervised NET interventions
- Carried out a large number of NET therapies
- Carried out a large number of TAU counselling
- Conducted the statistical analysis
- Drafted and revised the manuscript

Article 3: Subjective Perceptions of Ongoing Trauma and Violence among Iranian Married Women (Manuscript in preparation for publication)

Tahereh Orang, Thomas Elbert

My Contributions:

- Designed the study
- Carried out the whole process of recruitment
- Carried out logistics
- Carried out all the clinical interviews
- Carried out all the qualitative interviews
- Transcribed, coded, and analyzed transcripts
- Conducted the statistical analysis
- Drafted and revised the manuscript
1 Introduction

Violence is not limited to war, torture or genocide and is not always executed by political regimes or criminal gangs. A lot of violence takes place in intimate relationships. Intimate Partner Violence (IPV) or spousal abuse can be one of the most devastating personal experiences, not only resulting in mental health problems and daily dysfunctionality at the individual level, but also creating economic and political burdens within each society (Weissman, 2007). Although IPV encompasses personal conflicts such as marital arguments, family quarrels, or sexual conflicts, it is no longer regarded as a private issue, but rather as a public health problem in almost all the world (Dahlberg & Mercy, 2009).

However, IPV-affected women in many low-to-middle income countries, particularly in the Middle East, still suffer from a marked lack of social support and legal justice due to institutionalized patriarchal values and cultural norms (Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Overstreet & Quinn, 2013; Paul, 2016; Rowan, Mumford, & Clark, 2015; Umubyeyi, Persson, Mogren, & Krantz, 2016). These women cannot easily access appropriate governmental institutes or private organizations to seek formal help. In addition, they are further deprived of informal help from family, relatives or friends due to the social and cultural acceptance of domestic violence and gender inequality. Therefore, many abused women are forced to endure violence, submit to their abusive partners and live their lives under continuous threat and violence. In addition to, and in consequence of physical, emotional and sexual violence inflicted by their partners, they develop serious mental health problems such as Post-Traumatic Stress Disorder (PTSD) and depression, which, in turn, deplete their mental health resources and further constrain them into vicious cycles of violence. The current project aims to 1) shed light on the mental health status and demographics of this group of IPV-affected women and 2) investigate whether women living under ongoing domestic violence could benefit from psychological interventions such as Narrative Exposure Therapy (NET), and 3) if the amount of IPV would decrease following individual psychotherapy with victims. In addition, exploration of their subjective perceptions of living with long-lasting, continuous IPV and having psychotherapy under ongoing IPV might help us to better understand violent experiences from their point of view and adapt future research and intervention programs to suit their specific needs and requirements.

1.1 Intimate Partner Violence (IPV) against women

Intimate partner violence (IPV) is one of the most common and significant factors in the development of mental health disorders in women worldwide, and can be seen as psychological abuse (such as insults, belittling, constant humiliation, intimidation, threats of harm, threats to take away children), physical violence (such as slapping, hitting, scratching and biting), sexual coercion (such as forced sexual initiation and lack of sexual hygiene), controlling behaviors and stalking. According to an official definition, IPV is "a pattern of abusive behaviors including a wide range of physical, sexual, and psychological maltreatment used by one person in an intimate relationship
against another to gain power unfairly or maintain that person's misuse of power, control, and authority" (Walker, 1999, p. 23).

IPV in its nature is a continuous and cumulative violence usually occurring over a period of time in the context of intimate relationships (Courtois, 2004), and the traumas that abused women suffer from are repetitive and prolonged rather than limited to an individual event. Various studies show that women often experience more than one type of victimization in the context of IPV, and physical and psychological abuse frequently overlap (Krebs, Breiding, Browne, & Warner, 2011; Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005). Moreover, the amount of psychological abuse in various studies is higher than physical violence. In addition, intimate partner sexual violence and stalking, which are usually treated as indications of severity of violence, in themselves result in greater serious mental and physical health consequences and partner victimization than the experience of physical violence alone (Agcay, Inanici, Çolak, & Inanici, 2015; Bennice, Resick, Mechanic, & Astin, 2003; Campbell & Soeken, 1999; Cole, Logan, & Shannon, 2005; Dardis, Amoroso, & Iverson, 2016; Logan, Shannon, & Cole, 2007; Taft, Resick, Panuzio, Vogt, & Mechanic, 2007; Wusu, 2015).

1.2 IPV global and regional prevalence

Regardless of cultural, legal and structural differences between high-income and low-to-middle income countries, IPV is omnipresent. The most recent and comprehensive assessment, conducted by the World Health Organization (2013) in 79 countries and two territories, showed that the global prevalence of physical and/or sexual intimate partner violence among women who ever had a partner is 30%, and the highest prevalence (37%) is found in the WHO regions of African, Eastern Mediterranean and South-East Asia.

According to another global estimate of physical or sexual partner violence, provided from 141 studies in 81 countries, 30% of women aged 15 and older have experienced violence during their lifetime (Devries et al., 2013). The prevalence data derived from this study shows considerable variation in different regions, for example, the percentage of IPV reaches to 66%, 35%, and 19% in Central Africa, Middle East, and Western Europe respectively. Different cultural values, social norms and sociopolitical structures are responsible for this broad spectrum of IPV occurrences across the globe. It is estimated that more than 600 million women live in countries where IPV is regarded as a private issue rather than a public concern. IPV-affected women in low-to-middle-income countries, particularly in the Middle East, might face more challenges dealing with violence not only within their social network due to patriarchal cultural norms, but also at a national and governmental level, as they lack domestic violence-sensitive regulations and the supports which are available in most high income-countries. Therefore, they might be re-traumatized by official agencies and institutions while they seek help. The previous research shows that the definition of IPV, the tolerance of violence, subsequent mental health outcomes, and help-seeking behavior are all affected by cultural and societal factors (Mookerjee, Cerulli, Fernandez, & Chin, 2015; Overstreet & Quinn, 2013; White & Satyen, 2015). Thus, more studies are needed
to explore the specific characteristics of female victims of IPV in low-to-middle-income countries, especially countries in the Middle East. In doing this, we can better understand the mechanism and consequences of IPV, in order to provide appropriate help system and policy guidelines.

1.2.1 IPV prevalence in the Middle East and Iran

Less is known about IPV in the Middle East, where the available studies indicate that figures are markedly high (Boy & Kulczycki, 2008). For instance, a study in Jordan showed that 87% of interviewed women had been victims of different types of IPV during the previous year. The prevalence rates in Turkey and Erbil city of Iraq were reported at 78% and 59% respectively (Al-attrushi, Al-tawil, Shabila, & Al-hadithi, 2013; Al-nsour, Khawaja, & Al-Kayyali, 2009; Guvenc, Akyuz, & Cesario, 2014). According to a national survey on domestic violence against women conducted in 28 provincial capitals of Iran, the overall prevalence of violence during marriage is 66.3% and at least 30% of respondents reported one act of serious physical violence in the course of marriage (Vameghi, Khodaie Ardakani, & Sajjadi, 2013). Another study in the eastern part of Iran on 251 married women found that the prevalence of overall violence was 78%, while 38% of women reporting minor violence, 40% reporting both severe and minor forms of violence, and 1% reporting severe violence alone (Moghaddam Hosseini, Asadi, Akaber, & Hashemian, 2013). A further study from the north of Iran reported mild forms of physical abuse (73%), emotional (92%) and sexual (50%) abuse at least once during their lifetime. This figure was 3% (physical), 10% (emotional) and 5% (sexual) for moderate forms, and 0.5% (physical), 1% (emotional) and 2% (sexual) for severe forms of abuse (Ghahari, Khalilian, Mazdarani, & Zarghami, 2008).

Not only is the IPV prevalence in the Middle East substantially higher than other documented regions, but the prevalence investigations might actually underestimate true prevalence, as social taboos and lack of human rights education, lead to underreporting of IPV. For instance, a recent study conducted in Saudi Arabia to estimate the IPV prevalence among female patients attending in the primary healthcare centers excluded sexual violence assessment from the study due to the alleged 'sensitivity' of the issue (Alzahrani, Abaalkhail, & Ramadan, 2016). It was also supposed that the amount of intimate sexual violence reported in a national survey on domestic violence against women in Iran is under-reported (Vameghi et al., 2013). A systematic review of IPV studies conducted in the Middle East revealed that IPV is not often reported and mostly kept secret due to fear of isolation and rejection (Boy & Kulczycki, 2008). The structural gender inequality and patriarchal social norms that dominate cultures in the Middle East might further lead to specific help-seeking behaviors and IPV-related characteristics. The study conducted in Saudi Arabia revealed that most abused women seek help from personal contacts such as family members and friends, and only a few report violence to the police or legal system (Alzahrani et al., 2016). This pattern nearly repeats itself in other countries in this region such as Iran. IPV in Iran is a complicated phenomenon as it is closely intertwined with structural violence against women. For example, IPV is still a private crime in Iran, and there are very few victim agencies or domestic violence shelters and those that do exist provide limited access for women in need. Thus, this context might escalate the severity and frequency of violent assaults in private households.
1.3 Risk factors for IPV against women

A systematic review of risk factors for IPV identified young age, unemployment, and low income, as a higher risk factor, while findings were inconsistent in terms of education (Capaldi, Knoble, Shortt, & Kim, 2012). For instance, previous research shows low educational level in women is a serious risk factor for IPV in Turkey, while low level of education of husbands or higher level of education in women to their husbands were risk factors for IPV against women in Iran (Farrokh-eslamlou, Oshnouei, & Haghighi, 2014; Ghahari et al., 2008; Guvenc et al., 2014; Moghaddam Hosseini et al., 2013). Another study of Bedouin Arab women revealed that women with more years of education report higher levels of physical violence. This phenomenon might come from a greater willingness of the Bedouin women to challenge male authority (Boy & Kulczycki, 2008). This inconsistency replicates for women's employment as studies show women's employment has the potential to either reduce or increase risk of victimization depending upon geo-cultural context (Devries et al., 2013).

Childhood abuse is one of the most well studied risk factors for IPV in various populations (Pico-Alfonso et al., 2006; Seedat, Stein, & Forde, 2005). Numerous studies have reported high degrees of correlation between child abuse and IPV (Affifi et al., 2009; Daigneault, Hébert, & Mcduff, 2009; Follette, Polusny, Bechtle, & Naugle, 1996; Gómez, 2011; Papadakaki, Tzamalouka, Chatzifotiou, & Chliaoutakis, 2009; Whitfield, Anda, Dube, & Felitti, 2003), and a particularly strong constellation of child sexual abuse, IPV and PTSD (Becker, Stuewig, & Mccloskey, 2010; Griffing et al., 2006; Scott, 2007). Chan (2011) showed that child sexual abuse has a direct relationship with increased risk of sexual IPV in adulthood, and suggested that child sexual abuse histories must be recorded in IPV therapeutic interventions. Coid and colleagues (2001) also showed using a huge sample of 1207 women that child abuse increased the risk of re-victimization in adulthood, and that women who had experienced multiple instances of child abuse are at a higher risk of re-victimization in adulthood. It has been suggested that dissociation mediates the relationship between childhood abuse and later victimization, i.e. the experience of child abuse predisposes an individual to use dissociation as a primary defense mechanism detaching themselves from reality, which consequently leads them to ignore threatening cues of violence in an abusive relationship and to fail to take proper care in dangerous situations (Becker-Lausen, Sanders, & Chinsky, 1995; Kluft, 1990).

In addition to experiences of childhood abuse, victims of IPV are more likely to be repeatedly victimized by non-, ex-, and current partners than in the general population (Rodriguez-menés, Puig, & Sobrino, 2014). Pico-Alfonso (2005) examined the contribution of lifetime violence experiences, including childhood abuse, adulthood victimization by people other/s than their partner, and IPV, on the development of PTSD symptomology. They found that, apart from IPV experiences in adulthood, adulthood psychological violence by people other than the partner had an independent, significant effect on PTSD variance. Wilson and colleagues (2012) further examined childhood abuse and community violence exposure as potential risk factors in the development of PTSD symptoms following exposure to IPV and found that both childhood abuse
and community violence experiences accounted for variance in PTSD symptom severity but in the opposite directions, i.e. women who experienced community violence reported lower levels of PTSD symptoms from IPV, while PTSD symptoms were higher for women who experienced childhood abuse. Moreover, research found that IPV-affected women with a history of additional traumatic events such as life-threatening illness, torture or sexual misconduct as a minor, experience more severe PTSD symptoms compared with women only exposed to IPV (Graham-bermann, Sularz, & Howell, 2011).

1.4 Continuous and ongoing IPV

Recent investigations in population-based samples show that IPV experiences are not limited to abused women residing in shelters or referring to criminal justice. There are also a huge number of women currently living under ongoing IPV and suffering from IPV-related mental health disorders (Coker, Weston, Creson, Justice, & Blakeney, 2005). These women might not even be motivated to participate in IPV surveys. Research shows that IPV-affected women currently living with an intimate abuser are less willing to participate in IPV surveys while in their homes due to safety concerns (Ranney, Madsen, & Gjelsvik, 2012). Meanwhile, research in community-based samples shows that the rate of IPV-affected women suffering from moderate-to-severe PTSD reaches 24% (Coker et al., 2005). In this regard, unlike most investigations conducted on women who live in shelters, Taft and colleagues (2005) investigated PTSD symptoms among current and former female partners of men participating in a partner abuse treatment program. These women have never sought treatment. The results of this study showed that PTSD was a major disorder among these women and that, indeed, the likelihood of PTSD in these women is comparable to that of women living in shelters. In the baseline assessment, over half of these women were suffering from PTSD, and in the one-year follow-up assessment, this figure was 30%, and many more showed PTSD symptoms without meeting the full diagnostic criteria.

Studies have shown that women who currently live with their partners and have experienced trauma over the last year are less likely to seek treatment than those who experienced IPV-related trauma a long time ago (Iverson, Resick, Suvak, Walling, & Taft, 2011). They might be unable to report abuse for various reasons such as fear, hope for change in one’s partner, financial concerns, lack of alternatives, cultural factors, and pressure from their social network (Hughes & Jones, 2000). Moreover, the common PTSD symptoms in these abused women deplete or reduce the psychological resources necessary for the termination of an abusive relationship and for beginning an independent life (Arias & Pape, 1999). The situation might be more complicated in low-to-middle-income countries in the Middle East, as research shows Middle Eastern women not only justify the acts of domestic violence and abuse by their partners, but also they think it is their fault (Boy & Kulczycki, 2008).

Previous research has showed that a cessation of IPV significantly decrease the severity of IPV-related PTSD, however, it does not specifically distinguish whether the women separated from the abuser, abuse stopped some point in the past or it is still ongoing (Coker et al., 2005).
Therefore, there is a need for further research to exclusively focus on the feasibility and efficacy of intervention programs in the context of continuous exposure to IPV.

1.5 Health outcomes associated with IPV

Several studies show that women exposed to domestic violence are at higher risk of developing mental health problems. PTSD, depression, suicidal ideation and suicide attempts, substance use, chronic pain, and illness such as various forms of headache, recurrent indigestion, and diarrhea are frequently recognized as the most common mental and physical health consequences of IPV (Bonomi, Thompson, et al., 2006; Chandra, Satyanarayana, & Carey, 2009; Coker et al., 2002; Coker, Smith, Bethea, King, & Mckeown, 2000; Fanslow & Robinson, 2004; Golding, 1999; Mechanic, Weaver, & Resick, 2008; Stein & Kennedy, 2001).

Post-traumatic stress disorder (PTSD), appears to be the most detrimental consequence of IPV. It is characterized by four symptom categories, namely intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity (DSM-5). Dutton and colleagues (2006) propose that PTSD is a major pathway mediating the relationship between exposure to violence and adverse health outcomes. For example, depression, which frequently co-occurs with PTSD, is not only regarded as a primary reaction to trauma exposure but also as a consequence of PTSD (Golding, 1999; Lipsky, Field, Caetano, & Larkin, 2005; Martinez-torteya, Bogat, Eye, Levendosky, & Ii, 2009). Cardiovascular and immunological and/or inflammatory disorders, structural and functional brain alterations, chronic illnesses, risk-taking behavior and substance abuse have also been associated with PTSD (Dutton et al., 2006; Gola et al., 2013). A meta-analysis of 11 studies concluded that the weighted mean prevalence of PTSD among IPV-affected women was 63.8% and there was a dose-response relationship between IPV experiences and PTSD symptom severity (Golding, 1999; Martinez-torteya et al., 2009). Further, unlike its initial appearance, physical violence does not exert the most significant effect on the mental health in these women; in fact, studies show that in some cases, psychological abuse makes a larger contribution to the prediction of the PTSD symptoms caused by IPV than physical violence (Arias & Pape, 1999; Mechanic et al., 2008; Pico-alfonso, 2005; Street & Arias, 2001).

Depression is a common and serious mental health problem among IPV-affected women, leading to feelings of sadness and/or a loss of interest in activities, Changes in appetite, sleep disorders, poor concentration and/or suicidal ideations. The weighted mean prevalence of depression among battered women was reported as 47.6% (Golding, 1999). In addition, women with experiences of multiple forms of IPV (physical, sexual, and psychological) are at greater risk to develop depression symptoms (Martin et al., 2006). Research shows the current depressive symptomology among female victims of IPV modulate emotional dysregulation and personality traits such as suspiciousness, cognitive distortions and social avoidance (Torres et al., 2013).

Perceived stress, defined as "the degree to which situations in one’s life are appraised as stressful" is found to be a maintenance factor in PTSD and depression in female survivors of interpersonal violence (Hu, Koucky, Brown, Bruce, & Sheline, 2014). Further research indicated
that the investigation of "objective" factors such as the frequency of violence experiences, the number of perpetrators, or the duration of stressors mostly used to assess IPV and relevant health outcomes, does not render a thorough picture of symptom configurations and there is a need for IPV-related subjective appraisals to determine specific psychological problems. For instance, research showed women’s IPV stressfulness appraisals are linked to depressive symptoms over and above frequency and severity of IPV and women who report highly stressful IPV are more likely to demonstrate the comorbidity of depression and PTSD (Martinez-torteya et al., 2009).

In addition to the well-documented association between IPV and mental health problems categorized in Axis I of Diagnostic and Statistical Manual of Mental Disorders (DSM), there are a few studies that investigate the relationship between IPV experiences and personality disorders. IPV-related personality disorders is a sensitive topic, as there is a danger of victim-blaming approaches to IPV and count women's internal flaws as the cause of violence occurrence. However, previous research showed that IPV-affected women had higher scores than a non-abused control group, in the three pathological personality scales, i.e. schizotypal, borderline and paranoid. Scholars argued that IPV, specifically long-lasting threat and abuse, might facilitate developing specific psychopathological personality traits and put abused women at further risk of re-abuse (Pico-Alfonso, Echeburua, & Martinez, 2008). Further research also confirmed the high rates of comorbidity between PTSD and Borderline Personality Disorder (BPD) (Clarke, Rizvi, & Resick, 2008).

IPV not only increases the risk of developing physical and psychological symptoms, but also overwhelmingly affects daily functioning, work performance, and life satisfaction within abused women. A longitudinal study revealed that IPV-affected women, compared with women without IPV, were significantly more likely to show greater functional impairment and less life satisfaction at the 5-year follow-up (Zlotnick, Johnson, & Kohn, 2006). In addition, a diagnosis of PTSD among abused women further diminishes quality of life (such as social functioning, vitality and role limitations due to emotional problems) compared with abused women without a diagnosis of PTSD (Laffaye, Kennedy, & Stein, 2003).

1.6 Re-victimization

Repeated victimization or re-victimization by either the same partner or a new partner is the rule, not the exception in the context of interpersonal violence (Rodriguez-mené et al., 2014). According to the British crime survey, more than two-thirds of female victims of non-sexual IPV were re-victimized within a year (Walby & Allen, 2004). Several studies investigating contributors to IPV repetition resulted to a broad spectrum of risk factors. For instance, research shows that women with cumulative lifetime victimization and substance abuse are at greater risk of re-victimization by a new partner (Cole, Logan, & Shannon, 2008). Furthermore, childhood abuse is a well-documented risk factor for further abuse in future intimate relationships (Bender, Cook, & Kaslow, 2003). Dutton and colleagues (2005) reported that women with a certain IPV pattern containing high levels of physical violence, psychological abuse, and stalking, but low levels of
sexual violence were at higher risk of re-victimization during the last year. Further investigation of the role of victim-related variables in IPV re-victimization revealed that victim's avoidant attachment (including rejecting the partner or pushing him away) was a significant predictor of both physical and psychological IPV only when victims had high and average levels of anger. However, victim anger by itself did not show a main effect in predicting re-victimization. In addition, it was found that psychological abuse perpetrated by the victims was a significant predictor of either physical or psychological IPV victimization (Kuijpers, van der Knaap, & Winkel, 2012).

Although victim advocates might question the idea of centering research on contribution of survivors’ characteristics to re-victimization, due to fear of victim-blaming approaches to IPV, previous research argues that investigating victim vulnerabilities could improve intervention programs and empower women to seek help (Krause, Kaltman, Goodman, & Dutton, 2006). For instance, one study shows that victims' intrusion symptoms of PTSD predict IPV physical and psychological re-victimization. This study argues that IPV women with higher levels of intrusion are more likely to perpetrate psychological abuse themselves, which may put them at greater risk of receiving further violence (Kuijpers, Knaap, & Winkel, 2012). Moreover, the use of maladaptive mechanisms of numbing and avoidance associated with PTSD increase the risk of re-abuse (Krause, Kaltman, Goodman, & Dutton, 2008; Krause et al., 2006; Street, Gibson, & Holohan, 2005; Strigo et al., 2010).

To explain the dynamics between maladaptive coping skills and re-victimization, scholars argue that numbing would desensitize a victim to real danger and decrease the likelihood of identifying current threats and properly reacting to them (Krause et al., 2008, 2006; Street et al., 2005; Strigo et al., 2010). In addition, avoidance seemingly protects IPV-affected women against further abuse, specifically when they are currently living with the abuser. However, it simultaneously consolidates an abusive relationship, as an abuser might take advantage of the symptom and treat survivors' resignation as an opportunity to expand their control and domination.

1.7 IPV-related intervention programs

Although IPV is a worldwide public health issue, it is extremely context-specific. Several determinants such as socio-cultural, religious, economic-political, and health status factors contribute to dynamics, manifestations and consequences of IPV occurrences in each society. Therefore, medical, social and legal practitioners, and IPV researchers need to recognize the complexity and multidimensional nature of IPV, and address a variety of factors including socioeconomic status, mental health status, cultural settings, political agenda, and infrastructure in data analysis, policy making and intervention programs (Bonomi, Allen, & Holt, 2006; Oetzel & Duran, 2004).

Over recent decades, mental health approach to IPV has been highlighted and there have been growing efforts to produce and improve counselling, therapeutic and advocacy interventions for IPV victims/survivors around the world. Eckhardt and colleagues (2013) conducted a systematic
review of intervention programs for IPV perpetrators and survivor-victims, and found that contrary to the ambiguous results reported by batterer intervention studies on the reduction of the risk of re-abuse, counselling and therapeutic intervention programs for victim-survivors of IPV have shown promising results on the reduction of mental health effects of IPV, including PTSD and depressive symptoms. Higher levels of social support, quality of life, and self-esteem and lower levels of trauma-related guilt, and anxiety were also associated with intervention programs among IPV-affected women. Most victim intervention studies have not integrated the re-victimization outcome into assessment as it is not expected that change in the victim would lead to changes in an abuser's violent behavior. However, empowering IPV-affected women through intervention programs might cause them to acknowledge their basic human rights, resist violence, seek further help, and break vicious cycles of abuse.

Counselling and therapeutic interventions employ different approaches to ameliorate mental health effects of IPV. Eckhardt and colleagues, reviewing 31 victim intervention studies, concluded that Cognitive Behavioral Therapy (CBT) approaches for working with IPV survivors produced the most promising results. Among current CBT investigations for Victims of IPV, two programs are notable: Kubany and colleagues' (2004; 2003; 2002) Cognitive Trauma Therapy for Battered Women (CTT-BW) and Johnson and colleagues' (2011) Helping to Overcome PTSD through Empowerment (HOPE) program. The CTT-BW focuses on battered women who have ended their abusive relationship. The HOPE, in contrast, addresses the mental health needs of women currently in shelters. Both methods intend to manage symptoms of PTSD and its associated features.

Other victim-related intervention programs also revealed valuable results, mostly in terms of mental health improvements, including a culturally informed empowerment group for African American survivors of IPV (Kaslow et al., 2010), a crisis intervention model (Kim & Kim, 2001), forgiveness therapy (Reed & Enright, 2006), interpersonal therapy (Zlotnick, Cpezza, & Parker Donna, 2011), couple therapy (Karakurt, Whiting, van Esch, Bolen, & Calabrese, 2016), supportive counselling (Cruz, Cruz, Weirich, McGarty, & McColgan, 2013) and a feminist-oriented counselling and grief resolution counselling (Mancoske, Standifer, & Cauley, 1994). They contain a broad spectrum of theories and techniques targeting different aspects of victim vulnerabilities. However, there is a recent growing trend to employ trauma-based interventions and exposure therapies to improve mental health status of IPV victims.

1.7.1 Exposure-based therapeutic methods

The first-line psychological treatments for PTSD have been identified as Trauma-focused CBT and Eye Movement Desensitization and Reprocessing (EMDR). Although most studies reported similar efficacy for both of techniques as well as superiority over other therapies, there are some studies that suggest that CBT is more effective than EMDR. CBT-based techniques, including prolonged exposure, and cognitive restructuring, are the most frequently recommended therapies for dealing with symptoms of PTSD following various types of traumatic events. Education about
common reactions to trauma, relaxation training, and stress inoculation, imaginal reliving of traumatic memories and identification and modification of cognitive distortions are further required for CBT treatment. Research showed the most important change following CBT treatment for PTSD was the change in PTSD-related maladaptive cognitive distortions (Kar, 2011).

More specifically, prolonged exposure therapy (PE), a CBT-based treatment developed by Foa and Kozak in 1986, is the most well-established and thoroughly tested form of treatment for PTSD (Rauch, Eftekhari, & Ruzek, 2012). The PE protocol contains four main components, including psychoeducation, in vivo exposure, imaginal exposure, and emotional processing. PE is thought to work through habituation to fear structure, and emotional processing. However, recent evidence indicates that inhibitory learning, not fear habituation, is central to long-term extinction (Craske et al., 2008; Rauch et al., 2012). Fear habituation explanation held that to modify the fear structure throughout therapy sessions, it is necessary to activate fear structure via imaginative or in vivo exposure, and integrate new, realistic information about present conditions and past traumatic situation into the current fear structure. Repeated exposure to trauma-related stimuli through within- and between-session habituation reduce fear and help survivors to distinguish between the memory of trauma and the trauma itself, as well as helping them to separate the past from the present. This enables them to identify and repair the trauma-based dysfunctional cognitions, behaviors, and emotions and to adopt newer behaviors appropriate for their current life (Foa, 2011).

However, the inhibitory learning-based approach disregards 'fear reduction' as the primary goal of exposure therapy, and instead focuses on 'fear toleration', creation of non-threat associations, and enhancement of the accessibility and retrievability of the secondary learning over time and in different contexts. The inhibitory learning model of extinction learning proposes that the original CS-US association learned during a traumatic event cannot be erased, but rather is left intact. The therapeutic goal is to develop newly learned associations of CS-US, which give the CS an additional inhibitory meaning (CS-noUS) apart from the original excitatory meaning (CS-US). Therefore, the new, well-practiced pairings compete with the original excitatory associations and inhibit them from activation. In this approach, the so-called 'fear reduction' within exposure trials or in the final stage of therapy is not a prerequisite for extinction learning, instead maintaining elevated fear throughout exposure therapy is a technique that results in violations of excitatory expectancies and consolidates the therapeutic outcomes (Craske et al., 2008, 2014). In the end, psychoeducation about each step of the therapy and the nature of PTSD symptoms facilitates the procedure and motivates survivors to continue with their therapy.

Previous research has shown the significant impact of PE on the reduction of the psychological effects of single-incident traumas. Its effectiveness on populations with multiple-incident traumas, particularly child sexual abuse, have only relatively recently been included in PE therapeutic investigations (Rauch et al., 2012). Repetitive, prolonged exposure to traumatic events is a common phenomenon among traumatized people, specifically in the context of interpersonal violence. This raised questions about the applicability of the current definition of PTSD to people suffering from complex trauma. To bridge the gap, Herman (1992) introducing the concept of Complex PTSD, argued that the current diagnosis of PTSD does not distinguish
between single-incident traumas and multiple-incident traumas, particularly in the context of intimate relationships. However, PTSD-related intervention programs, above and beyond the tight frame of current diagnostic indices, have already differentiated between appropriate treatment materials assigned to each condition. According to current treatment guidelines for Complex PTSD (cPTSD), treatment of survivors of cPTSD includes three phases. In the initial stage, it is necessary to work on stabilization and safety by teaching emotion regulation, establishing a positive therapeutic relationship, and increasing understanding of the role that trauma plays in self-destructive behaviors. This first step lays the groundwork for a subsequent exposure therapy. This first phase is followed by trauma processing and re-integration (Myrick & Green, 2014). However, De Jongh and colleagues (2016) conducted a critical review of the current investigations on the so-called "three-phased approach" and concluded that there is no evidence that a phase-based approach results in greater health outcomes, in comparison to first-line trauma-focused treatments. They argue that the current treatment guidelines for individuals with cPTSD are too conservative and might deprive patients of conventional evidence-based trauma-focused treatments and postpone their potential health benefits. They recommend that trauma-focused therapies be routinely offered to people suffering from presentations of complex PTSD, consistent with current treatment guidelines for the diagnosis of PTSD.

Several treatments, such as exposure therapy (Stapleton, Taylor, & Asmundson, 2007), cognitive trauma therapy (Kubany et al., 2004; Kubany & Watson, 2002), Helping to Overcome PTSD through Empowerment (HOPE) (Johnson et al., 2011), Interpersonal therapy (IPT) (Condino, Tanzilli, Speranza, & Lingiardi, 2016) and group therapy for abused women (Schlee, Heyman, & O’learyi, 1998) have been focused on the reduction of PTSD among IPV-affected women. However, most of these studies targeted survivors of IPV, i.e. the abused women who managed to leave the abusive relationship, either through seeking refuge from shelters, or getting a divorce. Nevertheless, mental health needs of abused women who have not been able to successfully access legal/professional help and have had to continue living in the context of continuous threat and violence, have been neglected so far. Warshaw and colleagues (2013) questioned the usefulness of exposure-based treatments in the context of ongoing abuse and violence, arguing that PTSD-related mental health symptoms such as high arousal or avoidance are adaptive and rational responses that could avoid or minimize abuse and protect a woman from further violence. However, this idea fails to take into account the fact that PTSD-related reactions to ongoing violence increase the risk of re-victimization and consolidate the vicious cycle of domestic violence (Krause et al., 2008, 2006; Kuijpers, Knaap, et al., 2012). Furthermore, it also does not take into account the new findings that even in the cases of continuous traumas, victims of domestic violence, war and ongoing violence can significantly benefit from exposure-based treatments, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Murray, Cohen, & Mannarino, 2013) and Narrative Exposure Therapy (NET) (Hinsberger et al., 2017; Neuner et al., 2008).
1.7.2 Narrative Exposure Therapy (NET)

Narrative Exposure Therapy (NET) is an evidence-based brief psychological intervention initially developed for the treatment of symptoms of PTSD in survivors of war and torture. It was developed by a group of researchers based in the University of Konstanz and the University of Bielefeld (Schauer et al., 2011). There have been a number of NET trials administered across a full spectrum of socio-economic settings; in traumatized children and adults; on populations of refugees and asylum seekers; and on people who have been exposed to natural disasters, childhood abuse and other types of trauma and violence. NET has shown a significant reduction in PTSD symptoms across many different patient groups. These include both individuals with cumulative traumatic events across the life span and in those who have recently experienced traumatic events as well as in those with chronic PTSD. The effects, when compared to other treatment forms or control groups, have proven to be long-lasting, being measurable immediately after treatment, as well as at six-month and at one-year follow-ups (Bichescu, Neuner, Schauer, & Elbert, 2007; Catani et al., 2009; Neuner et al., 2008; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Schaal, Elbert, & Neuner, 2009; Stenmark, Catani, Neuner, Elbert, & Holen, 2013).

Frequent exposure to traumatic stressors creates an associatively linked network of fear-related responses, emotions, cognitions and physiological responses, that we call the ‘fear network’. This network is reactivated whenever the person is exposed to reminders of trauma, which activates a set of conditioned trauma-associated responses. These consist of avoidance, dissociation, and hyperarousal. In a normal situation, these trauma-associated response tendencies, which occur when exposed to danger or a traumatic experience, optimize the organism’s responses. However, with recurrent exposure to traumatic stress, the fear network can become so easily activated, that it becomes detached from contextual cues such as time and location of the danger. As a result of this overgeneralized activation, the traumatized person will not regard the traumatic event as a memory, but instead feels a presence of fear everywhere. This is when PTSD develops (Schauer et al., 2011). NET connects the traumatic memories, especially the implicit sensory, physiological, affective, and cognitive associative memories to their context (time and place where the event happened) through the construction of a detailed narrative of the event and its consequences. The therapist, therefore, requires the client, during therapy sessions, to talk in detail about the most emotionally arousing experiences. This includes positive as well as negative memories. The former function as an emotional resource during the difficult process of processing the negative traumatic events. Throughout the sessions, the power of the traumatic reminders to trigger strong emotional responses will gradually subside. The discussion of the traumatic events will continue until client’s emotional responses are subsided. NET therefore aims to transform the fragmented account of the traumatic experiences into a coherent narrative of the person’s entire life. That is, NET seeks to alter the trauma associative network/memory by reconnecting its components with the episodic memory, and thus reduce PTSD symptoms and their accompanying maladaptive coping mechanisms, such as avoidance, dissociation and numbing (Onyut et al., 2005).
Although NET is a specialized treatment for symptoms of PTSD, a number of studies have also shown the effectiveness of NET in the reduction of depression symptoms, the improvement of daily function and physical health (Bichescu et al., 2007; Halvorsen & Stenmark, 2010; Robjant & Fazel, 2010). One reason that depression symptoms can be reduced through NET is that depression is frequently a by-product of acute PTSD symptoms (Dutton et al., 2006), therefore, when the acute symptoms of PTSD are reduced, the symptoms of depression also subside. In addition, a significant factor in the reduction of depression symptoms through NET is the integration of traumatic memories into the more general context of autobiographical memory and the cognitive reorganization, which consequently gives the traumatic memories some meaning in the context of the individual's life. In fact, through integration of traumatic fragmented memories into the autobiographical memory, reprocessing of meaning changes self-concept, increases awareness of unhealthy patterns of coping, and helps the individual and therapist to address associated features such as shame and guilt. For instance, a battered woman or an abused child might lose trust in human nature and feel isolated, as she realizes that her most intimate relationship in life not only disregards her basic needs of care and affection, but also repeatedly hurt her. She might take on the whole responsibility for the abuse and consider herself worthless or guilty in order to protect the intimate relationship and make it meaningful. Reconstruction of the story of the traumatizing relationship within therapeutic sessions gives the survivor/victim a more realistic picture of each agent's responsibility, to recognize probable resources in her environment, and make a realistic meaning of the situation. Moreover, the reduction of the intense emotional and physiological responses to traumatic memories would also facilitate cognitive reorganization and re-evaluation of the event, and its meaning for the individual. For instance, a soldier who is no longer burdened with the flashbacks of seeing his comrade die, is now in a better position to think about his responsibility for the events leading to the other's death (Schauer et al., 2011).

The feasibility and efficacy of NET among the populations of women exposed to IPV has not yet been investigated. However, NET could potentially be beneficial for this group of traumatized people as its narrative aspect is helpful for an individual's sense of agency. What this means is that NET encourages the individual to narrate the events in their own words thereby enabling them to make personal sense of the event (Semmler & Williams, 2000). In this regard, Baird (1996) suggests that one of the primary needs of victims of all severe and long-term violence, is to regain the sense of control over their lives. In addition, because NET considers not only single-incident trauma, but many different types of life events, either traumatic, stressful, or empowering experiences, it is well-suited to the complex, long-standing nature of domestic violence. Moreover, previous research showed that exposure-based treatments, such as NET, are highly successful in reducing symptoms of avoidance and numbing, the two maladaptive mechanisms thought to be responsible for re-victimization (Krause et al., 2008). A further study on the relationship of alexithymia and PTSD, in women exposed to domestic violence has shown a high degree of correlation between high symptoms of PTSD in these women and difficulty in expressing feelings and emotions, which is one aspect of alexithymia (Dąbkowska, 2007). Finally, one recent qualitative study conducted by Volpe and colleagues (Volpe, Quinn, Resch, Douglas, & Cerulli, 2016) demonstrated the feasibility and acceptability of NET among pregnant, adolescent mothers who were at risk of developing PTSD and depression, and concluded that both adolescents and service providers agreed on the benefits of NET implementation. Therefore, NET is likely to be a
suitable treatment method, as it is primarily based on frequent exposure to traumatic memories and verbalizing them through a coherent narrative of the individual’s life since birth.

Finally, IPV has social and cultural aspects as well as psychological ones. In some countries, violence often presents the only way to cope with unsolved problems, as it is accepted by the society. Therefore, an awareness raising process has to be initiated. The testimonial part of NET enables IPV-affected women to tell their stories, which not only helps them psychologically, but also increases the public awareness and responsibility for implementing social and cultural changes in dealing with violence within families.

1.8 The rationale of the present thesis

The author believes that the current thesis is of importance for several reasons. First, female victims of IPV are one of the most vulnerable social groups, particularly women who are living in a context of ongoing threat and violence. This problem is even more severe in the patriarchal societies of the Middle East. Second, psychological treatment could ameliorate IPV-related mental health effects, and decrease the risk of re-abuse by correcting maladaptive coping mechanisms. In addition, the treatment of pathological symptoms of IPV might have significant effects on the whole family. With the improvement of the abused women in the family, their children might be less exposed to domestic violence and themselves less vulnerable to attack. Many studies have shown that children who have experienced or witnessed domestic violence are more likely to engage in violent relationships with their spouse or children in future. Therapeutic interventions in abused women can, therefore, prevent the development of a vicious cycle in predisposed families (Catani et al., 2009). Third, a successful therapeutic intervention together with research on domestic violence can increase public awareness of violence within families and encourage social action on this problem within society. Finally, this can test whether NET can be extended beyond its conventional boundaries, from victims of war and torture, to victims of IPV in different cultures and settings.

With this rationale in mind, the current project aimed to firstly examine socio-demographics and psychological characteristics of female victims of IPV living under ongoing stress and trauma exposure in the Middle East. This is presented in the first article. Second, it investigates the efficacy of NET in reducing PTSD and other mental health symptoms in a sample of Iranian women with exposure to continuous IPV, and explores whether psychotherapy in general, and NET in particular, significantly reduces IPV experiences presented by abused women living under ongoing threat and violence. The design and procedure to accomplish the second goal and the consequent results are presented in the second article. In the third article of the thesis, the qualitative analysis of the traumatic events recounted by these women, the exploration of the potential patterns in their life stories, and history of abuse would increase the current knowledge of female victims of IPV. Finally, in the last section of the thesis, all findings of the three articles are discussed and general conclusions and implications for the future research and clinical practice are presented.
2 Trauma-Related Suffering in Women Exposed to Continuous Intimate Partner Violence in Tehran, Iran

2.1 Abstract

**Background:** The current study investigates the specific characteristics of abused women suffering from Post-Traumatic Stress Disorder (PTSD) and living under ongoing Intimate Partner Violence (IPV). It explores whether additional lifetime traumatic events and childhood adversities contributes to the development of IPV-related PTSD within this group.

**Methods:** Forty-seven IPV-affected women with a diagnosis of PTSD were interviewed assessing the symptoms of depression and perceived stress, the experiences of childhood adversities and lifetime traumatic events, and the impairment of everyday functioning.

**Results:** The general linear model analysis revealed that the main predictor for the current PTSD score was IPV experiences in the last year. Further analyses sketched a portrait of specific characteristics of this group.

**Conclusion:** The present study proposed that abused women live in a dangerous familial environment might have a different demographical and psychopathological profile than abused women who are able to receive help from shelters and victim agencies.

**Keywords:** Intimate Partner Violence (IPV), ongoing threat and violence, continuous trauma and violence, domestic violence, Post Traumatic Stress Disorder (PTSD)
2.2 Introduction

Intimate Partner Violence (IPV) is a serious threat to women’s mental health and violates human rights on a global scale. Driven and amplified by cultural mechanisms, its frequency varies locally (Devries et al., 2013). According to a study by the World Health Organization (World Health Organization, 2013), which was conducted in 79 countries and two territories, the global prevalence of physical and/or sexual intimate partner violence reached 30%, showing the highest prevalence in the African, Eastern Mediterranean and South-East Asia regions, with 37%. Less is known about IPV in the Middle East, where some studies indicate that figures on IPV are substantially higher (Boy & Kulczycki, 2008). For instance, the prevalence of IPV in Turkey was reported to be about 78%, lifetime IPV experienced by women living in Erbil city of Iraq was 59% and a study in 28 provincial capitals of Iran showed that the overall prevalence of IPV during marriage was 66% and at least 30% of respondents experienced one act of serious physical injury during the course of marriage (Al-atrushi et al., 2013; Al-nsour et al., 2009; Guvenc et al., 2014; Vameghi et al., 2013).

Post-traumatic Stress Disorder (PTSD), caused by exposure to multiple traumatic stressors, is the most frequently investigated IPV outcome. Research shows that psychological abuse, beyond physical violence, has an even larger contribution to the prediction of PTSD symptoms, pain and poorer physical health (Arias & Pape, 1999; Dutton et al., 2006; Mechanic et al., 2008; Pico-alfonso, 2005). A meta-analysis revealed that weighted mean prevalence of PTSD among victims of IPV amounts to 64% and IPV-affected women’s level of daily functioning is more impaired if they present with PTSD (Golding, 1999; Laffaye et al., 2003). Studies consistently show that the greater the cumulative exposure to threat and violence, the greater the likelihood of developing PTSD (Schauer et al., 2003; Wilker et al., 2015). Depression, which frequently co-occurs with PTSD, is another serious mental health consequence of IPV (Chandra et al., 2009; Coker et al., 2005; Golding, 1999). Furthermore, perceived stress was regarded as a maintenance factor for PTSD and depression within IPV-affected women (Hu et al., 2014).

Recent growing research on community-based samples shows that the rate of IPV-affected women suffering from moderate-to-severe PTSD is around 24% (Coker et al., 2005). Although previous studies showed that a cessation of IPV significantly decreases the severity of IPV-related PTSD, studies conducted on community-based samples of IPV-affected women do not specifically distinguish whether the women separated from the abuser, abuse stopped some point in the past or it is still ongoing (Coker et al., 2005). Research shows that IPV-affected women currently living with an intimate abuser are less willing to participate in IPV surveys while in their homes due to safety concerns (Ranney et al., 2012). They are unable to report abuse for various reasons such as fear, hope for change in one’s partner, financial concerns, lack of alternatives, cultural factors, and pressure from their social network (Hughes & Jones, 2000). The situation might be more complicated in low-to-middle-income countries in the Middle East due to the fact that different cultural/religious values and sociopolitical structures affect the definition of IPV, the tolerance of violence, subsequent mental health outcomes, help-seeking behavior and available resources (Mookerjee et al., 2015; Overstreet & Quinn, 2013; White & Satyen, 2015). Thus, more studies are needed to explore the specific characteristics of female victims suffering from IPV-related
PTSD and living under continuous domestic violence in low-to-middle-income countries, especially of the Middle East, to better understand the mechanism and consequences of IPV.

Although the impact of IPV on PTSD has been well documented, other lifetime traumatic experiences, such as childhood abuse, add to the vulnerability and increase the risk of mental illness (Nandi, Crombach, Bambonye, Elbert, & Weierstall, 2015). Research shows that childhood abuse is a common risk factor for IPV in various populations, and victims of IPV are more likely to be poly-victimized by non-, ex-, and current partners than the general population (Pico-Alfonso et al., 2006; Rodriguez-menés et al., 2014; Seedat et al., 2005). Beyond childhood abuse, studies examining the impact of IPV experiences on the development of IPV-related PTSD rarely factor in the influence of additional traumatic experiences, such as the sudden loss of loved ones, accidents, natural disasters, life-threatening illnesses, and war experiences. There is only one recent study of Graham-Bermann and colleagues (2011) that investigates the impact of additional adverse events among victims of IPV in the development of PTSD. The results of this study demonstrate that 86% of study participants who suffered from IPV experienced more than two other types of adverse events (e.g. life-threatening illness, torture or sexual misconduct as a minor) in addition to IPV in their lifetime. Furthermore, the results revealed that IPV-affected women with a history of additional adverse events experienced approximately twice as many avoidance and physiological arousal symptoms as women only exposed to IPV and that after controlling the experience of IPV, number of adverse life events significantly predict PTSD total score and its subscales. However, only 8% of participants in Graham-Bermann’s study were living with a violent partner at the time of the interview. The present study aims to expand the current knowledge of IPV victimization by assessing the characteristics of women living under continuous threat and violence.

In sum, there is a high prevalence of violence reported by female victims of IPV in the Middle East, which makes a major contribution to PTSD prevalence. Of the women with PTSD, there is a lack of knowledge about the full spectrum of potential causes. The contribution of lifetime traumatic events, plus IPV, and child abuse, and their interaction needs to be examined. The present study seeks to extend the prior knowledge of IPV-related PTSD and aims to investigate a) the socio-demographic characteristics of Iranian women with PTSD and continuous exposure to IPV, b) the relations between outcome variables for IPV-affected women with PTSD living under ongoing threat and violence, and c) the contribution of lifetime traumatic events and violence experiences to the development of PTSD.

2.3 Methods

2.3.1 Procedure

Iran does not provide easy access to institutionalized shelter facilities or victim agencies for female victims of domestic violence. Therefore, participants were recruited through distribution of flyers in health centers, local community centers, community support centers for the families of addicts,
day clinics, police stations, websites, and social networking services and by referrals of those places. Diagnostic interviews took place in private rooms at a variety of locations such as health centers, community local centers, day clinics, and private institutions across Tehran. Interviews were conducted by one psychologist (a female master’s level graduate) having received training in clinical diagnosis using structured interviews and being supervised by one experienced clinical psychologist (PhD) with international experience in traumatic stress studies and treatment.

2.3.2 Subjects

A sample of 47 IPV-affected women were recruited between 2013 and 2015 in Tehran, Iran. Inclusion criteria consisted of experiences of IPV over the past year or lifetime, the diagnosis of PTSD with a minimum score of 15 on the PSS-I, an age between 16 and 60 years, and participants had to be living currently with the violent partner at the time of the interview. None of the participants suffered from schizophrenia, epilepsy, mental retardation or substance abuse. Informed written consent was obtained from each participant. The religion of all participants was Islam. All participants, apart from two who migrated from Afghanistan, were from Iran and had been living in Iran for more than 10 years. Table 2.1 shows participants’ status in terms of age, duration of marriage, education as well as other demographic variables.

By financial independency mentioned in table 1, we refer to participants’ ability to meet their daily life needs such as finding food and clothing on their own. “Mental health visit” means that the
participants have visited a counselor, psychologist or psychiatrist at least once during their marital life. Both “physical health medicine” and “mental health medicine” refer to taking medicine for their physical or psychological symptoms at the time of interview. Moreover, the cut-off point for household income per month is 1,000,000 Iranian Rial (approximately 285 USD).

2.3.3 Instruments

Persian language versions of all instruments were provided using translation and blind back translation. Moreover, all instruments were conducted as structured interviews.

Functional and Mental Health Status Measures

Following the sociodemographic questionnaire, interview format of Posttraumatic Diagnostic Scale (PSS-I) was used to assess all DSM-IV criteria of PTSD experienced within the four weeks preceding the interview, including information about the nature of the traumatic event, the level of functional interference and three PTSD sub-scales of re-experience, avoidance, and arousal symptoms. The PDS/PSS-I is a 17-item screening instrument on a 4-point-Likert-scale (0 = not at all to 3 = very much). The PSS-I has demonstrated satisfactory test-retest reliability, internal consistency, and convergent and concurrent validity (Ertl et al., 2010; Foa, Cashman, Jaycox, & Perry, 1997; Griffin, Uhlmansiek, Resick, & Mechanic, 2004). The Patient Health Questionnaire (PHQ-9) was used to evaluate depression symptoms within the two weeks preceding the interview. PHQ-9 scores each of the 9 DSM-IV criteria as “0” (not at all) to “3” (nearly every day). The PHQ-9 has been well validated in different studies (Spitzer, Kroenke, & Williams, 1999). Perceived Stress Scale (PSS-4) was employed to measure the degree to which situations in woman’s life are appraised as stressful, as well as how unpredictable, uncontrollable, and overloaded participants find their lives over the course of the last month preceding the interview. Participants rate each of the 4 items on a 5-point-Likert-scale between 0 (never) and 4 (very often). The PSS-4 was found to have the same reliability and validity as the PSS-14 and PSS-10 and is widely used in different settings (Karam et al., 2012; Leung, Lam, & Chan, 2010; Örcüt & Demir, 2009; Roberti, Harrington, & Storch, 2006). To evaluate impairment of daily life functioning, The Work and Social Adjustment Scale (WSAS) was used. WSAS contains 5 items and is ranged on a 0 to 8 scale; 0 indicating no impairment at all and 8 indicating very severe impairment. The WSAS psychometric properties were analyzed and demonstrated in different studies and disorders (Mataix-cols et al., 2005; Mundt, Marks, Shear, & Greist, 2002).

Violence Experiences and Traumatic Events Measures

Composite Abuse Scale (CAS), a 30-item well validated research instrument, was used to estimate the frequency of IPV experiences reported by abused women (Hegarty, Bush, & Sheehan, 2005). The CAS with a four sub-scales of Severe Combined Abuse, Emotional Abuse, Physical
Abuse, and Harassment, scales from 0 (never) to 5 (daily) over a period of 12-months. The CAS score is the sum of the 30 items; a score of 7 or higher is the criterion for exposure to IPV. We conducted the CAS twice, first for IPV-related events that happened during the twelve months preceding the interview (scored as “last year” or “recent”), and second for those that happened more than 12 months prior to the interview, especially when IPV was at its worst (scored as “past”). To screen for potentially traumatic events in a respondent's lifetime, The Life Events Checklist (LEC), a brief 17-item measure, was conducted. For each item, the respondent checks whether the event (a) happened to them, (b) was witnessed by them, (c) does not apply. The LEC has demonstrated adequate psychometric properties as an assessment of traumatic exposure (Gray, Litz, Hsu, & Lombardo, 2004). In addition, childhood adversity (within first 18 years of life) was measured using Modified Adverse Childhood Experiences (short MACE-I). The MACE, with 40 yes/no items, estimates the occurrence of neglect or/and physical, emotional and sexual abuse by family members or strangers, witnessing of interparental violence, witnessing of violence to siblings, peer violence and partner violence during childhood. Two studies so far showed its validity for detailed assessment of childhood adversities (Isele et al., 2014; Teicher & Parigger, 2015).

2.3.4 Statistical analyses

Descriptive data were expressed as frequencies (%), mean scores, and standard deviations. Socio-demographic variables were explored using Welch’s t-test and Fisher’s Exact test, to identify whether specific socio-demographics were associated with higher risks of experiencing violence and trauma exposure or developing mental health symptoms. Pearson and Spearman’s rho tests were used to demonstrate a) correlations between recent IPV and PTSD score and their sub-scales, and b) associations between recent IPV, other forms of violence experience and trauma exposure and relevant current mental health status. A general linear model was conducted to investigate the relationship among the recent IPV, child abuse and lifetime traumatic exposure and PTSD symptomology. The predictors were entered in two blocks. Block 1: recent IPV, block 2: recent IPV, childhood abuse, and lifetime traumatic exposure. The dependent variable was the total score of PTSD.

2.4 Results

2.4.1 Socio-demographics and IPV

All participants reported IPV incidents over the past year ranged from 9 to 96 (M= 44.14, SD=19.30). Of these, 25 women (53%) reported sexual abuse by their husband, 45 women (96%) were exposed to severe combined abuse, 38 women (81%) were beaten, slapped, shoved, or
experienced other types of physical abuse, and 32 women (68%) suffered from harassment during the last year. All participants were exposed to psychological abuse over the last year.

Marriage duration had a significant negative correlation with the last year IPV ($r=-.31$, $p<.05$) and the severity of IPV has decreased during the course of marriage; i.e. women reported having experienced more IPV in the past ($M=50.25$, $SE=2.63$) than IPV in the last year ($M=44.14$, $SE=2.81$), ($t(46)=-2.61$, $p<0.05$); specifically, the severity of physical abuse ($Mdn=11$) and harassment ($Mdn=3$) in the past was significantly higher than the severity of physical abuse ($Mdn=7$), ($z=-4.05$, $p<0.01$) and harassment ($Mdn=2$), ($z=-2.13$, $p<0.05$) during the last year. There was no significant change in psychological abuse and severe combined abuse during the course of marriage.

There were also no significant differences between IPV-affected women regarding educational level, financial independency, monthly income, physical health, spouses’ job and education status.

2.4.2 PTSD and the history of violence and trauma

Almost all participants (96%) reported at least one type of childhood abuse. Among those women, childhood sexual abuse (49%), as well as psychological (83%) and physical (60%) abuse by parents, witnessing physical violence among parents (40%), emotional (85%) and physical (57%) neglect, and witnessing violence against siblings (68%) were experienced. There was no significant relationship either between childhood abuse experiences and recent IPV ($r_s=.03$, $p=.79$), or between childhood abuse and past IPV ($r_s=.005$, $p=.97$). There was no significant relationship between childhood abuse and outcome measures, i.e. PTSD, depression, perceived stress and functioning impairment.

Regarding the Traumatic Event Checklist (LEC), all participants reported at least four life-threatening events. Nearly all participants reported at least one experience of interpersonal traumatic violence (98%), and violent and/or sudden death of someone close (91.5%). Out of all participants, 81% reported at least one experienced or witnessed sexual trauma. Natural disasters (25.5%), life threatening illness or injury (51%), war experiences (47%), and accidents (66%) were also listed. Regarding PTSD sub-scale means, avoidance was the most prevalent and intrusion was the least common sub-symptom. We did find a significant relationship between childhood abuse and the types of lifetime traumatic events ($r_s=.52$, $p<.01$). There was no significant relationship between types of lifetime traumatic events and recent IPV or mental health outcome measures. Table 3 shows the correlation between lifetime traumatic events, recent IPV and current mental health status.
2.4.3 Socio-demographics and current mental health status

Regarding the socio-demographic variables, we did not find any significant differences, except for PTSD and depression; a) women married at the age of 18 or older at their first marriage had higher PTSD symptoms (M= 27.45, SD= 5.53), Welch’s t-test (1, 22.875) = 8.06, p<0.01) and higher depression symptoms (M= 15.51, SD= 4.1, Welch’s t-test (1, 28.084) = 4.44, p<0.05) than those who married under the age of 18 (PTSD; M= 22.14, SD= 5.99, depression; M= 13, SD= 3.57), b) women who took psychopharmaceutical drugs had higher PTSD symptoms (M=28.78, SD= 6.33), (Welch’s t test (1, 22.324) = 4.47, p<0.05) than those who did not use any medication (M=24.63, SD= 5.68), and c) women who did not have drug addicted spouses had higher depression scores (M=16, SD= 3.52), (Welch’s t test (1, 42.557) = 4.80, p<0.05) than those who did (M= 13.47, SD=4.30).

In addition, 85% of women married at the age of 18 or older had high school or university certificates, compared to only 36% of women who married under the age of 18 (Fisher’s Exact test X² (1) =11.34, p<.01). Further, 33% of women married at the age of 18 or older identified themselves as financially independent, while only 7% of women who married under the age of 18 did so. However, this result was not significant (Fisher's Exact test X² (1) = 3.54, p=.07).

There were no significant differences in PSS and WSAS values regarding socio-demographics.

2.4.4 The profile of IPV-related PTSD and current mental health status

Separated Pearson and Spearman rho’ correlation analyses were performed between a) pairs of PTSD subscales and IPV sub-scales and b) IPV and current mental health status, and results are illustrated in table 2.2 and 2.3 respectively. Furthermore, Figures 2.1 and 2.2 demonstrate relationship between the frequencies of IPV experiences in the last year and in the past years and PTSD sum score or daily functioning impairment respectively.
Figure 2. 1: Relationship between frequency of IPV occurrences in the last year (x-axis), frequency of IPV occurrences in previous years (y-axis), and PTSD symptom severity (colour bar). Greater exposure to IPV in the last year and in the past years, was related to higher PTSD symptom severity. High IPV experiences in the last year are individually associated with severe symptoms of PTSD.

Figure 2. 2: Relationship between frequency of IPV occurrences in the last year (x-axis), frequency of IPV occurrences in previous years (y-axis), and daily functioning impairment (colour bar). Dysfunctionality of everyday life mostly increases alongside the frequent exposure to IPV in both the previous year and in earlier years. Severely impaired daily functioning could also occur in the context of exposure to moderate IPV.
2.4.5 Testing the impact of multiple traumatic experiences on the development of PTSD symptomology

To test if multiple traumatic and violence experiences have an impact on the development of PTSD symptomology, we performed General linear model in which PTSD symptomology was regressed on IPV, childhood abuse, and lifetime traumatic experiences, including all two-way interactions. The model revealed that there was a significant main effect of IPV in the last year on PTSD symptomology ($F(3, 43) = 4.45, p<.01$, Adjusted R Squared=.18), while controlling for the effect of childhood abuse and lifetime traumatic events. In this model, childhood abuse ($B= .63, p=.52$) and lifetime traumatic events ($B= -.27, p=.78$) were not significant predictors of PTSD score variance, but IPV ($B= 2.95, p<.01$) was the strongest predictor. There was no significant interaction effect between IPV, childhood abuse and lifetime traumatic experiences on the development of PTSD symptomology. Table 2.4 shows the relevant unstandardized and standardized coefficients and the models' level of significance.
Table 2. 4: Unstandardized and Standardized Coefficients

<table>
<thead>
<tr>
<th>Step 1</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>25.88</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>Recent IPV</td>
<td>2.93</td>
<td>.80</td>
<td>.48**</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>25.88</td>
<td>.80</td>
<td></td>
</tr>
<tr>
<td>Recent IPV</td>
<td>2.95</td>
<td>.84</td>
<td>.48**</td>
</tr>
<tr>
<td>Childhood abuse</td>
<td>.63</td>
<td>.96</td>
<td>.10</td>
</tr>
<tr>
<td>Lifetime traumatic experiences</td>
<td>-.27</td>
<td>.98</td>
<td>-.04</td>
</tr>
</tbody>
</table>

Note: adjusted $R^2 = .21$ for step 1, adjusted $R^2 = .18$ for step 2. ** p<.01

2.5 Discussion

The purpose of the present study was to investigate IPV in relation to socio-demographics and mental health outcomes among women with a varying degree of exposure to continuous IPV. Furthermore, we sought to determine the extent to which additional lifetime traumatic experiences and childhood abuse contribute to the development of IPV-related PTSD. Consistent with Pico-Alfonso’s study (Pico-Alfonso, 2005), and in contrast to Graham-Bermann and colleagues’ findings (2011), the main predictor for the current PTSD score was IPV. To explain the different results, we could consider the specific characteristics of each sample. All participants in our study and nearly half of the abused women in Pico-Alfonso’s study were living with a violent partner and were continuously exposed to violence. Thus, their main complaint was IPV. By contrast, only 8% of participants in Graham-Bermann’s study were living with a violent partner. Therefore, abused women who are living in a context of continuous violence might show a subtly different pathological profile compared with IPV women who succeed in leaving the violent environment. However, we should mention that due to the inclusion criteria, all participants of the present study had a PTSD diagnosis with a minimum score of 15. As a result, the range of PTSD sum score was between 15 and 37. Our data were thus susceptible to PTSD variance restriction, which might affect the apparent contribution of additional lifetime traumatic events to the development of PTSD symptoms.

Moreover, inconsistent with previous research (Costa et al., 2015; McMahon et al., 2015; Seedat et al., 2005; Weber et al., 2008; Widom, Czaja, & Dutton, 2014), we did not find any significant relationship between childhood abuse and IPV, or any significant effect of childhood abuse on the women’s mental health. This might reflect an underestimated reporting of childhood abuse. The women might have been more preoccupied with the urgent threat of violence and lack of access to legal and social support, and thus perceive the family of origin as an informal resource than a source of violence and trauma.

Regarding the demographics, we found that women who married at the age of 18 or older had higher PTSD and depression symptoms plus higher education levels than those married under the age of 18. This finding echoes previous research showing that socially empowered women are more likely to be vulnerable to IPV. One explanation could be that their high status contradicts...
cultural norms of patriarchal societies and thus could elevate their suffering (Moghaddam Hosseini et al., 2013).

Further, we found that women who took psychopharmaceutical drugs had higher PTSD symptoms than those who did not. In line with Johnson and Leone's study (Johnson & Leone, 2005), which showed that victims of intimate terrorism are more likely than women in nonviolent relationships to use psychopharmaceutical drugs, we could argue that going to a medical doctor and taking medicine might be explained as general help-seeking behavior. Leone, Johnson, & Cohen (Leone, Johnson, & Cohan, 2007) showed that IPV-affected women, particularly victims of intimate terrorism, are more likely to seek help from social institutions such as police, shelters, and hospitals. However, in a context of little social and legal support and lack of knowledge and sensitivity about IPV and its mental and physical health consequences within the medical community, the more obvious, accessible and socially accepted resource for abused women could be medication.

Another result revealed by the demographic analysis is that women who did not have a drug-addicted spouse reported higher depression scores than those who had. There is considerable empirical evidence that alcohol and drug use often precede and accompany domestic violence (Capaldi et al., 2012; Cunradi, Caetano, & Schafer, 2002). Insofar as women perceive this as a cause and effect relationship, they could be shielded from developing depression, as the violence has a cause and a meaning. In contrast, women whose husbands were not addicted could not use such an excuse and thus, they might see violence meaningless, which make them more vulnerable to depression.

The present study shows that the severity of IPV decreases during the course of marriage, which is in line with several studies (Agcay et al., 2015; Capaldi et al., 2012; Ghahari et al., 2008; Wusu, 2015). This reduction does not mean that the marriage has improved, since the amount of psychological abuse and severe combined abuse has not significantly changed. Young age, associated more with fertility, might provoke male partners to viciously guard existing mates to prevent defection (Duntley & Buss, 2012). However, the mechanism of control and abuse might change during the course of marriage, as fertility is not a matter of great concern at older age.

Finally, the present study supported the fact that psychological abuse as well as physical abuse is significantly associated with PTSD sub-scales. This finding is consistent with studies of Pico-Alfonso and colleagues (Pico-Alfonso et al., 2006) and Coker and colleagues (Coker et al., 2005), emphasizing that psychological abuse has an important role in developing PTSD symptoms, and even in our study, IPV-affected women were more agitated in the presence of psychological abuse, than by other kinds of violence. Moreover, our findings are in line with Laffaye and colleagues (Laffaye et al., 2003) showing a strong relationship between PTSD and daily functioning impairment.

A limitation of the present study is the restriction of PTSD variance, i.e. due to the primary study’s inclusion criteria, all participants who did not receive a PTSD diagnosis and scored less than 15 were excluded. Moreover, a lack of comparison group such as non-abused women or
abused women in shelters meant that we cannot clearly distinguish women with exposure to continuous IPV from other populations.

2.6 Conclusion

The present study highlights that abused women who are currently exposed to IPV and have to live in a dangerous familial environment might have a different psychopathological profile than abused women who are able to receive help from shelters and victim agencies. This underlines the need for further research on the specific characteristics of this group and political, social and cultural barriers that might prevent them from seeking help, especially in less developed countries.

2.7 Acknowledgement

We sincerely thank Dr. Maryam Rasoulian for providing us the ethical permission of the present study.
3 The Efficacy of Narrative Exposure Therapy (NET) in a Sample of Iranian Women Exposed to Ongoing Intimate Partner Violence (IPV) - A Randomized Controlled Trial-

3.1 Abstract

**Background:** The mental health needs of IPV-affected women living under continuous threat and violence are currently not well understood. The present study investigates the feasibility and efficacy of Narrative Exposure Therapy (NET), compared with commonly used counselling (treatment-as-usual, TAU), in a group of currently abused women in Tehran, Iran.

**Methods:** 45 IPV-affected women with a diagnosis of Post-traumatic Stress Disorder (PTSD) were randomized to 10 to 12 sessions of either NET (n=24) or TAU (n=21). Primary outcome measures, including PTSD, depression and Perceived Stress symptoms were examined at pre-treatment and 3- and 6-month follow-ups. Intimate partner violence experiences, general lifetime traumatic events, childhood adversities, borderline symptoms, and daily functioning impairment were also inspected.

**Results:** NET participants showed a significantly greater symptom reduction in comparison with the TAU group in PTSD, depression, and perceived stress at both follow-ups. Improvement in daily functioning and reduction of IPV experiences and borderline symptoms at 3- and 6-month follow-up were pronounced but not significantly different between the two treatment groups.

**Conclusion:** IPV-affected women living under continuous threat and violence would benefit from trauma-focused interventions such as Narrative Exposure Therapy (NET).

**Keywords:** narrative exposure therapy, intimate partner violence, domestic violence, continuous traumatic stress, ongoing threat and violence, posttraumatic stress disorder
3.2 Introduction

Intimate Partner Violence (IPV) violates human rights and poses a serious threat to mental health. When IPV is continuous and severe, Post-Traumatic Stress Disorder (PTSD) and depression are frequent consequences. Treating the damage inflicted by IPV is a challenging task, particularly when abused women live under continuous and ongoing threat and violence without an easy way to escape from the abusive relationship and without possibilities to seek formal support. In low-to middle-income countries, cultural settings, gender inequality, and lack of resources deprive abused women of professional support (Paul, 2016; Rowan et al., 2015; Umubyeyi et al., 2016). Even when social support and the possibility of legal action is available, as is the case in some high-income countries, women often remain unable to seek the professional help they need (Henning & Klesges, 2002; Hyman, Forte, Du Mont, Romans, & Cohen, 2009). Most will stay in the abusive relationship even when troubled by adverse physical and mental health consequences. Reasons cited by these women include preserving their relationship and protecting their partners from criminal prosecution, external barriers such as financial concerns, lack of alternatives, cultural factors, pressure from their social network, lack of legal and social support, abusive partner control tactics, or depletion of psychological resources necessary for decision making due to IPV-related mental health problems (Arias & Pape, 1999; Fugate Leslie Landis et al., 2005; Hughes & Jones, 2000; Mookerjee et al., 2015; Overstreet & Quinn, 2013; Rodríguez, Valentine, Son, & Marjani, 2010; Rolling & Brosi, 2010). Thus, assistance to those who suffer from IPV has to account for the likelihood that the woman will remain in the abusive relationship. The goal of assistance is to restore mental health of the women living in these situations. Doing this can have multiple positive outcomes. Firstly it diminishes the mental damage of violent behavior, secondly, it is possible that it could change the dynamic of the abusive relationship, minimizing or even eliminating further violence. The current study aimed to investigate the efficacy of Narrative Exposure Therapy (NET) in reducing mental health symptoms and in particular PTSD in a sample of married women living under continuous and ongoing violence and threat to bodily integrity and fitness. We were interested not only in the therapy’s direct reduction of clinical symptoms, but also the broader follow-on effects in the women’s domestic lives.

It is estimated that 1 out of 3 women worldwide suffer from physical and/or sexual IPV, with considerably higher rates in some regions (WHO, 2013). For instance, the overall prevalence of IPV during marriage in Iran is estimated to be 66%; and 30% of those respondents experienced at least one act of serious physical violence in the course of their marriage (Vameghi et al., 2013). Abused women often experience multiple types of IPV simultaneously.

PTSD appears to be the most detrimental consequence of IPV (Dutton et al., 2006). Depression, which frequently co-occurs with PTSD, is not only regarded as a primary reaction to trauma exposure but also as a consequence of PTSD (Golding, 1999; Lipsky et al., 2005; Martínez-torteya et al., 2009). Perceived stress was regarded as a maintenance factor in PTSD and depression among female survivors of interpersonal violence (Hu et al., 2014). Moreover, research showed that IPV-affected women, compared with non-abused women, are more likely to suffer symptoms of personality disorder, such as borderline symptoms (Clarke et al., 2008; Pico-Alfonso et al., 2008). In addition, women who suffered IPV and had a diagnosis of PTSD were more impaired
on physical and social functioning than IPV-affected women without PTSD (Laffaye et al., 2003). Previous research has shown that women with IPV-related PTSD employ maladaptive coping mechanisms such as avoidance and numbing which in turn increase the risk of re-victimization over time. Furthermore, IPV-affected women with higher levels of intrusion symptoms are more likely to perpetrate psychological IPV themselves, which in return might put them at greater risk of re-victimization (Kuijpers, Knaap, et al., 2012). Therefore, addressing PTSD symptoms in the treatment of abused women might not only improve overall health, but also reduce the risk of re-victimization. However, there is an apparent lack of randomized control trial interventions investigating the efficacy of therapeutic interventions in reduction of IPV experiences (Condino et al., 2016).

Most of the treatment studies with IPV-affected women were conducted in abused women living in domestic violence shelters and related institutions (Condino et al., 2016; Johnson et al., 2011; Kim & Kim, 2001), or in women who were not in an abusive relationship and who were living in safety at the time that they were receiving treatment (Crespo & Arinero, 2010; Iverson et al., 2011; Kubany et al., 2004; Reed & Enright, 2006). Nevertheless, women living in a situation of continuous abuse and violence are also in the need of professional psychological treatment. Consequently, the current study aimed to investigate the efficacy of NET as a treatment for reducing IPV-related mental health problems among married women living under continuous threat and violence.

NET is an evidence-based, short-term treatment designed to address repercussions of exposure to accumulative and multiple types of trauma, mostly among victims of war and torture (Schauer et al., 2011). A number of studies have shown the efficacy and feasibility of NET in the reduction of PTSD symptoms and depression and improvement in daily function and physical health. This was found in both unstable, unsafe living conditions with continuous threat as well as safe settings in high-income countries (Neuner et al., 2008, 2004; Schauer et al., 2011; Stenmark et al., 2013). However, there has been no treatment study to specifically investigate the efficacy of NET in reduction of IPV-related mental health disorders among victims of IPV. Only one recent qualitative study conducted by Volpe and colleagues (Volpe et al., 2016) explored the feasibility and acceptability of NET among adolescents who were either pregnant or who had children, and who were at risk of IPV-related mental health disorders (PTSD and depression), which revealed that both adolescents and service providers agreed on the benefits of NET implementation.

NET connects the traumatic memories to their context through imaginary exposure while focusing on construction of a detailed chronological narrative. In addition, NET focuses on a series of traumatic events rather than on a single trauma event, and also considers all good and empowering events and experiences as potential resources (Schauer et al., 2011). Therefore, it takes into account traumatic and violent events that IPV-affected women have experienced over their lifetimes, and helps them to recognize recurring patterns in their relationships. Cognitive reorganization is another major component of NET, which helps victims of violence to give meaning to their traumatic experiences and clarify their role in the traumatic experience (e.g. relieve feelings of guilt and shame). Therefore, we predicted that IPV-affected women living under ongoing threat and violence would benefit from NET through a reduction in their mental health.
symptoms, an increase in their daily functionality, and a sense of empowerment that helps them to stop or reduce violence by seeking further formal/informal help or leaving the violent context.

The main objectives of the present research were to firstly investigate whether NET significantly reduces the PTSD and depression symptoms shown by IPV-affected women living under continuous threat and violence. Secondly, we predicted that NET therapy would significantly improve daily functioning and reduce perceived stress and borderline symptoms. Third, our exploratory objective was to examine whether psychotherapy in general, and NET in particular, would significantly reduce IPV experiences presented by abused women living under ongoing threat and violence.

3.3 Methods

3.3.1 Settings

The present study was conducted in the city of Tehran/Iran. We recruited women currently living in a context of continuous IPV through health professionals, social activists and other relevant persons/institutions working in roles involving abused women. Consequently, a variety of places such as day clinics, community centers, or private institutes were chosen as locations for the interview and the treatment sessions. The factors determining the suitability of a place was that it be quiet and private, and close to the participant’s home, as most participants did not dare to travel far from home. The female participants mostly kept their participation in the study secret from their husbands.

3.3.2 Participants

We assessed 63 women for eligibility in the study. Inclusion criteria were having experienced IPV during the past year or lifetime, the diagnosis of PTSD with at least the minimum cut-off point of 15, age between 16 and 60, and a married status of living with a violent partner at the time of the interview. We first briefly asked them a few questions on the phone or by email to assess whether they fitted the study framework, then invited them for a 2-hour diagnostic session to be fully assessed for eligibility. Of 63 volunteers, 47 met the inclusion criteria. Thirteen had experienced IPV, but did not present with PTSD. Three remaining candidates had been suffering from PTSD but their major traumatic stressors as indicated by intrusions were not related to IPV. Of 47 eligible candidates, two could not participate in therapy due to personal life circumstances. None of the candidates met the general clinical exclusion criteria, which were substance abuse, suffering from schizophrenia, epilepsy, or intellectual disabilities. The 45 IPV-affected women were randomized to each of two treatment arms. Randomization was implemented with the psych package in R developed by Revelle (Revelle, 2011). Because of ethical considerations regarding abused women’s right to have immediate access to help, we did not have any waiting list group. Within a
two-week period after the diagnostic session, we randomly assigned participants to one of the
treatment arms and began therapy sessions.

The treatment study in Tehran was approved by the Ethical Review Board of the Psychiatry
Institute, Tehran University of Medical Sciences (TUMS). The trial was registered under
"ClinicalTrials.gov ID: NCT01731418". Informed consent was obtained from each participant.

3.3.3 Local Team

All pre-treatment and 3- and 6-month follow-up diagnostic interviews were conducted by a group
of three local counselors (all female Master’s level psychology graduates), who had been trained
in clinical assessment using structured interviews. The first interview sessions of each were
supervised by an internationally experienced, PhD-level clinical psychologist (S.A.) with
international experience in traumatic stress studies and psychotherapy. The interviewers were
blind with respect to the treatment.

The therapy sessions were conducted by another group of three local counselors (all master’s
level psychology graduate women). We assigned therapists to one of the treatment groups,
depending upon availability of therapists and the proximity to therapy settings. All three
counselors participated in treatment as usual group (TAU), but only two of them conducted NET.
These had received training in NET through workshops held by experienced NET trainers.
Additionally, the first sessions of NET were supervised by one clinical psychologist (S.A.) with
expertise in treatment of trauma-related suffering, and a local expert (T.O.) to ensure that the
therapy sessions were in accordance with the NET manual guidelines.

3.3.4 Measures

Persian language versions of all instruments were created using translation and blind back
translation. Moreover, all instruments were applied as structured interviews.

Primary Outcome Measures

Posttraumatic Stress Symptom Scale – Interview (PSS-I). The PSS-I is the interview format of
the PDS, a screening instrument with 17 items rated on a 4-point-Likert-scale (0 = not at all to 3 =
very much), which investigates whether participants suffered from posttraumatic stress symptoms
within the four weeks preceding the interview. The PSS-I aims at assessing all DSM-IV criteria of
PTSD, and thus it includes information about the nature of the traumatic event and the level of
functional interference. The PSS-I has demonstrated satisfactory test-retest reliability, internal
consistency, and convergent and concurrent validity (Ertl et al., 2010; Foa et al., 1997; Griffin et
al., 2004).
**PHQ-9.** The Patient Health Questionnaire (PHQ) is the depression module, which scores each of the 9 DSM-IV criteria as “0” (not at all) to “3” (nearly every day). The PHQ-9 has been well validated in different studies (Spitzer et al., 1999).

**Perceived Stress Scale-4.** The Perceived Stress Scale (PSS) is designed to measure the degree to which situations in one’s life are appraised as stressful and how unpredictable, uncontrollable, and overloaded participants find their lives over the course of the last month preceding the interview. (Cohen, Kamarck, & Mermelstein, 1983). Answers are scored for each of the 4 items on a 5-point-Likert-scale between 0 (never) and 4 (very often). The PSS-4 was found to have the same reliability and validity as the PSS-14 and PSS-10 and is widely used in different settings (Karam et al., 2012; Leung et al., 2010; Örücü & Demir, 2009; Roberti et al., 2006).

**Secondary Outcome Measures**

**Composite Abuse Scale (CAS).** The CAS, a 30-item validated research instrument, is a widely used self-report questionnaire of behaviors that women describe as abusive by their partners. The four sub-scales of CAS are Severe Combined Abuse, Emotional Abuse, Physical Abuse, and Harassment, scaled from 0 (never) to 5 (daily) over a period of 12-month. A score of 7 or higher is the criterion for exposure to Intimate Partner Violence (IPV). Several studies have shown a high reliability and validity of this instrument in clinical settings (Hegarty et al., 2005).

**The Life Events Checklist (LEC).** The LEC is a brief, 17-item, designed to screen for potentially traumatic events in a respondent’s lifetime. For each item, the respondent checks whether the event (a) happened to them, (b) witnessed it, (c) does not apply. The LEC has demonstrated adequate psychometric properties as an assessment of traumatic exposure (Gray et al., 2004).

**Modified Adverse Childhood Experiences (short MACE-I).** The MACE is designed to screen for traumatic events that happened during childhood (birth-to-18) and estimates neglect or/and physical, emotional, and sexual abuse by family members or strangers, witnessing of interparental violence, witnessing of violence to siblings, peer violence and partner violence. MACE is a newly developed scale and until now, two studies show that it enables a valid and detailed assessment of childhood adversities (Isele et al., 2014; Teicher & Parigger, 2015).

**The Work and Social Adjustment Scale (WSAS).** The WSAS is a widely used 5-item measure of disability. WSAS is ranged on a 0 to 8 scale: 0 indicating no impairment at all and 8 indicating very severe impairment. Its psychometric properties were analyzed and shown in different studies and disorders (Mataix-cols et al., 2005; Mundt et al., 2002).

**Borderline Symptom List (BSL-23).** The BSL-23 is a shortened form of the full version of the BSL-95. The self-report questionnaire assesses borderline-specific symptomatology on a five point response scale ranging from 0 (not at all) to 4 (very strongly). Previous research supported the validity and reliability of the BSL-23 as a self-report measure of Borderline Personality Disorder symptomatology (Glenn, Weinberg, & Klonsky, 2009).
3.3.5 Procedure

In order to reach IPV-affected women who were currently living with a violent husband, we distributed flyers and requested referrals from various relevant institutions and sources, such as health centers, local community centers, community support centers for families of addicts, day clinics, police stations, web advertising, and social networking services.

Each therapy consisted of 10 to 12 sessions independent of the treatment group. Each therapy period lasted between 3 to 6 months due to various cancellations and interruptions, such as IPV occurrence during the therapy, everyday problems, or unexpected journeys or illness.

3.3.6 Treatment Conditions

Psychoeducation. Immediately following the diagnostic assessment, each of the 45 participants individually received psycho-education, which explained the nature and prevalence of PTSD in such a way that they understood their PTSD symptoms and their harmful effects on their everyday life. We also determined the relationship between health problems and the women’s trauma and violence experiences whenever it was appropriate. For this purpose, we adopted the standard written rationale provided in the second edition of the NET manual (Schauer et al., 2011). The manual separates psycho-education into three components including normalization, legitimization and description of trauma reactions. The interviewer firstly normalized the patient’s reactions after trauma by emphasizing that such reactions are understandable and common among traumatized people. Then, she related the symptoms experienced today to the traumatic situation, and lastly, explained the patient’s symptoms such as intrusions, avoidance and hyperarousal.

Narrative Exposure Therapy (NET). The training curriculum was based on the second edition of the manual “Narrative Exposure Therapy”, developed by psychologists at the University of Konstanz (Schauer et al., 2011). In NET, the patient chronologically and repeatedly talks about their traumatic life experiences in detail, and in doing so, they intensely re-experience the emotions, thoughts, and even physical sensations associated with this event. In the process, the patient constructs a narration of their life. The fragmented and intense sensory elements of the traumatic experiences are translated into an ordered verbal narrative, and integrated into the broad narrative of the patient’s life. Because we anticipated that participants would experience continuous threat and violence from their partners, we allocated one to two sessions of consultation to work on safety issues and the current violence in the whole process of NET therapy. This consultation included encouragement to seek help from resources such as family of origin, police or lawyers, coping skill enhancement and safety planning, and human rights education. Further, at the beginning of each exposure session, the therapist initiated a short discussion of IPV occurrences or marital arguments over the previous week, to make sure the patient was ready to work on past traumatic events. Each NET session lasted approximately 120 to 150 minutes. In case of recent severe IPV occurrences, the session was canceled or postponed.
The first NET session always began with psycho-education about PTSD symptoms, and explanation of the goal and procedure of treatment. Shortly afterwards, the patient, with the help of the therapist, completed the “lifeline” exercise. This begins with a piece of thin rope that represent the course of life. The patient then places small stones albeit of varying size and flowers along this line: the stones represent violence or traumatic experiences; and flowers depict joyful events and successes. The lifeline aims to chronologically reconstruct the patient's biography, from her birth up to the present, plus their hopes or wishes for the future. It represents all the violence and traumatic experiences throughout childhood and adulthood. This helps therapist and patient to recognize the most detrimental events and determine which events will be the focus of the following 9 to 10 exposure sessions. Flowers are important, since they represent resources for resilience and self-efficacy in the current situation. Subsequent exposure sessions are devoted to detailed accounts of the most traumatic and violence experiences, which in turn activate the whole fear/trauma network and causes the patient to re-experience the same feelings, sensations, thoughts, and physiological responses that they went through during the traumatic events. Although this detailed remembrance of the past is disturbing at first, fear and anxiety typically declines after one or two exposure sessions as habituation takes place. This enables the patient to talk about her worst experiences without reactivation of trauma/fear network. Here again psycho-education is crucial, as it helps the patient to understand the procedure of therapy and not to avoid active processing of unpleasant traumatic events. At the end of a session or in the beginning of the next session, cognitive restructuring process deconstructs the violence-related traumatic events to uncover what patient's and husband's responsibility were at the time of the event, why violence happened and how it might be possible to prevent it reoccurring. This meaning-making process provides a patient with new insights into the causes of violence and may provide her with strategies to minimize or stop it. In the end of each exposure session, the therapist checks whether the patient feels okay again and if there is still anything that needs to be discussed. The therapist starts each of these sessions by asking about the patient's recent thoughts or feelings related to past experiences or if any IPV happened during the previous week and the client did not feel safe. In case of experience of serious IPV during the previous week, the session would be either postponed or mostly reserved for safety planning and acknowledgment of their suffering. The NET therapy ends with an overview of all the events, represented by the stones and flowers, in the patient's life and an outlook on the future, covering the patient's expectations, goals, worries and hopes.

As domestic violence is repetitive and continuous in its nature, and the participants in this study were still at risk of further violence, we chose to focus on stones that were more predominant in their intrusions or more relevant to their current complaint. Further, we chose different stones that represented multiple aspects of IPV such as physical abuse, sexual coercion or emotional violence. Where there was childhood abuse or witnessing domestic violence during childhood, we made sure to investigate one or two serious events thoroughly, since the studies show that child abuse experiences make individuals vulnerable to further abuse in adulthood (Gómez, 2011). The very first experiences of violence during the marriage were also of importance as they mark the onset of a new chapter in the individual's life, left grave mental scars and underlie their current maladaptive coping mechanisms such as dissociation or submission.
Apart from exposure to the traumatic events, NET provides an opportunity for the victim to express their suffering, and be heard. A therapist sometimes is the only person in the victim’s world that acknowledge their pain and suffering and recognizes their right to justice. This approval can empower victims of violence to speak out and stand up for their human rights.

**Treatment-As-Usual (TAU).** Treatment-As-Usual was defined as the commonly used psychotherapy for abused women in Iran, including life skill training and supportive counselling. Therapists in the TAU group were asked to provide a report of all therapeutic methods employed in each session. The methods were chosen based on the specific characteristics of the clients, and their own wishes, and ranged widely from joint sessions with an abusive husband to cognitive behavioral techniques. Thus, each client in the TAU group received an individually tailored set of different therapeutic methods, such as life skill training (e.g. anger management, problem solving), cognitive behavioral techniques, acceptance and commitment therapy (ACT), improvement of self-knowledge, involvement of violent husbands in an open discussion on marital and sexual conflicts, treatment of their children’s behavioral problems, and establishment of contacts and resources such as lawyers or free legal counselors to ask for justice. Each TAU session approximately lasted 90 to 120 minutes. The final session mostly entailed an outlook on the future with regard to safety planning and available resources.

In contrast to NET, the TAU group was allowed to focus on currently important complaints and events, but not on traumatic memories or experiences of violence from the past. The focus of therapy was to cope with everyday life difficulties, the current problems with violent husbands, and IPV prevention.

3.3.7 Participation and Dropouts

Participants were randomly allocated to the different conditions: 24 participants were allocated to the NET group, and 21 were offered TAU. A total of 10 participants did not begin or complete the treatment for various reasons: Three clients (2 NET, 1 TAU) dropped out during the course of therapy due to extremely high IPV occurrences. Three participants (2 NET, 1 TAU) discontinued therapy, as they could not tolerate overwhelming emotions that related to talks about IPV experiences. Two NET participants discontinued therapy as they had to move to another city to live, and the other two participants (1 NET, 1 TAU) did not continue therapy because they reported that their lives had become too busy. Figure 3.1 presents the flowchart of the study protocol.
We did t-tests and chi-square tests to examine if there were any significant differences between completers and dropouts in terms of socio-demographic variables and their mental health status at baseline. We did not find any significant differences between two groups, except for client’s education (Fisher’s Exact Test: $X^2(1) = 5$, $p=.04$). The significant result showed that only 13% of women who dropped out had a high school diploma or higher education, while 87% of completers graduated from high school or went to university. We did not find any significant difference between NET and TAU in the number of dropouts (Fisher’s Exact Test: $X^2(1) = 1.43$, $p=.29$).
We also did logistic regression for several different pairs of variables to investigate if there were any variable among demographics or study variables that could significantly predict therapy completers or dropouts, but none of the models were significant. The type of therapy was not a significant predictor of dropouts.

3.3.8 Baseline Characteristics

Table 3.1 shows a demographic analysis of participants divided into two treatment groups. There were no significant difference between the two groups in terms of socio-demographic variables and violence/traumatic experiences at baseline.

Subsequently, we compared the two treatment groups of NET and TAU with each other at baseline to assess if randomization resulted in significantly different primary and secondary outcome measures. Results showed that the only significant difference was found on the perceived stress scale, i.e. on average, NET participants experienced greater perceived stress (M=11.70, SD =2.02) than participants in the TAU group (M= 9.56, SD=2.78) at baseline (Welch’s t-test: t (1, 27.32): 6.34, p<.05).

Table 3.1: Baseline Violence and Traumatic Experiences and Socio-demographic Characteristics of Patients Divided by Groups (N=45)

<table>
<thead>
<tr>
<th></th>
<th>NET group (N=24)</th>
<th>TAU group (N=21)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
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<tr>
<td>Client’s education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under diploma</td>
<td>9 (37.5)</td>
<td>5 (23.8)</td>
<td>.32</td>
</tr>
<tr>
<td>Diploma and above</td>
<td>15 (62.5)</td>
<td>16 (76.2)</td>
<td></td>
</tr>
<tr>
<td>Husband’s education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under diploma</td>
<td>10 (41.7)</td>
<td>10 (47.6)</td>
<td>.68</td>
</tr>
<tr>
<td>Diploma and above</td>
<td>14 (58.3)</td>
<td>11 (52.4)</td>
<td></td>
</tr>
<tr>
<td>Client’s job</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>16 (66.7)</td>
<td>12 (57.1)</td>
<td>.51</td>
</tr>
<tr>
<td>Working (full- or part-time job)</td>
<td>8 (33.3)</td>
<td>9 (42.9)</td>
<td></td>
</tr>
<tr>
<td>Husband’s job</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jobless/retired</td>
<td>7 (29.2)</td>
<td>4 (19)</td>
<td>.43</td>
</tr>
<tr>
<td>Working</td>
<td>17 (70.8)</td>
<td>17 (81)</td>
<td></td>
</tr>
<tr>
<td>Financial independency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8 (33.3)</td>
<td>4 (19)</td>
<td>.28</td>
</tr>
<tr>
<td>No</td>
<td>16 (66.7)</td>
<td>17 (81)</td>
<td></td>
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<tr>
<td>Family salary per month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-income</td>
<td>10 (41.7)</td>
<td>11 (52.4)</td>
<td>.47</td>
</tr>
<tr>
<td>Middle income</td>
<td>14 (58.3)</td>
<td>10 (47.6)</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0</td>
<td>4 (16.7)</td>
<td>1 (4.8)</td>
<td>.42</td>
</tr>
<tr>
<td>1 or 2</td>
<td>14 (58.4)</td>
<td>14 (66.7)</td>
<td></td>
</tr>
<tr>
<td>3, 4 or 5</td>
<td>6 (25)</td>
<td>6 (28.6)</td>
<td></td>
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<tr>
<td>Age at first marriage</td>
<td></td>
<td></td>
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<tr>
<td>Under 18</td>
<td>9 (37.5)</td>
<td>5 (23.8)</td>
<td>.32</td>
</tr>
<tr>
<td>18 and above</td>
<td>15 (62.5)</td>
<td>16 (76.2)</td>
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<tr>
<td>Husband’s drug abuse</td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>8 (33.3)</td>
<td>8 (38.1)</td>
<td>.93</td>
</tr>
<tr>
<td>No</td>
<td>12 (50)</td>
<td>10 (47.6)</td>
<td></td>
</tr>
<tr>
<td>Quit drugs</td>
<td>4 (16.7)</td>
<td>3 (14.3)</td>
<td></td>
</tr>
<tr>
<td>Physical health</td>
<td></td>
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</tbody>
</table>
3.3.9 Statistical Analyses

The study's hypotheses were examined through the use of mixed designs, with symptom change as a three-level repeated measures variable and treatment group as a two-level between-subjects variable for each outcome measure. We tested interactions between within-subjects and between-subjects variables to examine different effects of treatment groups over time. Mauchly's tests of sphericity were calculated for the repeated measures ANOVA, and the results showed the assumption was met for all five primary outcome measures including PSS-I, PHQ-9, PSS-4, WSAS, and BSL-23. Hedges' $g$ was calculated to determine within and between group effect sizes.

### 3.4 Results

#### 3.4.1 Symptom Change

Table 3.2 gives the results of the primary outcome measures at pretest, 3-month and 6-month follow-ups. All 17 NET participants which had completed the treatment, participated in the 3- and 6-month follow-up interviews and were included in the analysis. Of 18 TAU completers, one participated only in the 3-month follow-up, so we used last-observation-carried-forward method to include her in the analysis while the other TAU participant did not show up in any post-test assessments, thus we excluded her from the analysis. Therefore, the data of 17 TAU completers were included in the final analysis.

The results revealed that there was a significant interaction effect between PTSD symptom change and the type of treatment. The contrast analysis further revealed that the NET group showed greater improvement from the pre-treatment to the 3- and to the 6-month follow-ups than the TAU
group. Table 3 presents the statistical values. Upon analysis of interaction effect between three PTSD sub-scales, i.e. intrusion, avoidance and arousal and the type of treatment, we found that only avoidance symptoms significantly differed between NET and TAU groups from pre-test to the 3-month follow-up (F (1, 32) = 7.59, p<0.5). The within and between group effect sizes are reported in table 3.2.

Table 3. 2: Means and Standard Deviations and Effect Sizes of the Outcome Variables by Treatment Groups

<table>
<thead>
<tr>
<th>Treatment groups</th>
<th>pre</th>
<th>3-month</th>
<th>6-month</th>
<th>Within group Hedges’ g pre to 3-month</th>
<th>Within group Hedges’ g pre to 6-month</th>
<th>Between group effect size (pre to 3-month)</th>
<th>Between group effect size (pre to 6-month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET (N=17)</td>
<td>25.94 (5.65)</td>
<td>12.52 (10.03)</td>
<td>12.58 (8.70)</td>
<td>1.60</td>
<td>1.77</td>
<td>.38</td>
<td>.34</td>
</tr>
<tr>
<td>TAU (N=17)</td>
<td>27.41 (5.87)</td>
<td>20.70 (6.86)</td>
<td>19.52 (7.23)</td>
<td>1.02</td>
<td>1.16</td>
<td></td>
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<td>Posttraumatic Stress Symptoms-Interview (PSS-I)</td>
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<tr>
<td>NET (N=17)</td>
<td>15.88 (2.91)</td>
<td>7.11 (5.27)</td>
<td>6.88 (4.91)</td>
<td>2.01</td>
<td>2.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU (N=17)</td>
<td>13.82 (5.17)</td>
<td>10.05 (4.09)</td>
<td>11.17 (6.34)</td>
<td>.78</td>
<td>.44</td>
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<tr>
<td>Patient Health Questionnaire (PHQ-9)</td>
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<td></td>
</tr>
<tr>
<td>NET (N=17)</td>
<td>11.70 (2.02)</td>
<td>7.05 (3.52)</td>
<td>7.29 (3.09)</td>
<td>1.58</td>
<td>1.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU (N=17)</td>
<td>9.58 (2.69)</td>
<td>8.29 (3.15)</td>
<td>7.76 (2.63)</td>
<td>.43</td>
<td>.66</td>
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<tr>
<td>Perceived Stress Scale (PSS-4)</td>
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<tr>
<td>NET (N=17)</td>
<td>4.87 (1.51)</td>
<td>2.96 (2.55)</td>
<td>3.12 (2.61)</td>
<td>.88</td>
<td>.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU (N=17)</td>
<td>5.45 (1.55)</td>
<td>4.20 (1.67)</td>
<td>3.81 (1.72)</td>
<td>.75</td>
<td>.97</td>
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<tr>
<td>The Work and Social Adjustment Scale (WSAS)</td>
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</tr>
<tr>
<td>NET (N=17)</td>
<td>45.11 (14.03)</td>
<td>24.29 (18.76)</td>
<td>25.41 (16.59)</td>
<td>1.22</td>
<td>1.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAU (N=17)</td>
<td>45.82 (21.22)</td>
<td>31.23 (15.84)</td>
<td>32.47 (18.09)</td>
<td>.76</td>
<td>.66</td>
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<td></td>
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<tr>
<td>Borderline symptom list (23)</td>
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</table>

In addition to the basic analysis of the PTSD scale reported above, we investigated whether traumatic experiences (ones that happened during therapy and at 3- and 6-month follow-ups) had an impact on PTSD symptom change across groups. We entered this as a covariate (called ‘recent traumatic events’) into the current mixed design, and found that regardless the impact of recent traumatic events on symptom change, there was still a significant difference between groups in terms of reduction of PTSD from pre-test to the 3-month follow-up (F (1, 31) = 8.38, p<.01), and from pre-test to the 6-month follow-up (F (1, 31) = 6.88, p<.05). IPV experiences at 6-month follow-up were also entered into the basic model to test whether the difference between groups in terms of reduction of PTSD symptoms was affected by the experience of intimate partner violence in the last year (between initial scores and 6-month follow-up). Results showed that regardless of the experience of IPV during the last year, there was a significant interaction effect between PTSD symptom change and the type of treatment at 3-month follow-up (F (1, 31) = 5.54, p<.05) and at 6-month follow-up (F (1, 31) = 4.29, p<.05), i.e. participants in the NET group still showed significantly better improvement from the pre-treatment to the 3- and 6-month follow-ups compared with participants in TAU group.

Regarding depression, we found significant results when we analyzed the interaction of depression symptom change across time and treatment group. The results showed that the depression symptom change differed between NET and TAU groups. Further, the contrast analysis of the depression variable indicated that the NET participants improved more from the pre-treatment to the 3 and the 6-month follow-ups than the improvement that participants experienced in the TAU group. The interaction analysis of Perceived stress scale (PSS-4) at three time points.
across treatment groups revealed that perceived stress change over time was significantly different in the two groups. In other word, the NET participants improved more from the pre-treatment to the 3- and to the 6-month follow-ups than the TAU participants did in further contrast analyses. Contrary to our hypothesis, no significant interaction between symptom change at different time points and the type of treatment was found for work and social adjustment scale (WSAS). None of the contrasts between pre-treatment to 3- and 6-month follow-ups for WSAS scores across groups were significant. However, regardless of the type of treatment, there was a significant main effect of functionality score change at different time points. Further contrast analysis of WSAS scores over time showed that there was a significant improvement in functionality from pre-test to 3- and to the 6-month follow-ups. Borderline symptom change (BSL-23) did not show any significant interaction between time, and type of treatment. There was a significant main effect of borderline symptom change across time independent of treatment group. Follow-up contrasts between pre-test and 3- or 6-month follow-ups showed significant reductions in symptoms. Contrasts between pre-test and 3-or 6-month follow-ups showed no differences across groups. All results are shown in table 3.3 and figure 3.2.

Table 3.3: Mixed-model Analyses of Main Effects, Interactions and Contrasts for Outcome Measures

<table>
<thead>
<tr>
<th>Scale</th>
<th>Source</th>
<th>F (df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS-I</td>
<td>Symptom change</td>
<td>43.60 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>Symptom change + Type of treatment</td>
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<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>3.88 (2,64)*</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>5.73 (1,32)*</td>
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<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>4.44 (1,32)*</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Symptom change</td>
<td>21.62 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>Symptom change + Type of treatment</td>
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</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>4.95 (2,64)*</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>7.00 (1,32)*</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>7.79 (1,32)**</td>
</tr>
<tr>
<td>PSS-4</td>
<td>Symptom change</td>
<td>18.89 (2,64)**</td>
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<tr>
<td></td>
<td>Symptom change + Type of treatment</td>
<td></td>
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<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>4.71 (2,64)*</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>7.85 (1,32)**</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>6.27 (1,32)*</td>
</tr>
<tr>
<td>WSAS</td>
<td>Symptom change</td>
<td>13.50 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>Symptom change + Type of treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>0.47 (2,64)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>0.70 (1,32)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>0.02 (1,32)</td>
</tr>
<tr>
<td>BSL-23</td>
<td>Symptom change</td>
<td>17.80 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>Symptom change + Type of treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>0.60 (2,64)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>1.12 (1,32)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>1.05 (1,32)</td>
</tr>
</tbody>
</table>

Note: *p < 0.05, **p < 0.01. x indicates interaction of IPV change and type of treatment.
Figure 3.2: Outcome Changes at Pre-test, 3-Month and 6-Month Follow-ups by Treatment Groups
Note: Error Bars: +/- 1 SE. Solid line: NET group, Dotted line: TAU group. a) Depression means, b) PTSD: Post-Traumatic Stress Disorder, c) BSL: Borderline Symptoms List, d) PSS: Perceived Stress Scale, and e) WSAS: The Work and Social Adjustment Scale, presented at pre-test, 3-month and 6-month follow-ups.

3.4.2 IPV Score Change

We also conducted mixed design to analyze IPV sum score change across the three assessment points, for each treatment group. The assumption of sphericity for the repeated measure ANOVA was met for IPV sum score and three subscales of it. Mauchly's test was significant for the physical abuse subscale, thus we used the Huynh-Feldt correction to meet the assumption of sphericity. We did not find any significant results either for the IPV sum score and treatment type interaction, or for any contrasts from the pre-treatment to the 3- and 6-month follow-ups across groups. The only significant result was the main effect of IPV change that the participants experienced across time regardless of the type of therapy they were involved in. The contrast analysis also indicated that there was a significant decrease in IPV sum score from pre-treatment to 3- and to the 6-month
follow-ups regardless of the type of therapy. Four IPV subscales containing severe combined violence, emotional abuse, physical abuse, and harassment were further analyzed through mixed design, and no significant treatment by time interactions were found. However, some IPV subscales showed significant change from pre-treatment to 3-month or to 6-month follow-ups regardless of the type of therapy. For instance, there was a significant main effect of severe combined abuse score over time. Further contrast analysis revealed that there was a significant decrease in severe combined abuse score from pre-treatment to 3- and also to the 6-month follow-ups. The results were the same for emotional and physical abuse. However, harassment did not show any significant main effect of change over time. Results are shown in table 3.4.

Table 3.4: Mixed-model Analyses of Main Effects, Interactions and Contrasts for CAS Scale and its Four Subscales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Source</th>
<th>F (df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS (IPV sum-score)</td>
<td>IPV change</td>
<td>17.22 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>IPV change ¥ Type of treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>.42 (2,64)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>.62 (1,32)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>.03 (1,32)</td>
</tr>
<tr>
<td>Subscales</td>
<td></td>
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<tr>
<td>Severe combined abuse</td>
<td>Main effect</td>
<td>12.14 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>10.08 (1,32)**</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>19.24 (1,32)**</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>Main effect</td>
<td>11.55 (2,64)**</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>5.89 (1,32)*</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>25.79 (1,32)**</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>Main effect</td>
<td>3.52 (2,64)*</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>4.15 (1,32), p=0.05</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>4.53 (1,32)*</td>
</tr>
<tr>
<td>Harassment</td>
<td>Main effect</td>
<td>3.01 (2,64)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 3-month</td>
<td>1.06 (1,32)</td>
</tr>
<tr>
<td></td>
<td>• Pre- to 6-month</td>
<td>5.22 (1,32)*</td>
</tr>
</tbody>
</table>

Note: * p < 0.05, **p < 0.01. ¥ indicates interaction of IPV change and type of treatment. CAS: Composed Abuse Scale.

3.4.3 Clinical Significance

Reliable and clinically significant change indexes test whether score change between initial assessment and follow-up is more likely to be attributable to the experiment measures, as opposed to simple measurement unreliability. Therefore, with the reliability of 0.64 and cut off point of 15 at PSS-I scale, we calculated clinically significant change in PTSD means between pre- to 6-month follow-up and found that 8 of the 17 NET but only 2 of the 17 TAU participants were reliably and clinically improved.
We also investigated if there was a significant difference in percentages of PTSD diagnosis at 6-month follow-up between two groups. Results showed that the difference between the treatment groups was significant ($X^2 = 5.76, df (1), p<.05$). In other words, while 12 participants (71%) in the NET group indicated an absence of PTSD at 6-month follow-up, the number was 5 (29%) in the TAU group.

3.5 Discussion

The present study represents the first treatment study of abused women with PTSD living under continuous threat and violence at the time of treatment. We investigated the efficacy of NET in reducing PTSD and depression symptoms and improving daily functioning among IPV women living with an abusive partner. We further explored whether psychotherapy in general, and NET in particular, would significantly reduce IPV incidents experienced by these women. Of all participants, 10 (22%) did not complete therapy and dropped out in the beginning or middle of sessions. The dropout rate in the present study is comparable to the average dropout rate in treatments of PTSD across different studies (Imel, Laska, Jakupcak, & Simpson, 2013; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008), and even lower if considering unsafe living conditions of abused women being currently in danger. In line with previous research, we found that trauma-focused intervention does not predict increased dropout (Imel et al., 2013). The only significant difference between dropouts and completers was the client’s level of education, i.e. 87% of completers had a high school or university certificate, while the level of education was much lower among dropouts. This finding challenges previous research, which has not taken into account the level of education as a significant predictor for dropout in PTSD-related interventions or for the use of available resources by abused women (Lucea et al., 2013; Minnen, Arntz, & Keijsers, 2002; Schottenbauer et al., 2008).

Concerns that the implementation of exposure-based interventions in the context of ongoing threat and violence might be a risk to the wellbeing of the women (Warshaw et al., 2013) were not supported by the current study. NET participants showed greater reduction in PTSD, depression symptoms, and perceived stress at 3- and 6-month follow-ups than the participants in the TAU group. Further assessment confirmed that unlike the TAU group, around 70% of participants in the NET group no longer fulfilled criteria for PTSD diagnosis at 6-month follow-up. Moreover, the between-group effect sizes demonstrated a small to medium superiority of NET over TAU in treatment of PTSD, depression and perceived stress (see table 3.2). These results are in line with exposure-based therapies conducted by Kubany and colleagues (Kubany et al., 2004) and Stapleton and colleagues (Stapleton et al., 2007), showing that abused women benefit from exposure therapy to psychologically distance themselves from their trauma histories and activate their psychological resources. In this regard, Minnen and colleagues (Minnen et al., 2002) investigated predictors of therapeutic outcome and dropout in patients with chronic PTSD that benefited from prolonged exposure therapy and concluded that it is not necessary to exclude patients from prolonged exposure therapy on the basis of pre-treatment characteristics. Therefore, in line with previous research, the present study supports the idea that even women currently living in an abusive relationship could benefit from individual psychotherapy in general, and NET in particular, to improve their mental health status. This finding is comparable with the results of
NET studies conducted within insecure and low-income living conditions (Neuner et al., 2004; Robjant & Fazel, 2010).

In addition to the overall results, we found that, compared with the TAU group, avoidance symptoms showed greater reduction in the NET group. This finding is comparable with Kubany and colleagues (2004), who showed that exposure therapies could be more successful in reduction of numbing and avoidance symptoms, where other PTSD treatments were not. Moreover, along with Murray and colleagues (2013), this finding suggests that exposure therapies enable abused women living under ongoing threat and violence to differentiate between real dangers and overgeneralized trauma reminders, and consequently apply appropriate skills to each condition. Reduced avoidance might empower abused women living in a context of continuous violence and trauma exposure to overcome their fears, confront the abuser’s excessive demands, and resist violation of their rights. The significance of this finding is still greater, when one takes into account the fact that intimate abusers extend their coercive control over their victims by provoking terror and fear. Previous research has indeed affirmed the need for dealing with avoidance and numbing symptoms in intervention strategies in order to decrease the likelihood of re-abuse (Krause et al., 2008, 2006; Street et al., 2005; Strigo et al., 2010).

There were no significant difference between NET and TAU groups regarding improvement of daily functioning and reduction of IPV experiences. However, both groups, showed significant improvement in daily functioning and a substantial reduction of IPV experiences at both follow-ups. This further indicates that women may benefit from treatment even when it is not possible to immediately stop the exposure to IPV.

The findings of this first randomized controlled trial of trauma-focused intervention for abused women currently living under threat and violence deserve replication. Different contexts and also large sample sizes are desirable. All raters were clinical experts with diagnostic experience, and all had been trained in the same clinical setting. Additionally, all interviewers carried out interviews for both treatment conditions and were subjected to the same training and supervision process. But we did not quantitatively test inter-rater reliability. Further quantitative and qualitative research could contain weekly appraisals of IPV occurrences and psychological symptoms during the course of therapy to shed light on the interrelationship between current IPV and therapy implementation.

3.6 Conclusion

The present study addressed the gap in literature regarding the lack of RCTs for abused women forced to live in an abusive relationship and revealed that NET as a trauma-focused intervention could help them considerably. Our investigation shows that NET should be integrated into aid packages offered to victims of IPV, as they empower abused women to more effectively resist violence within intimate relationships, possibly by strengthening their psychological capacity to differentiate between real dangers and trauma reminders. The present study once again highlights the fact that domestic violence requires a multidimensional approach. In other words, victim’s lives, particularly in low-to-middle income countries, will not be improved by excessively focusing on court proceedings or law enforcement while postponing mental health needs required for personal growth and decision making until later.
3.7 Acknowledgements

We sincerely thank Dr. Parviz Azadfallah, The head of department of psychology, Tarbiat Modares University, Tehran, Iran for his invaluable comments on the first draft of the study design. We also gratefully appreciate the indispensable work of our two colleagues in the project, Zahra Noee (M.S., Iran University of Medical Sciences) and Hoda Layegh (M.S. Islamic Azad University, Tehran Science and Research Branch), which patiently conducted the interviews. We deeply acknowledge the support of Dr. Matin Bazargani, Dr. Reza Askari, and all colleagues in South Tehran Health Center which generously helped us to reach the study participants.
4 Subjective Perceptions of Ongoing Trauma and Violence among Iranian Married Women

4.1 Abstract

**Background:** Traumatic stressors that lead to post-traumatic stress disorder (PTSD) are thought to show specific characteristics. The present exploratory question is how abused women perceive traumatic stressors in the context of ongoing intimate partner violence (IPV) and whether abused women's subjective perceptions of trauma and stress precisely corresponds with the official definitions described in international standard diagnostic classifications. Their subjective appraisals of receiving psychotherapy under ongoing IPV were further investigated.

**Methods:** Forty-seven married women suffering from PTSD following ongoing exposure to IPV, were interviewed. The most severe traumatic stressors were identified using the Life Events Checklist (LEC), and, semi-structured interviews were conducted to further explore abused women's descriptions of psychotherapy under ongoing IPV.

**Results:** The present exploratory results revealed that abused women considered psychological abuse and temporal aspects of violent experiences as well as physical abuse as the most disturbing stressors in their life. Further, we identified two different patterns of trauma load across abused women's lifetime, and clarified the benefits and risks of psychotherapy interventions under ongoing IPV.

**Conclusion:** The present study highlighted the gap between standard diagnostic definitions of traumatic stressors, and actual experiences and subjective perceptions of the most severe disturbing incidents among victims of ongoing IPV, and suggested further reworking in current standard trauma characteristics to meet needs of victims of chronic and continuous violence.

**Keywords:** PTSD, intimate partner violence, traumatic stressor, subjective perception, trauma, ongoing IPV, psychological violence
4.2 Introduction

Globally, nearly one-third of women in partnerships are affected by physical and/or sexual intimate partner violence (IPV) (WHO, 2013). Many of them remain in their current abusive relationship due to an evaluation of perceived costs and benefits, and/or they are prevented from leaving because of lack of resources, abusive partner control tactics, or maladaptive coping mechanisms (Arias & Pape, 1999; Ben-ari, Winstok, & Eisikovits, 2003; Fugate Leslie Landis et al., 2005). They are continuously exposed to multiple, cumulative stress and traumas in daily life, which result in the development of mental health problems (Bonomi, Thompson, et al., 2006; Chandra et al., 2009; Coker et al., 2002, 2000). Depression and Post-Traumatic Stress Disorder (PTSD) are known as the most serious consequences of psychological and/or physical IPV, which exacerbate victims' pain and suffering. In addition, symptoms of PTSD, such as avoidance and numbing put IPV-affected women at risk of further victimization and re-abuse (Krause et al., 2006; Picoalfonso, 2005). The current PTSD diagnostic approach has been mainly focused on specific objective characteristics of traumatic experiences, and has rarely taken into account the victim-related subjective perceptions of trauma exposure among victims of multiple traumatic experiences. Therefore, the present study aims to investigate subjective perceptions of continuous and multiple threat and violence, discover specific characteristics of traumatic experiences from victims’ perspective, and examine whether there is a correspondence between subjective perceptions of trauma exposure and objective definitions of trauma accepted by PTSD diagnostic assessments.

The construct of PTSD does not distinguish between single-incident non-intimate traumatic events such as car accidents, natural disasters or sexual assaults by strangers and multiple-incident, structured continuous violence within intimate relationships, such as domestic violence. In all its forms, IPV affects the well-being and can damage the mental health including cognitive and emotional functioning. As Casey and colleagues (Casey, Murphy, & Creech, 2016, p. 7) note, it may be helpful to expand the definition of a traumatic stressor to include the respective adverse experiences: “Most notable are persistent experiences of emotional abuse, in which a child or adult is denigrated, humiliated, devalued, or intimidated; significant abandonment and detachment experiences; emotional neglect; and physical neglect. Even if not accompanied by trauma exposures consistent with the DSM-5 or ICD-10 definitions, such as physical or sexual abuse, these other adversities can alter one's core beliefs and emotions regarding safety, closeness, trust, power, and control. The results are often manifested as serious problems in intimate relationships.” Previous research shows that subjective appraisals of stressfulness of IPV experiences determined by abused women are strong predictors of depression over and above objective measurements such as frequency and severity of IPV and women who report highly stressful IPV are more likely to demonstrate comorbid depression and PTSD (Martinez-torteya et al., 2009). Therefore, there is a need for investigating subjective perceptions of IPV victims about traumatic events that cause them to develop PTSD symptomology.

Finally, we have limited knowledge about women's subjective perceptions of the most severe and damaging traumatic events. The literature is silent on how victims of complex trauma appraise their traumatic experiences, and pick one or two traumas from a long list of repeated, continuous
occurrences of threat and violence, when they are subjected to standard checklists of structured diagnostic evaluations. Other relevant questions include what specific characteristics those chosen worst traumatic events exhibit, and whether there are specific patterns of trauma exposure among victims of complex trauma. In addition, we need to know how far subjective perceptions of the worst traumatic experiences correspond with the current definition of trauma accepted by PTSD diagnostic examinations. Exploratory research on these issues has major implications for PTSD diagnosis and treatment specific to survivors of continuous and ongoing traumatic stress. For instance, such a research might help us expand the range of traumatic stressors, taking into account women's adverse experiences that have been dismissed so far. In addition, with regard to women's perspective on trauma and suffering, therapeutic focus can be modified, i.e. a counsellor or therapist realizes that what type of adversities have the most severe impact on women's psyche and need to be dealt with during treatment. The goal of the present study is to explore this area to shed light on abused women's subjective perceptions of the worst traumatic events, and the potential patterns of lifetime traumatic events. We further investigated their perceptions of treatment in the context of ongoing trauma and violence.

4.3 Methods

4.3.1 Participants

In total, we interviewed 47 married women who have been suffering from PTSD following ongoing exposure to IPV. Data were drawn from a randomized controlled trial investigating the effects of psychological treatments in reduction of depression and PTSD symptoms in this population (See Orang et al., 2017). All the participants were Muslim, and apart from two who migrated from Afghanistan, the remaining ones were Iranian nationals (96%). The average age reported for the participants was 37 (SD=8.8), which ranged from 25 to 58. The average number of years married was 18 (SD=10.3), ranging from 2 to 41. Thirty-three women (70%) had a diploma or a university degree, and 17 women (36%) had a part-time or full-time job position at the time of interview. Thirty-three women (70%) were engaged/married at the age of 18 or above. The remaining women were married off as children (under 18). Thirty-five women (74%) regarded themselves as financially dependent on their husbands for fulfilling the basic needs of food, clothing, and accommodation. The remaining women reported a financial capacity to meet basic needs. Twenty-one women (45%) assigned themselves to a low-income class (with a monthly income of approximately 285 USD), while the remaining participants belonged to a middle-income class. Of the whole sample, 16 women (34%) reported that their husband was currently drug addicted, and 7 women (15%) reported their husband had quit drugs in the last year or past years preceding the interview. In the whole sample, 5 did not have any children (11%), 30 had one or two children (64%), and 12 (25%) had at least three children at the time of the interview.
4.3.2 Procedure

The data for the present study were collected through a multi-level procedure. In part I, women living in the city of Tehran, Iran, were recruited between 2013 and 2015 through advertisements in different settings such as health centers, police stations, websites, and social networking services. All the interviews were conducted by one psychologist (a female master’s level graduate) having received training in clinical diagnosis using structured interviews. The data were collected using the Life Events Checklist (LEC), a 17-item questionnaire, which conducted in a semi-structured interview format. The LEC assesses exposure to 16 events known to potentially result in PTSD or distress and includes one additional item assessing any other extraordinarily stressful event not captured in the first 16 items. One LEC item, i.e. Severe human suffering, was removed from the interview as most participants could not relate to that. Each woman was asked to a) briefly recount whatever stories/examples she could remember from her life for each item of LEC, and b) out of these, specify the three worst traumatic events, the three that were still emotionally overwhelming, and if there were intrusions resulting from them. Each LEC interview lasted 45 minutes on average. All the stories/memories recounted by the woman were documented by the interviewer and informed consent was obtained from each participant. Finally, to maintain respondent anonymity and confidentiality, their real names and locations were changed.

Part II of the present study was conducted after completion of the main treatment study. First, the data, gathered through the lifeline exercise, i.e. the first session of Narrative Exposure Therapy (NET), were investigated to identify whether there were any patterns for emotionally strongly arousing events (bad-stones or good-flowers) across participants' lifelines. The lifeline exercise consists of a piece of thin rope representing the chronology of life, onto which stones are placed as symbols for stressful, traumatic experiences and flowers for joyful, empowering events respectively. The therapist completed this exercise with each participant and documented the relevant events. At the end, the therapist took a photo and drew a sketch of the lifeline.

In part III of the present study, four women from the original sample, who completed either the NET therapy or Treatment-As-Usual (TAU), were invited to attend a 2-hour semi-structured interview shortly after participation in the 6-month follow-up. They were asked multiple open-ended questions regarding their experiences of IPV during marriage, childhood abuse, coping strategies in the context of ongoing abuse, perceived social support and their subjective perception of the treatment they have been received. For the aim of the present study, only the subjective experiences of psychotherapy were picked for further content analysis. The four women were chosen for the detailed interview according to their availability. The small number was down to the limited resources of the present study. All four interviews were conducted, taped, and directly transcribed by the same interviewer who interviewed them in the earlier sessions.
4.3.3 Data Analysis

In part I, women's accounts of lifetime traumatic experiences were examined and analyzed by the author using descriptive statistics and content analysis methods. First, all the relevant anecdotes of each type of trauma were counted to determine whether each type of trauma had happened once/twice, three to nine times, or 10 times or more over the course of life. These three categories of trauma frequency were represented as "One-off", "Fragmentary", and "Continuous" in the text. Second, the three traumatic events that participants regarded as the most severe, were given further thematic analysis (Part I). 48 conceptual categories/codes were identified through thorough reading and coding of the trauma accounts. Once this process has been completed, the author re-read and re-viewed all the trauma accounts in each category to ensure that they fitted with the provided codes. Finally, 10 codes/themes were finalized, including "Battering", "Danger of death or serious physical injury", "Traumatic death", "Childhood abuse", "Sequence of traumatic events", "Chronic violence", "Violence at specific dates", "Psychological violence", "Husband's love affair" and "Withholding a child". The reason the remaining 38 codes were removed from further analysis was that they did not reach a saturation point, as they were scarcely recounted by the participants.

In part II, 10 lifelines were investigated to identify potential patterns of stones (traumatic events) and flowers (resources). Finally, the category of "trauma load" was identified. The trauma load refers to dispersion of traumatic events over the course of life, containing two sub-categories of "new chapter" and "repetitive plot", which will be discussed later.

In part III, the content analysis of four women's accounts of the experience of psychotherapy in the context of ongoing IPV was conducted and several main conceptual categories were identified, including "self-improvement", "the direct effect of individual psychotherapy on marital relationship", "the possibility of increase in violence", "the importance of working on IPV-related traumatic memories", and "The relationship between therapist and victim of violence".

4.4 Findings

4.4.1 Descriptive statistics

Frequency of lifetime traumatic events of different types were categorized into "One-off", "Fragmentary", and "Continuous". As it is expected, traumas with a relational nature are more frequent and continuous in the context of IPV. More than half of the women were continuously (weekly/monthly/periodically) exposed to physical assaults mostly by their husband. Repeated marital sexual violence was also common, as 43% of the women were exposed to at least three sexual assaults during their lifetime. Of all, 39 women (83%) reported three to nine more stressful events in response to the last item of LEC. The examples given for the last item of LEC "other stressful events", were mostly related to relationship issues. Some examples of this item were
illustrated as follows; "The man I loved stopped calling me and cut our relationship.", "I always was stressed out because of my husband's job as it was something illegal.", "My husband was paranoid, always checking to see if I was with someone else.", "Severe verbal abuse by my husband", "I had to use drugs to accompany my husband" and "my brother's alcohol addiction, which is a burden on me and the whole family."

Table 4.1 and figure 4.1 show further information about the lifetime frequency of different types of traumatic events.

Table 4.1: Frequency of traumatic events experienced/witnessed during lifetime (n=47)

<table>
<thead>
<tr>
<th>Traumatic events: n (%)</th>
<th>No trauma</th>
<th>One-off</th>
<th>Fragmentary</th>
<th>Continuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural disaster</td>
<td>35 (74%)</td>
<td>11 (23%)</td>
<td>1 (2%)</td>
<td>-</td>
</tr>
<tr>
<td>Fire/explosion</td>
<td>26 (55%)</td>
<td>20 (43%)</td>
<td>1 (2%)</td>
<td>-</td>
</tr>
<tr>
<td>Transportation accidents</td>
<td>19 (40%)</td>
<td>25 (53%)</td>
<td>3 (6%)</td>
<td>-</td>
</tr>
<tr>
<td>Serious accident at work etc.</td>
<td>29 (62%)</td>
<td>15 (32%)</td>
<td>3 (6%)</td>
<td>-</td>
</tr>
<tr>
<td>Exposure to toxic substance</td>
<td>44 (94%)</td>
<td>3 (6%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Physical assault</td>
<td>1 (2%)</td>
<td>-</td>
<td>19 (40%)</td>
<td>27 (57%)</td>
</tr>
<tr>
<td>Assault with a weapon</td>
<td>21 (45%)</td>
<td>11 (23%)</td>
<td>9 (19%)</td>
<td>6 (13%)</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>16 (34%)</td>
<td>11 (23%)</td>
<td>7 (15%)</td>
<td>13 (28%)</td>
</tr>
<tr>
<td>Other unwanted sexual experience</td>
<td>19 (40%)</td>
<td>18 (38%)</td>
<td>7 (15%)</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>War experience</td>
<td>29 (62%)</td>
<td>12 (25%)</td>
<td>4 (8%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Captivity</td>
<td>31 (66%)</td>
<td>12 (25%)</td>
<td>4 (8%)</td>
<td>-</td>
</tr>
<tr>
<td>Life-threatening illness or injury</td>
<td>24 (51%)</td>
<td>21 (45%)</td>
<td>2 (4%)</td>
<td>-</td>
</tr>
<tr>
<td>Sudden violent death</td>
<td>23 (49%)</td>
<td>17 (36%)</td>
<td>7 (15%)</td>
<td>-</td>
</tr>
<tr>
<td>Sudden accidental death</td>
<td>6 (13%)</td>
<td>38 (81%)</td>
<td>3 (6%)</td>
<td>-</td>
</tr>
<tr>
<td>Serious injury/harm you caused to someone else</td>
<td>24 (51%)</td>
<td>15 (32%)</td>
<td>6 (13%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Other stressful events</td>
<td>8 (17%)</td>
<td>-</td>
<td>30 (64%)</td>
<td>9 (19%)</td>
</tr>
</tbody>
</table>

Note: "One-off" represents that traumas happened one or two times over the course of life, "Fragmentary" and "continuous" show that whether traumas occurred three to nine times, and 10 or more times during lifetime respectively.
4.4.2 Part I: The most severe events chosen by abused women

Ten different modes of most severe events were identified. Through the data analysis procedure, these concepts were collapsed into three main categories, including "Physical violence", "Psychological abuse", and "Time Effect". "Physical violence" experienced by the participants corresponds with the current definitions of trauma characteristics necessary for PTSD diagnoses. "Psychological abuse" has been experienced in different types. The category of "time effect" represents temporal aspect of continuous IPV, which is supposed to be enduring and long-standing, covering years of daily, weekly or monthly threat and violence. The three categories of worst events and their respective sub-categories, presented in the following sections, are not independent from each other. One story of violence and trauma might contain elements of all categories, i.e. on the one hand, it can be a threat to the body integrity (physical violence), and on the other hand, it might destroy victims' dignity and self-worth (psychological abuse), repeatedly happening over the course of life (time effect).

Physical Violence

This category includes four types of physical violence, containing "battering", "danger of death or serious physical injury", "traumatic death", and "childhood abuse". The worst events in this category generally correspond to the conventional definition of trauma in the current PTSD diagnoses.

Battering. This category refers to different types of physical violence including punching, kicking, pushing, biting etc. Several women chose this category as the worst event at least once. For instance, one woman stated, "My husband seriously battered me and my son. I will never forget
that day." Additional examples of this category include statements such as "My husband lost his identity card and he hit me because he thought I had taken that.", "My mother-in-law provoked my husband to hit me, he kicked and insulted me, and two days later he punched me again in the head.", and "We were in the car and my husband were driving the car very fast, I asked him to slow down, but he started hitting me." All incidences of battering that were chosen as the worst event, were perpetrated by husbands and happened during marriage.

**Danger of death or serious physical injury.** This refers to very severe acts of physical violence that resulted in serious injury or potentially death. It involved the use of a knife, broken glass, chains, and other objects against women or included suffocating and beating them so severely that it could lead to death. Several women reported worst events which were assigned to this category. Almost all the violent acts in this category were perpetrated by the women's husbands. The following quote gives a typical example of these incidents: "I was pregnant when my husband chained me and poured some fuel on me", "When I refused to have sex with him [husband], he broke the glass of the window, and attacked me with broken glass in his hand, I was so afraid", and "He wanted to suffocate me."

**Traumatic death.** This refers to the sudden and violent death of someone close, such as parents, siblings, or a child. 10 women stated that the death of one family member was the worst event of their lives. None of the reported deaths were due to something natural such as old age, but all were sudden and chaotic. For example, one woman said, "I lost my child at the age of two, and my husband has always blamed me for that.", "I lost my mother when I was three. She was beaten to death by my father before my eyes.", and "I lost my father when I was 17. It was a shock, I was devastated. Then I decided to get married to feel better."

**Childhood abuse.** This refers to experiences of child sexual and physical abuse mostly by fathers or brothers. In general, this category was reported as the worst event seven times, including 6 incidents of severe physical abuse, and one of severe sexual abuse. Here are some examples of this category: "My father beat me with a stick and threatened me and forced me to marry my husband.", "My father threatened to behead me. I was shocked.", and "My father raped me for years when I was a child."

**Psychological Abuse**

This category refers to psychological abuse, containing a broad range of unmarked injuries and scars, which was broken down into three sub-categories as follows: "psychological violence", "husband’s love affair", "withholding a child".

**Psychological violence.** A lot of the women's pain and suffering originates with incidents in this category. One sentiment that came up repeatedly throughout the interviews was that they could forget the battering and physical pain that their husband inflicted on them, but they would never forget the humiliation, insults, and mental pain they have been exposed to. This shows the extent to which psychological violence is overwhelming for them and needs to be taken into consideration when conducting mental health assessments. One psychological violence was humiliation,
reported by a number of women as the worst event, as illustrated in the following participant statement, "We wanted to go on a trip, and my husband gave all the money for the trip to his friend's wife and told her whenever it was necessary, she could give some money to me [participant]. He did not directly give the money to me as his wife, I felt like nothing at that moment." Another example of humiliation was "My son was two years old and the TV fell down and broke his leg. When I took him to a hospital, a nurse said to me, shame on you that couldn’t take care of your child. When he said that I felt so embarrassed, my ears started ringing. I couldn’t hear and see anymore."

An additional psychological violence was preventing a woman from following her wishes and interests. For example, one woman stated, "I was close to getting my final language certificate that my husband came to my English institute and insulted me in front of my classmates and accused me of having a sexual relationship with my English teacher. I couldn't go to class afterwards, I even couldn't read my English books anymore. Even now, I feel bad when I think about it." Other participants mentioned verbal abuse as an important element of psychological violence. An example of this is the statement, "My mother-in-law called my parent's home at midnight and cursed and insulted me and my parents." Another woman stated, "The worst thing is my husband's words, he calls me slut, whore etc." Other participants considered excessive blaming as the worst event, for example, one participant said, "After my child's death, he [husband] always blamed me for his death, or whenever our children get sick, he blames me for that." Threats, honor slander, neglect and isolation were other forms of psychological violence frequently mentioned as the worst event. Regarding threats, one woman stated, "He [husband] threatened me to kill my ex-boyfriend with his gun." Several women reported stories of honor slander as the worst event in their lives, for example one woman said, "The first night of my marriage, after having sex with my husband, I didn't have vaginal bleeding. They [husband, family members] all insulted me and took me to the doctor. My brother threatened to kill me with a knife." Regarding neglect, one participant stated, "My husband hit my head to the ground, because I wanted him to have sex with me and he didn't." Isolation is also illustrated in the following statement, "He locked me in the house in the first years of our marriage and didn't let me see my family."

**Husband's love affair.** This category refers to a husband's disrespect to the marital commitment and his sexual dishonesty. Six women mentioned affairs as the worst event. This category is illustrated by the following participant statement, "The day he [husband] got arrested, I saw him with a woman in the police station. I realized then they were in a relationship for a long time."

**Withholding a child.** This refers to the experiences of women whose children were forcibly taken by husbands or a husband forced them to abort a child. Five women mentioned this as the worst event. For example, one woman reported, "my husband forced me to leave my two little daughters behind in Afghanistan and immigrate to Iran. He even doesn't let me talk with them on the phone." Another woman said, "After my brother's death, he [husband] forced me to leave my house and children, without seeing them for 9 months."
Time Effect

This category reflects the impact of time in women's experiences of prolonged exposure to trauma and violence. Living in a context of repetitive, ongoing intimate violence might cause victims' perceptions and descriptions of traumatic events differ from the perceptions of survivors of single-incident traumas. Therefore, we need diagnostic assessments and psychosocial interventions that take the temporal aspect of IPV into consideration. In this regard, we defined the temporal features of traumatic events in the descriptions of the participants, including "chronic violence", "sequence of traumatic events", and "specific dates or days".

Chronic violence. This category directly shows the overwhelming effect of prolonged exposure to trauma and violence on women's memory, speech and narration. Women choosing this category as the worst event can barely distinguish between several repetitive traumatic events and specify which incidents were more painful, distressing or upsetting. Thus, they mention a whole period of time, containing a broad range of severe and mild violence occurrences, as the worst event. For example, one woman stated, "I was sexually abused and attacked by my husband for two years, it was the worst event of my life." Another illustrative quotation is as follows: "The first ten years of my marriage were a nightmare, as my husband was so violent, and his family also interfered with our life and provoked him to do more violence." Even when the participants were asked to specify one or two worst events within these years of severe violence, they stated they were not able to choose between them as all seemed the same.

Sequence of traumatic events. This category refers to a cumulative load of abuse and violence across a short period of time in which traumas sequentially follow one another. Several women mentioned a sequence of traumatic events, instead of one single-incident trauma, as the worst event. For example, one woman shared the following anecdote, which illustrates this category:

"My husband took my car and left home for two months. I complained to the police, but then I withdrew the complaint as I was scared of him. He came back home, and he severely battered me that night, he wanted to suffocate me. He hit me till the morning repeating why you complained to the police. He left home at 6 am. One night after, the police arrested him with a criminal woman. He had affair with her. I was so desperate, asking myself why he did this to me. Then he went to prison, as I had complained to the police for my marriage settlement (bride price), but then I again felt pity for him and abandoned the complaint. One day after he was released from the prison, he again left home."

Another woman stated, "I had recently given birth to my first child and my husband started an argument, repeatedly asking me why I married him. Why you didn't get married to your ex-suitor? Are you still in love with him? He interrogated me for hours and shouted at me and insulted me and finally he hit me and threw me out of the home. It was a snowy night. When I begged him to let me in, he didn't open the door. I had to stay behind the door in the snow till the morning."

Specific dates or days. This category refers to violent occurrences that happened on an important date such as a wedding anniversary, birthday, wedding day, or during pregnancy. It also denotes the first or last time the violence occurred. A specific date/time can bring special meaning to a victim's experience of violence, having a stronger negative affect on her psyche. This category
shows that it is not merely the characteristics of trauma (e.g. severity, frequency) that matters, but also internal attributions and autobiographical contexts can determine which experiences have the capacity to turn into a trauma. Sometimes these special dates/times mark a beginning of a new chapter in a victim's life, occasionally they represent a turning point in a survivor's life, when she decides to take action and protect herself from further abuse, and most commonly they track the trajectory of a victim's suffering. Several women considered abusive behaviors on a specific date/day as the worst traumatic event. For example, one woman stated, "The first time he [husband] hit me was one of the worst days of my life. My son was 6-week old back then." Another woman said, "He [husband] destroyed the first birthday of my one-year old daughter. He was drunk then. He hit guests and attacked me."

4.4.3 Part II: Trauma Load

Multiple stressful and traumatic events are pervasive across the life of victims of IPV, sometimes with an early onset in childhood and an extension into puberty, youth, and adulthood. Regarding the dispersion of traumatic events across participants' lifelines, two patterns of trauma load were identified. The first pattern is called "New Chapter" as it represents IPV experiences of women who reported that they were not exposed to severe threats and violence before marriage (e.g. during childhood) and their pain and suffering started when they began married life. Therefore, the experience of IPV was a new chapter in their life, disconnected from earlier chapters, throwing them to a new world with new challenges, and goals. The second pattern is a "repetitive plot", a continuation of threats and violence from childhood to adulthood, from the family of origin to the family of their own. Details of each pattern and its typical lifeline are reported below.

**Pattern One: A New Chapter**

Most women belonging to the first category report that they were shocked when they faced violence by their partner, as they had not experienced violence before. They state that it took months or years for them to realize that they were trapped in an abusive relationship as it was something new to them. At first, they refuse to believe that it is something serious, and they do not take action, as they are not able to understand it. They are shocked by the acts of violence perpetrated by their partner, needing time to recognize their new situation and grasp its meaning. Further, they think it is something accidental and temporary, and it will resolve in time. In addition, they usually do not have enough knowledge about IPV and its sub-categories, its facilitators or obstacles, to spot it at this early stage. Therefore, they generally do not take action and keep silent. They tolerate the violence and hope it will end soon. However, the violence not only lasts and repeats again and again, but also escalates. Consequently, their survival instinct takes action to prevent the rise in domestic violence. They protest, argue, fight, and defend their rights, needs and wishes against the husband/partner and struggle to recover the lost equilibrium in their life. However, they gradually realize that their struggles cannot stop violence, but it might lead to an escalation of it, i.e. it can provoke the husband to exert considerable pressure and power within
the relationship and isolate the woman to such an extent that she finally feels forced to concede and surrender. Therefore, a victim's fear and helplessness enable the abuser to consolidate the abusive relationship and preserve it for years. A typical example of this pattern is exemplified Maryam, a 54 year-old woman, who has endured more than 30 years of domestic violence. Her main concerns about her husband leaving her forced her to seek help. She uncovered an overwhelming helplessness during the lifeline task when she had to remember the multiple traumatic events during her marriage. Prior to that, she was quite happy, reminiscing about her life before marriage. Figure 4.2 shows her lifeline.

**Pattern Two: A Repetitive Plot**

This pattern shows that present traumatic events and violent experiences are a continuation of earlier ones in childhood. Occurrences of trauma and violence are not limited to the marital relationship, but widespread across the woman's life. Women belonging to this category are familiar with abuse and violence before they enter marriage. It seems that physical and psychological violence in a relationship is a norm, rather than an exception. Therefore, they might easily adjust themselves to the new abusive relationship as they have already developed adaptive and maladaptive coping mechanisms to deal with it. However, their pain and suffering increases, as previous research shows that there is a dose-response relationship between accumulative traumatic exposures and severe mental health problems (Schauer et al., 2003). Figure 4.3 represents a typical lifeline for this category, belonging to Sima, a 28 year old woman, who have been exposed to physical, sexual, and psychological violence for almost all her life.
Figure 4. 2: A typical lifeline of trauma load representing marriage as a new chapter

Birthday: 1960, Shahrood: I wish I was not born!
8 yr., Shahrood: I was beaten in school by my teacher and quitted school.
9 yr., Accident with a car.
9 yr., Shahrood: Went back to school. I loved my new teacher but I failed the exam.
8 to 10 yrs., Shahrood: Happy time with my friends!
10 yr.: Moving to Tehran.
12 yr.: Went to school again.
15 yr.: Started working in a hospital, getting independent and having high self-confidence.
17 yr.: Changing my job.
17.5 yr.: Changing my job again, I wanted to get married!
18 yr.: The day of engagement to my husband, I got regretful the minute I said yes to him!
18-20 yrs.: 2 years of engagement, I hated him, cat and mouse game between us, I had the power in the relationship.
20 yr.: I was pregnant with my first child: Psychological abuse by the husband!
My first child was born.
21 yr. We moved to our house.
My daughter was 1 yr. that my husband started beating me, he always kicked me in the head.
22 yr. My second child was born.
23 yr. I heard that my husband was in a relationship with another woman.
After 5, 6 yrs. of the marriage, my husband cared more about his friends than his own family, Our fights started!
for 15 years of marriage, he badly hit me, mostly in head, then I got dizziness and fell to sleep (once a month).
He badly hit me and then threatened to burn the house (several times).
He strongly hit me, poured fuel on himself and threatened to kill himself (several times).
26 yr. My third child was born.
28 yr. He seriously hit me and wanted to explode the house with gas.
30 yr. My forth child was born.
30 yr. He hit me and threw me out of the home as I didn’t agree with him to let his family member rent our rooms.
33 yr. My fifth child was born.
37 yr. He threw me out of the home and threatened me to burn the house with gas.
40 yr. He made us get back home from travel as we didn’t agree with him to stay in a smelly hotel.
50 yr. My mother died of stroke.
53 yr. My husband left us and went to another city for living.
53 yr. My husband started a relationship with a young girl.

Future: I want my husband back home but he doesn’t want to do so.
Figure 4.3: A typical lifeline of trauma load representing a repetitive plot of life

- 1987, Malayer, birthday: My mother was alone when I was born as my father was with his another wife.
- 4 yr., Malayer: House fire
- 6 months later, my grandmother died and my brother hit me badly that day.
- 6 yr. My father made a wall in our house to separate the lives of his two wives: discrimination started!
- 9 yr. My two older brothers hit me and pushed me down the stairs.
- 10-11 yrs. sexual abuse by my half brother (several times)
- 11 yr. I was badly beaten by my older brother.
- 10-15 yrs. I was regularly beaten by my brothers.
- 12 yr. Suicide attempt
- 13 yr. I attempted suicide as my mother and siblings badly humiliated me.
- 14 yr. My brother badly hit me as he thought I had a boyfriend.
- 15 yr. My brother hit me and cut my hair with knife.
- 16 yr. I witnessed my father hit both his wives and poured hot water on them.
- 18 yr., Syria, I was raped by a stranger.
- 18-23 yrs., Tehran, My brother tried 4 times to rape me, but I didn’t let him!
- 18-23 yrs., Tehran, I started a job.
- 21 yr. Kish, I witnessed my two brothers badly fought with each other.
- 22 yr. Malayer, My family members hit me and accused me of sexual relationship with a man.
- 23 yr. I got engaged with my husband, 4 months fight between my family and my husband’s family!
- 23 yr. My half brother threatened me with a knife.
- One month after the engagement, my husband wanted to divorce me and didn’t talk with me anymore.
- 24 yr., Malayer, My wedding party fight, there was a big fight between families and my husband hit me.
- One day after my marriage, I was beaten by my husband again.

After one month, I got pregnant!
- I had to break up with my family. My husband and his family humiliated me a lot because of my own family.
- At 7 months of pregnancy, my husband hit me.

- 24 yr. I got pregnant again!
- I was badly hit by my husband and fainted because my husband didn’t want me to abort the second child.
- When my second child was born, a big fight again happened between my family and my husband’s family.
- 27 yr., I was beaten by him that I fainted. I went to police and they put him in prison for some hours.
- I don’t know what to do!
Part III: Women's Experiences of Psychotherapy in the Context of Ongoing Violence

This section refers to qualitative analysis of subjective experiences of four women who have completed a course of psychotherapy, conducted under ongoing threat and violence. Of four women, two participated in Narrative Exposure Therapy (NET) sessions, a trauma- and exposure-based method, and the remaining two received supportive counselling and/or routine, mental health interventions (See Orang et al., 2017 for further details). Table 4.2 shows their sociodemographic information.

Table 4.2: Participant's socio-demographic information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Education</th>
<th>Job</th>
<th>Marriage duration</th>
<th>Children</th>
<th>Current marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shirin</td>
<td>30</td>
<td>Bachelor</td>
<td>Accountant</td>
<td>5 years</td>
<td>0</td>
<td>Divorced</td>
</tr>
<tr>
<td>Zahra</td>
<td>37</td>
<td>Diploma</td>
<td>Housewife</td>
<td>19 years</td>
<td>2</td>
<td>Married</td>
</tr>
<tr>
<td>Narges</td>
<td>38</td>
<td>Diploma</td>
<td>Secretary</td>
<td>22 years</td>
<td>2</td>
<td>Divorced</td>
</tr>
<tr>
<td>Mona</td>
<td>26</td>
<td>Diploma</td>
<td>Housewife</td>
<td>7 years</td>
<td>1</td>
<td>Married</td>
</tr>
</tbody>
</table>

A short summary of each participant's description is reported below, along with a title which represents the core concept of their therapy experience.

**Puzzle**

Shirin (30 yrs.) who finally managed to get a divorce after the end of therapy, described her experience of the treatment as follows; "This therapy was like a torture, I didn’t enjoy it, I was always frustrated when I came home from therapy. You [therapist] pointed exactly at the spots I never wanted to look at. This was difficult for me as I always was escaping. But it was good as it pulled out my feelings. I had pain when I was talking about those bad events, but in the end, those strong feelings and that huge pressure which had been always attacking me, reduced. I remember I couldn’t cry the first days of my therapy, but then I managed to cry. I was so sad and desperate. When I was living with Ali [husband], I didn’t have time to pay attention to my feelings or understand them or tell myself I have any rights. I blamed myself a lot. Everyday life with my husband was a huge pressure and I even didn’t have time to breathe. In therapy, I told myself, it is ok if you are sad, I felt my body and my feelings, and then it seemed all the feelings were gone. Sometimes, my body became paralyzed. I felt that how much the feeling was alive. I could now walk up one level above me and see myself from there. I couldn’t escape anymore. My memories came back. It seemed the puzzle was completed when I remembered and accepted my bad memories with Ali. I used to ignore all the bad things and repeat to myself that Ali would change to be better because I wanted to live with him. Then we worked on my memories and I realized that Ali has not changed since the day we met. He was doing the same shit. I had to decide, I told myself forgive him, accept him and live with him, or forgive him and get a divorce. This room was a place of pain for me. A pain that led to good, all my feelings were pulled out of my body, and I became calmer."
Self-care

Narges (38 yrs.) also reported that NET empowered her to finally get a divorce; "I hated my husband. I couldn’t even look at his face in the 6 last years of our marriage. It took 18 years to rid myself of him. He was always telling me leave him. I always wanted to get a divorce, I went to court 3 times but each time, at the last moment, I changed my mind. I was afraid. I couldn’t make a decision. I had doubts, thinking it might have been my problem. Maybe he was right and I was making mistakes. I was always worried that if I got a divorce, I would regret it. I couldn’t get a divorce and I couldn’t tolerate that marriage. I was so desperate, and life was so meaningless. I was crying all the time. It was like this until somebody introduced your project to me, it was like a miracle in my life. During the class, I realized I never noticed my feelings. For example, I didn’t know that I should show my feelings when I am sad, and when somebody has hurt me, I should react to that. I didn’t care about myself; I only cared about others, and I only wanted my husband to love me. I was always worried about people: what they think, what they feel. I didn’t know what was happening inside me. During the class, I realized I have right to be sad, I should care about myself, I realized how much I was humiliated for years during this marriage. I finally understood I was right to want a divorce. I had gone to get a divorce three times, and each time my husband had changed his mind because he probably had realized I was not sure, but this time, I was so sure what to do. I got a divorce in one day. My husband asked me why I am in such a hurry, we can do it later, but I said to him with certainty we should do it today. I was so sure and it was a miracle. I remember the moment I was in court, some worries about divorce came to my mind, but I told myself you have done everything to preserve this relationship and nothing worked. I was right and it was not a mistake to do it."

Miracle

Conversely, Zahra (37 yrs.) stated that, contrary to her expectation, counselling did not lead to a significant change in her life; "I came for counselling after 20 years of marriage, but it wasn’t that effective. My husband hit me again when the therapy was happening. Maybe my expectations were too high. I was looking for a miracle, but it didn’t happen. Maybe it’s not possible to profoundly change things only within 10 sessions! Maybe you need to go for more sessions if you really want big changes! Before I came to counselling I had thought I would bring lasting peace to my life, a permanent peace, not a temporary one. When I came to these sessions, I started to become more courageous, to resist my husband's extra demands, to defend myself from my husband, to listen to my feelings, but this resistance resulted in more violence, he severely beat me because I opposed him. Now I don’t want to continue therapy anymore, I am afraid of listening to my feelings anymore. I listened to my feelings twice before in my marital life, and both times led to chaos. No, I think it doesn’t work if only I come to therapy, my husband should also join. It’s not just enough to change myself, I was always thinking that it was my fault if he hurt me, I was always blaming myself for violence, and I tried to come to therapy to fix myself. I tried my best to change my behavior during those sessions, I thought my behavior might have changed for better during
therapy. But now I realize my husband also needs change his behavior. It's not only my fault. Now I prefer not to talk, oppose or even say a word in order to prevent my husband from getting angry."

Life Skills

Finally, Mona (26 yrs.) reported she was satisfied with the result of counselling as it helped her marital relationship to grow; "We fought each other a lot. When I came here [to therapy], I realized I needed to know how to wait, how to control myself. This patience helped me a lot in my marital life. I learnt not to argue with my husband when he was angry, then when I was quiet and calm, my husband also calmed down because of my patience. Before coming to therapy, whenever my husband insulted me or my family, I insulted him or his family back. If he hit me, I threatened him, telling him I would get other people to attack him. We were fighting all the time, and it finally led to chaos. But now, whatever he says, I don't answer, or I tell him you are right, then after some minutes or hours, he feels sorry about things he said and apologizes to me. It doesn't end to a fight anymore. This helped my husband to trust me again. He didn't trust me at all, but now he is gradually trusting me... He asked if we can try for a second child... We fight a lot less. He knew I came to therapy, and he always encouraged me to continue. He said to me that this counselling changed me a lot. He didn't come to counselling, but his behavior changed when mine changed. I think I was like a child before. When I got married I was 18. I was so inexperienced. The counselling helped me to grow more."

A reoccurring theme in each participant's account was self-improvement. Mental health interventions helped them to learn new life/communication skills, and/or grow a sense of self-worth. For example, Zahra stated; "One thing which was so predominant in my sessions was self-protection. Why you don't defend your rights? My counselor asked me "why are you silent when they [husband and his family] violate your rights? You should defend yourself." I felt courageous inside, a feeling started growing inside me. I was so happy within the period of counselling. I was energetic. I felt powerful. Sometimes I wondered if my counselor might think I didn't need to come to the sessions anymore, as I was so happy those days." Another example of self-growth was building a sense of self-coherence through therapy sessions, as they managed to review all their good and bad memories and integrate them into one life story. This procedure helped them to boost their self-confident and decision making power. Shirin's experience of self-coherence was illustrated as follows; "I used to ignore all the bad things that happened between us and repeat to myself that Ali [my husband] would change for the better, I repeated it to myself because I wanted to live with him. Then we worked on my memories and I realized that Ali has not changed since the day we met. I couldn't escape anymore. I was in therapy when he again attacked me. I told myself it's enough, he never changes, and he is the same person."

In addition to self-growth, women reported that the experience of therapy directly affected their marital relationship, and their husband's behavior. In other word, the benefit of individual psychotherapy was not limited to only women, but also it extended to their partners, who did not participate in the sessions. For example, Narges believed that therapy helped her to
finally get a divorce because "My husband realized that I was serious this time, he realized that I was sure about the decision I was going to make, so he easily accepted my decision when I said I wanted a divorce. We got a divorce in one day! Before that, I went to court 3 times but each time, at the last moment, I changed my mind. I was afraid. I was not sure if it was the right decision, and my husband refused to divorce me as he saw my fear and doubts.” Mona also stated that her husband changed his behavior when she managed to improve herself during therapy; "He didn't come to counselling but his behavior changed when mine changed. Whenever I came back home from the counselling session, he admired me and told me how much I had changed through the counselling! I've told him that the counselor says we shouldn't fight each other in the presence of our son, and after that, he has been trying a lot to control himself. Now, he started to trust me again..."

Furthermore, it seems that psychotherapy in the context of ongoing threat and violence does not always result in positive effects, but it can also lead to negative results such as further fear and surrender of power as Zahra experienced; "I had another big fight with my husband when I was in therapy. It was after the ninth session that the fight happened. I felt I had a right to object to him when he started to insult me and accuse me of something that I hadn't done. But he got angrier and beat me severely. Now I don't want to continue therapy anymore, I am afraid to listen to my feelings. I listened to my feelings twice before, and both times led to chaos."

Two of the participants that received NET reported that working on IPV-related traumatic memories helped them to feel confident to react to ongoing abuse and violence. This is in line with the literature that denial, dissociation, avoidance and numbing result in further victimization in the context of partner abuse, and exposure-based therapies predominantly reduce symptoms of avoidance and numbing, which, in turn, empower women to take action and resist abuse and violence (Krause et al., 2008, 2006; Kubany et al., 2004; Street et al., 2005). This is illustrated in the following statement by Shirin; "Before therapy, I used to escape from my bad memories, whenever a sad memory popped up, I pulled myself back, but now, I just watch them. It seems I was disconnected from my bad memories in order to ignore them, but then, during therapy, they were joined to my life. Ignoring my bad memories has resulted in more doubts and confusion, I couldn't decide. When I realized them [bad memories with her husband] during therapy, I became able to accept the reality of my life. Before, I set my bad memories aside and stuck to optimism, a stupid optimism! I was telling myself, Ali [Husband] would change for better, I should stay! But now, I am telling myself, Ali is as he is! Make a decision!"

Finally, another important concern is the quality of relationship between the client and therapist, whether it is empowering or disabling. Three participants reported that their relationship with their therapist enabled them to grow more independent; Mona defined her therapist as a "good friend" who listened to her and taught her life lessons. On the other hand, Shirin and Narges (NET participants) considered their therapists to be more passive in sessions, in a sense that therapists did not tell them what to do or what not to do, but gave them space to realize it themselves. For example, Narges stated; "My therapist didn't interfere with my divorce at all, I was the person who decided to do that, and I was sure it is a good decision. When I told my therapist that I went to the court, she was surprised! She asked me if I was sure that it wasn't too soon to get a divorce, I said
to her that I didn't think it was too soon at all. I was so sure about my decision." Conversely, Zahra's experience was different. She considered her therapist's words and behavior judgmental and indifferent. She reported; "She [therapist] attributed things to me during counseling, which was not fair, but I had to tolerate them. She didn't know everything about my life. I didn't tell her everything. I was afraid of being judged. She accused me of doing this and that and I felt very sad, but I didn't tell her anything... She didn't believe my words. When I told her that I couldn't keep a diary, because my husband might find it and read it, she refused to accept my worry..." This statement shows that how important it is for therapists/counselors who work with victims of IPV be sensitive to the dilemmas of the patient regarding domestic violence, to ensure that the abused women are not re-traumatized in the context of therapy.

4.5 Discussion

The present exploratory study of the subjective perceptions of women exposed to ongoing domestic violence provides new insights into IPV as a continuous and enduring stressor. To the best of the author's knowledge, this study is the first to examine subjective perceptions of the most severe traumatic experiences of abused women in the context of ongoing IPV, The traumas which led them to develop PTSD symptomology. Furthermore, the present study identifies the characteristics of traumatic events that are dispersed over the course of life. This research also documents the experiences of female victims of ongoing IPV of individual psychotherapy. The following section presents a discussion of a) how abused women determine the worst traumatic events that cause them to develop symptoms of PTSD, b) How traumatic events are dispersed across the lifetime of abused women and what implications the probable patterns of trauma load have, and c) how abused women describe their experience of psychotherapy in the context of ongoing IPV.

How do abused women determine the most severe traumatic events that cause them to develop symptoms of PTSD?

Consistent with the current definition of trauma as an actual or threatened danger to bodily integrity (DSM-5), most participants in the present study chose battering and severe injury as the worst event that resulted in pain and suffering. However, their perception of a traumatizing event was not limited to bodily harm. They repeatedly mentioned psychological IPV as one of the most detrimental events that led them to mental health problems. This finding is in line with previous research that psychological violence above and beyond physical abuse results in the development of PTSD symptomology among female victims of IPV (Pico-alfonso, 2005). Furthermore, they indicated that the temporal aspect of IPV occurrences has an important impact on their perception of trauma and violence. For example, the chronicity of violence disturbs a woman's memory, speech, and narration in a way that she barely can distinguish between multiple, repetitive traumatic events across life and recount a specific traumatic story. In this regard, previous research revealed that experiences of severe violence cause traumatic memories to be disconnected from
autobiographical contextual memory, meaning a traumatized woman might lose important details of time and location of each specific incident and only remember fragments of traumatic events entangled with each other (Schauer, Neuner, & Elbert, 2011). Consequently, most traumatic events and the related triggers become similar, forming an extended trauma network in her memory, and reducing her capacity to recall specific trauma, rather than a whole period of violence. An occurrence of trauma at specific dates/days that are meaningful and important to a victim, might further exacerbate their suffering as it has profound implications for their life story. Overall, the present findings suggest that temporal aspects of violence, psychological violence and physical abuse are the main concerns for abused women when describing their lifetime pain and suffering.

Finally, the current PTSD diagnosis does exclude psychological violence and temporal aspects of violent incidents, instead merely taking bodily threat and violence into consideration. Therefore, we propose that the current PTSD diagnosis category is not appropriate for evaluation of mental health suffering among victims of continuous trauma and violence such as IPV, regarding the fact that the current PTSD assessments do not include psychological abuse and temporal aspects of violence incidents in examination. Accordingly, there is a need for further research in the future to fill the gap in our knowledge in order to adapt the current PTSD definition and assessment for main concerns of victims of complex trauma.

How are traumatic events dispersed across the lifetime of abused women and what implications do the probable patterns of trauma load have?

Victims of IPV have usually gone through additional adversities, such as childhood abuse (Pico-Alfonso et al., 2006; Seedat et al., 2005). The present study found two patterns of trauma load across their life; one pattern, consistent with the previous research, shows that physical, sexual and psychological abuses are widespread and they not only suffer from current IPV, but also traumatic memories of childhood exacerbate their suffering. Therefore, it is of utmost importance to identify occurrences of childhood abuse during diagnostic assessments and consequently, deal with their effects through intervention programs. Another pattern presented in this research belonged to IPV women who did not experience additional adversities, in particular childhood abuse. They recounted stories of shock and confusion in the first months/years of marriage when they faced IPV from their partner for the first time. Future studies need to investigate specific characteristics of this group of IPV-affected women, as most of participants in this group reported that before marriage, they did not have any knowledge about IPV, its causes, effects, and ways of reducing it. Thus, when they faced it in their marital relationship, they were not able to recognize it. In addition, they stated that they were rarely involved in decision making or problem solving situations in their family of origin and mostly were expected to follow whatever they were told by their parents. Further research on this group can have important implications for primary and secondary prevention programs.
How do abused women describe their experience of psychotherapy in the context of ongoing IPV?

To answer this research question, a small number of participants were interviewed to describe their experience of psychotherapy. All women reported experiencing some degree of self-growth, which empowered them to oppose their abusive partner. Learning new life skills, improvement of self-confidence, and a growing sense of unity and coherence due to integration of traumatic memories into a wider life story, are among the most important therapeutic effects mentioned by these women. However, this self-growth scared one interviewee, as she considered it as a cause of further violence. She reported an occurrence of IPV within the course of therapy, when she felt powerful enough to resist her husband, which, in turn, led to her husband's physical violence. Thus, the new experience of violence within the course of therapy disappointed her expectations of therapy and discouraged her to further seek help as she was afraid her self-confidence and resistance increase the likelihood of IPV. Therefore, once more, the need for a multidimensional approach to IPV, including legal intervention and social support as well as treatment programs, is highlighted. In addition, the present study underscores how important it is for therapists/counselors to be knowledgeable and sensitive about the phenomenon of IPV and establish a non-judgmental communication with survivors/victims, to avoid them being re-traumatized in the context of therapy. Finally, in line with previous research, the two participant who received an exposure-based treatment (NET) reported that working on IPV-related traumatic memories helped them to improve decision-making ability as remembrance and integration of traumatic memories counteracted features of avoidance, ignorance, denial, and numbing, which are common among victims of complex trauma.

Finally, one potential limitation of the present study is due to the fact that the author has conducted all three stages of data collection, coding and analysis. Another important limitation is the relatively small sample size, particularly regarding women’s experience of psychotherapy under ongoing IPV. Future qualitative research is needed to further investigate treatment experiences of this group.

4.6 Conclusion

Despite the disturbing effects of psychological abuse and chronicity and continuity of violent experiences on mental health, standard diagnostic definitions of trauma and PTSD have been neglectful to take these factors into account so far. The present study, in line with the previous arguments, highlighted the importance of reconsideration in current standard trauma characteristics to address the needs and specific condition of victims of chronic and continuous violence such as IPV. Further, we concluded that living under continuous trauma and violence do not prevent abused women to benefit from treatment outcomes.
5 General Discussion

Intimate Partner Violence (IPV) results in a broad range of mental health problems, such as depression and Post-traumatic Stress Disorder (PTSD), in women worldwide, which in turn makes it more difficult for affected women to seek help and utilize available resources. This is especially the case in low-to-middle income countries such as Iran, where structured gender inequality infects all levels of society, including the legal system, and compounds to women's reluctance to seek help.

The present thesis investigates socio-demographic factors and mental health status of women affected by continuous IPV, and explores the feasibility and effectiveness of individual counselling/psychotherapy under ongoing threat and violence. Research articles provided in chapters’ 2, 3, and 4 address each of the goals of the thesis. In chapter 2, findings suggested that IPV-affected women living under ongoing violence might show a different psychosocial profile than abused women who are able to seek refuge in shelters or leave an abuser. The results presented in chapter 3 showed that living under ongoing trauma and violence does not prevent victims from benefiting from psychological interventions, particularly exposure-based therapies such as Narrative Exposure Therapy (NET). In this regard, NET showed promising results in the reduction of psychopathological symptoms. In addition, participants showed significant reductions in IPV experiences and disturbed functionality in 3- and 6-month follow-ups, regardless of the type of treatment. Finally, chapter 4 examined the suffering of IPV-affected women in qualitative detail. We found that although incidents of physical violence were considered to be especially traumatic, in accord with DSM-5’s definition of trauma, psychological abuse and temporal aspect of violent experiences, such as chronicity and continuity, were also regarded as main sources of suffering.

The following sections will discuss the findings of the present articles, based on the research questions outlined in chapter 1.

5.1 Discussion of the results

5.1.1 Psychosocial and psychopathological profile of women exposed to continuous IPV

In the first article, the investigation of the mental health status of Iranian women suffering from ongoing IPV-related PTSD, showed comorbidity of PTSD and depression, and a significant association between PTSD and daily functioning impairment. These results were in line with previous studies, revealing that depression frequently co-occurs with PTSD (Golding, 1999), and a PTSD diagnosis makes diminished quality of life among abused women more probable (Laffaye et al., 2003).

Although almost all participants (96%) had experienced incidents of childhood abuse, child abuse did not have a significant relationship with IPV, either in the previous year or across the lifespan. Participants’ experiences of childhood abuse were not further associated with PTSD
symptomology, depression, or functioning impairment. These results were not consistent with previous research, which show a high degree of correlation between IPV and child abuse (Afifi et al., 2009; Daigneault et al., 2009; Gómez, 2011). However, the specific characteristics of the present sample might explain the inconsistency between the present and previous research, as the women in the present study were living under ongoing IPV, overwhelmed with the current threat without a way of leaving the abusive relationship. This, in turn, might lead them to perceive the family of origin as an informal resource than a source of suffering. Further, the present study did not find any significant associations between additional lifetime traumatic events and mental health problems. A general linear model revealed that the experience of IPV in the last year, rather than child abuse, lifetime IPV, or additional traumatic experiences, significantly predicted PTSD symptoms in the present sample. This result is consistent with a previous study where nearly half of its participants were living with a violent partner (Pico-alfonso, 2005). It suggests that abused women living under ongoing IPV might show a subtly different pathological profile compared with IPV-affected women who managed leaving the violent environment.

Further analysis of the abused women living under ongoing IPV revealed that women with higher PTSD symptoms used more psychopharmaceutical drugs. This finding has further implications that go beyond the realm of therapy, and reflects the importance of psychosocial factors involved in treatment of victims of IPV; i.e. living under ongoing IPV in an environment where there is little access to social and legal support and lack of knowledge and sensitivity about IPV and its psychological consequences within the medical community, all together result in dysfunctional help-seeking behavior such as the abuse of prescription medicine. In this context, medicine is not only a practice to maintain and restore health, but rather a symbolic cry for help, as medication is sometimes the only accessible and socially accepted resource for abused women in such societies.

Child marriage and low education are not the only risk factors for IPV. In some contexts, socially empowered women are more likely to be exposed to IPV (Moghaddam Hosseini et al., 2013). In this regard, the present study found that although women married at the age of 18 and older had high education (diploma or university certificate) and mostly considered themselves as financially independent, they suffered from significantly higher PTSD and depression symptoms, than those who married under the age of 18. This finding suggests that in patriarchal societies like Iran, in transition from tradition to modernity, women with fairly high social status are likely to come into conflict with cultural norms and thus become susceptible to violence. However, in the second article, it was found that abused women with a high school or university certificate were more likely to complete therapy, while the level of education was much lower in dropouts. Therefore, we need to consider the pros and cons of demographics in the context of each single environment in planning intervention and prevention programs.

Women living under conditions of threat and abuse need find meaning in their current daily adversity, thus, they apply available socially accepted explanations to their condition. One generally accepted explanation for a partner's IPV perpetration is addiction, a condition which justifies violence and turns attention from systematic gender inequality and structured injustice within a society to personal defects such as drug dependency. Therefore, abused women who lack
such socially legitimate explanation might find violence meaningless and suffer more, reflecting the finding in the first article that women who did not have a drug-addicted spouse, reported higher depression scores than those who had.

Once more, the present findings about socio-demographics and relevant mental health outcomes among women exposed to ongoing IPV revealed that IPV is a multidimensional phenomenon and it is necessary to evaluate IPV, its causes, consequences, and intervention strategies in the specific environment it has occurred. Furthermore, the present thesis highlights that the pressure of ongoing trauma and violence, with burden of a non-supportive and/or oppressive society, might lead abused women to show a slightly different pathological pathway. Therefore, future research on ongoing IPV, particularly in societies susceptible to violence against women, is necessary.

5.1.2 Exposure-based psychotherapy under ongoing trauma

The second article represents the feasibility and effectiveness of exposure-based psychotherapy under continuous IPV for the first time. Before, it has been argued that implementation of trauma-focused interventions in the context of ongoing threat and violence might put abused women at further risk, as their psychological symptoms, such as avoidance or heightened sensitivity, can be an appropriate response to ongoing danger, and protect them from further abuse (Warshaw et al., 2013). However, our findings revealed that IPV-related PTSD and depression symptoms were significantly reduced after a short period of treatment even if abused women were still living in the context of ongoing IPV and mostly have had to hide psychotherapy from their husbands. The results further showed that NET, as an exposure-based therapy, was superior to other more commonly implemented counselling and supportive techniques, in the reduction of PTSD, depression and perceived stress symptoms. These results are in line with the previous exposure-based intervention studies among IPV-affected women, showing that implementation of trauma-focused therapies can enable abused women to distinguish between real dangers and overgeneralized trauma reminders and practise appropriate reactions in different conditions (Kubany et al., 2004; Murray et al., 2013; Stapleton et al., 2007). Similarly, previous research found that pre-treatment characteristics were not related to therapeutic outcome and dropout of prolonged imaginal exposure among patients with chronic PTSD, concluding that everybody in need could benefit from prolonged exposure treatment regardless of pre-treatment variables (Minnen et al., 2002). Consistent with Minnen and colleagues' study, the present study showed that apart from the clients' level of education, there was no significant difference between dropouts and completers, i.e. an exposure-based treatment such as NET did not result in increased dropouts.

Another reason for the superiority of exposure-based therapy over treatment as usual is that exposure therapies, compared with other PTSD treatments, are more successful in reduction of numbing and avoidance symptoms (Kubany et al., 2004). Similarly, the present results showed that compared with the treatment as usual group, avoidance symptoms were strongly reduced in the NET group. The importance of this result is thrown into relief when considering previous
findings regarding the necessity of dealing with avoidance and numbing symptoms in IPV-related intervention programs, as their reduction, in turn, decreases the likelihood of re-abuse (Krause et al., 2008, 2006; Street et al., 2005; Strigo et al., 2010). Previous research has shown that numbing and avoidance as maladaptive coping mechanisms, arisen out of long-lasting abusive relationships, desensitize a victim to real danger to an extent that she cannot properly react to the current threat, and lead a victim to use submission and compliance in order to protect herself, while, on the other hand, it mostly reinforces an abuser to step further forward (Krause et al., 2008, 2006; Street et al., 2005; Strigo et al., 2010). Therefore, exposure-based interventions, reducing numbing and avoidance symptoms, might change abused women's passive approach to continuous abuse to seek further help and resist violence.

Finally, daily functioning impairment and IPV experiences significantly decreased among the abused women from pre-test to 3- and 6-month follow-ups, however, we need to be cautious to generalize the findings, as the reductions might be affected by other un-evaluated variables such as time. There was no significant difference between NET and TAU in reduction of IPV experiences and functioning impairment among women living under ongoing violence. This finding once more emphasizes the fact that it is necessary to take a multidimensional look at IPV, and not to expect that mental health programs for the abused or an abuser can stop violence on their own, in the absence of legal, social, and cultural interventions.

5.1.3 The effectiveness of NET under ongoing IPV

This study represents the first time that the efficacy and feasibility of NET were investigated among IPV-affected women. Previously, the effectiveness of NET has been shown in different samples living in unsafe conditions under ongoing threat and mass violence (Crombach & Elbert, 2015; Gwozdziewycs & Mehl-Madrona, 2013; Hinsberger et al., 2017; McPherson, 2012; Mørkved et al., 2014; Neuner et al., 2004; Robjant & Fazel, 2010). Similarly, the second article showed the superiority of NET over non-exposure interventions in the reduction of PTSD, depression and perceived stress symptoms.

There are different reasons why NET is an appropriate treatment in the context of IPV; First, NET deals with the sequence of traumatic events that happened in a victim's lifetime, rather than a single trauma event, and considers the potential empowering good events as resources (Schauer et al., 2011). This is perfectly suited to the multifaceted nature of chronic IPV and complex trauma, and helps an IPV-affected woman to build a consistent autobiography of her life. Starting with childhood, moving to the present, and looking ahead to an open future, memories that were pushed aside because of repeated, long-lasting occurrences of IPV, are integrated into the autobiography. In other words, memories that are recalled become flexible again and open to change. Therapy transforms a memory from a disturbing, primarily sensory experience to a verbal memory that is ordered within the autobiographical context of the individual's life (De Quervain, Schwabe, & Roozendaal, 2016; Schwabe, Nader, & Pruessner, 2014). This might help them to become integrated and self-confident to take initiative and resist violence. Second, cognitive reorganization
and meaning making are central to NET, helping IPV victims to recognize the probable patterns underlying their violent experiences. The insight gained into the causes of violence and the role of each character in her life story in provocation of violence, assist a victim to recognize the need to seek appropriate help from specific sources such as therapy and/or police. Third, NET, due to its prominent narrative component, is easy to be implemented for abused women with any level of education, especially if they are living under ongoing threat and violence. IPV-affected women usually have difficulty in fulfilling therapeutic assignments in unsafe homes or concentrating on complex abstract discussions throughout therapy for a long time. They might also fear being judged or blamed by a therapist if they are repeatedly told that what thoughts or behaviors are correct or wrong in the context of IPV. NET's narrative character encourages a victim to tell her story and find her own voice. Meanwhile, the therapist with her primary role as a listener, bears witness to the victim's pain and suffering and promotes her dignity.

5.1.4 IPV-affected women's subjective perceptions of trauma and therapy

The third article presented subjective perceptions of abused women of the most severe traumatic experiences, which led to IPV-related PTSD. The importance of this study was that it showed that women's evaluations of continuous IPV do not correspond precisely to the current definition of traumatic stressors as described in the DSM-5 or ICD-10. In other words, while the characteristics of traumatic stressors in DSM-5 are limited to physical and sexual violence, our participants reported that psychological violence and temporal aspects of violent experiences, were also severely traumatizing. Similarly, in the first article, consistent with the previous research (Coker et al., 2005; Pico-Alfonso et al., 2006), psychological abuse was found to be significantly associated with PTSD symptomology, and even triggered more agitation in abused women, than other kinds of violence. These findings are in line with recent arguments by Casey and colleagues, discussing that emotional abuse, significant abandonment and detachment experiences, emotional neglect, and physical neglect also need to be considered as traumatic stressors (Casey et al., 2016). In this regard, the previous research has shown the importance of taking abused women's subjective appraisals of IPV experiences into account, as women with an evaluation of IPV experiences as highly stressful, are more likely to show comorbid depression and PTSD, and subjective perceptions of stressfulness of IPV experiences are strong predictors of depression over and above objective assessments such as frequency and severity of IPV (Martinez-torteya et al., 2009).

In regard to the new conceptual category of "temporal aspects of violence" presented in the third article, we proposed that a prolonged exposure to continuous IPV affect abused women's memory and remembrance, i.e. a) they had difficulties distinguishing between several repetitive traumatic events, and specifying a single traumatic event, when going through a standard checklist of structured diagnostic interview. Rather, they remembered a whole period of time, which sometimes included years of chronic violence, a complex of severe and mild violence occurrences, joyful moments and lost memories; b) Their chosen traumatic event was not a single incident that happened in an specific time and place, but a sequence of events dispersed across days or locations;
c) They regarded an IPV experience that occurred in a specific date/time (such as wedding anniversary or a child's birthday) as a much more stressful event, even if the violence of that experience was less severe than other IPV events. In other words, it was the specific date/time that gave a disturbing event a special effect. These findings once more emphasized that we need an appropriate approach in diagnoses and treatments to deal with traumatic experiences of victims of chronic violence, as their pain and suffering is more continuous and multiple, than related to a single specific incident (Schauer et al., 2011).

In the second part of the third article, we found two different patterns of trauma load across abused women's lifetime. One in accord with the previous literature that there is a high association between IPV and childhood abuse, meaning that violent experiences were dispersed throughout their lifeline, and perpetrated by a broad range of significant others such as husband/boyfriend, parents, and siblings (Afifi et al., 2009; Daigneault et al., 2009; Follette et al., 1996). The second pattern included IPV experiences of women who had gone through a phase of shock and confusion when confronted with IPV for the first time in their marriage, as they had not had intimate violence experiences before marriage, but rather had experienced a safe, happy or peaceful childhood. This group of women mostly reported that they were not involved in decision making or problem solving in their family of origin during childhood and did not have any knowledge regarding IPV before facing it in their marriage. Therefore, we argued that further research on this group will have important implications for primary and secondary prevention programs.

In the third part of the third article, the perceived experience of psychotherapy among women who were living under ongoing IPV, was investigated. The exploratory results showed that psychotherapy even under unsafe living conditions with an abusive partner was experienced as a pathway to self-growth, self-confidence, new life skills, and an integrated self. However, women's experience of psychotherapy under ongoing threat and violence was not always empowering. One participant described her counselling experience as disturbing, since the resultant improvement in self-expression provoked her husband's anger and led to increased violence. Therefore, it is necessary to highlight the importance of a multidimensional approach to IPV, including implementation of legal, social, cultural interventions as well as mental health programs.

5.2. Implications for the future

5.2.1 Future research

The present thesis specifically explored mental health needs of IPV-affected women living under ongoing threat and violence, and found that they could benefit from mental health interventions in general, and exposure-based treatments such as NET in particular. There is a huge body of research on IPV, its causes, effects, and relevant intervention programs, and it has been demonstrated that abused women, either living with an abusive partner or leaving them, are psychologically affected by IPV consequences and are in need of urgent therapeutic help (Coker et al., 2002; Eckhardt et al., 2013; Golding, 1999). However, most psychotherapy intervention programs or clinical trial
studies have been conducted on abused women who have managed to leave their abusive partner or seek refuge in shelters, and mental health needs of abused women currently in an abusive relationship have been neglected (Condino et al., 2016; D. M. Johnson et al., 2011; Kubany et al., 2004). This neglect becomes more notable when considering the huge number of abused women who have not been able to leave an abusive relationship or have chosen to stay with their abusive partner, but are still affected by IPV consequences (Arias & Pape, 1999; Hughes & Jones, 2000; Iverson et al., 2011). The situation is further worsened in low-to-middle income countries, where limited resources and structured gender inequality prevent abused women from receiving help (Paul, 2016; Rowan et al., 2015; Umubyeyi et al., 2016). Therefore, in line with the present thesis, further research on continuous and ongoing IPV, particularly in low-to-middle income countries, is needed to clarify abused women’s mental health condition and needs. In addition, a comparison of IPV-related psychological consequences and treatment outcomes in currently and previously abused women might clarify specific characteristics of each target group.

In the present thesis, we found evidence for the effectiveness of NET in the reduction of PTSD, depression, and perceived stressed symptoms under ongoing IPV. This is the first time that NET has been applied in the field of IPV. However, further replication studies in different settings and cultures are needed to generalize the findings. Future research further needs to examine whether psychotherapy, including exposure-based techniques, in the field of ongoing IPV can result in a reduction of IPV experiences. In this regard, the present thesis’s findings were limited due to the lack of a waiting list group, thus, further research is needed, as there is an evident lack of randomized control trial interventions on the effectiveness of individual psychotherapy in the reduction of IPV (Condino et al., 2016). In addition, future research needs to consider assessments of other relevant variables such as coping mechanisms, marital satisfaction, emotion regulation, and resiliency before and after therapeutic interventions, as these factors might facilitate help seeking behaviors or violence resolutions. Long-term follow-up assessments of treatment outcomes is further needed to investigate the persistence of therapeutic effects in the context of continuous IPV.

The current lack of research in the field of ongoing IPV is more pronounced in low-to-middle income countries, especially in the Middle East. Although IPV prevalence in this region is substantially higher than other regions, we little know about demographics of women at risk (Boy & Kulczycki, 2008; Devries et al., 2013). The high prevalence of IPV within Middle Eastern private households might be affected by cultural conflicts between modern values of gender equality and human rights, and traditional patriarchal norms, as younger generations of women challenge the normal power hierarchy and thus become exposed to further violence. In this regard, previous research has shown that a high level of education and employment can also be risk factors for women in this region. Ironically, these are the two demographic variables that generally were regarded as non-risk factors in western world studies (Boy & Kulczycki, 2008; Capaldi et al., 2012; Devries et al., 2013; Moghaddam Hosseini et al., 2013). Therefore, further research is needed to explore specific characteristics, and mental health status of IPV women in low-to-middle income countries, especially in the Middle East, to provide appropriate help and prevention programs in this region.
In the present thesis, we found that only IPV experiences in the recent year had significant power to predict PTSD symptomology among women under continuous IPV. We also found that extra traumatic and violent events, such as childhood abuse or IPV in past years of marriage, and additional lifetime traumas did not significantly predict PTSD variance. Our finding might be distorted by the PTSD variance restriction. Therefore, replication is needed to explore the broad range of traumatic experiences that develop PTSD symptoms among women with ongoing IPV experiences. Childhood abuse, additional lifetime adversities such as accidents, or illnesses, community violence, previous lifetime IPV, war, and torture experiences, might be potential catalysts to develop PTSD symptomology among currently IPV-affected women (Graham-bermann et al., 2011; Pico-alfonso, 2005; Wilson et al., 2012).

Finally, a rigorous qualitative research of IPV women's subjective perceptions of psychotherapy, especially when living in a context of ongoing violence and abuse, helps to realize their special needs and modify current therapeutic interventions to fit their condition. It is advisable to explore their experiences of different therapeutic methods, especially exposure-based ones such as NET, as we did in the present thesis, before rationalizing that trauma-based treatments in the context of ongoing abuse and violence interfere with the usefulness of PTSD-related mental health symptoms (Warshaw et al., 2013). In addition, future research on subjective descriptions of women with experiences of chronic IPV, and their perception of most severe disturbing experiences in a context of ongoing IPV, might lead to a re-consideration of current definitions of traumatic stressors in diagnostic manuals such as DSM-5. In the present thesis, we found that psychological abuse, consecutiveness and continuity of IPV experiences, as well as physical abuse were the most prominent sources of women's suffering. Previous research also repeatedly emphasized the role of psychological abuse in the development of IPV-related PTSD (Arias & Pape, 1999; Dutton et al., 2006; Mechanic et al., 2008; Pico-alfonso, 2005). There is a recent trend to broaden the concepts of trauma and PTSD, challenge the generally accepted knowledge, and open to new ideas and discoveries in this field (Yehuda et al., 2016). In this regard, it is necessary to acknowledge that PTSD is moving away from earlier conceptions of a mono-traumatic cause, and further includes elements of low-level but constant stress (Herman, 1992). Therefore, future inquiry is needed to investigate specific distinctions between acute, life-threatening traumatic stressors and chronic, non-fatal abusive incidents in the development of PTSD and relevant therapeutic implications.

5.2.2. Clinical implications

The present thesis suggested implementing intervention programs for women under continuous IPV, especially NET, to deal with IPV-related mental health problems. There is a generally accepted trend that IPV women first need to leave the abusive relationship and move to a safe space, such as shelters, to receive professional mental health interventions (Condino et al., 2016; Crespo & Arinero, 2010; Iverson et al., 2011; Johnson et al., 2011; Kim & Kim, 2001; Kubany et al., 2004; Reed & Enright, 2006). It is also generally supposed that, before applying trauma-focused and exposure-based programs, abused women need to go through a first phase of stabilization and safety planning in order to be prepared for exposure therapy (Myrick & Green,
However, with the support of findings in the present thesis and previous research, the phase-based approach to IPV seems too conservative and deprive many abused women of access professional therapeutic help (De Jongh et al., 2016). Therefore, it is advisable to integrate exposure-based techniques, specifically NET, into the first line intervention programs applied to abused women suffering from IPV-related PTSD, either living under ongoing IPV or settled in safe victim agencies. In line with previous research, the present thesis further suggests that many pathological symptoms can be related back to psychological abuse. Therapy for IPV-sufferers thus require a focus on these events (Coker et al., 2005; Pico-Alfonso et al., 2006). For instance, it is helpful to do exposure on 2 or 3 most severe incidents of emotional violence during NET, or ask for psychologically abusive experiences and their mental health effects within diagnostic interviews.

NET is a culturally appropriate exposure-based method, which significantly reduces symptoms of PTSD, depression, and perceived stress, and improves daily functioning among victims of chronic violence within a few sessions (Bichescu et al., 2007; Catani et al., 2009; Neuner et al., 2008, 2004; Orang et al., 2017; Schaal et al., 2009; Stenmark et al., 2013). We believe that NET is an appropriate treatment among IPV-affected women, as NET considers a sequence of traumatic events, rather than single-incident traumas, and further uses the empowering nature of lifetime good events as resources. These two features perfectly fit the IPV women's experiences and needs. Previous research has also shown that it is advisable to take into account a history of additional lifetime traumatic events such as childhood abuse, in addition to IPV experiences, in diagnosis and treatment of IPV-related mental health problems (Chan, 2011; Graham-bermann et al., 2011; Pico-Alfonso et al., 2006). Secondly, NET, due to its major components of story-telling, and verbal expression, is appropriate for any level of education within different cultures, helps abused women to find their own voice, makes meaning to their experiences, feel integrated, and make decisions based on their whole sense of self, rather than on fear and avoidance (Orang et al., 2017; Schauer et al., 2011). NET, in line with other exposure-based methods, reduces symptoms of avoidance, numbing, shame, and guilt, which are regarded as risk factors for re-victimization (Krause et al., 2008, 2006; Kubany et al., 2004; Street et al., 2005; Strigo et al., 2010). Third, Awareness-raising campaigns are needed to increase IPV-related knowledge in general public, and in potential or current victims of IPV, especially in low-to-middle income countries with patriarchal values and gender inequality norms. In this regard, NET with its testimonial aspect can be a key factor to communicate IPV women's stories to the public, increase public awareness and combine individual healing with societal reforms (Harvey & Butchart, 2007; Schauer et al., 2011).

Finally, in the present thesis, the need for a multidimensional approach to IPV is highlighted, i.e. although therapeutic methods such as NET can decrease psychological symptoms among IPV women, IPV occurrences and functioning impairment might not significantly subside until further cultural and legal interventions as well as mental health programs are implemented.
5.3 Overall conclusion

Women, even in modern societies, and high income countries, might not be able or willing to seek professional help and leave an abusive relationship. The situation in low-to-middle income countries, particularly in the Middle East, is more complicated, because structured gender inequality, lack of resources, and patriarchal norms can compel women to continue living in the context of continuous domestic violence. Therefore, these women are continuously at risk of developing mental health problems such as depression, and PTSD symptoms, which, in turn, deplete their mental health resources and compound their submission. First-line IPV intervention programs have been ignorant of specific needs and condition of this group of IPV women so far, as they implicitly or explicitly propose that the prerequisite for receiving psychological treatment is to leave an abusive partner and move to a safe place. However, our argument in the present thesis was that abused women who were living under ongoing IPV needed as much mental health help as the women who managed to leave an abusive relationship and seek refuge in shelters. We further suggested that IPV-affected women with continuous experiences of threat and violence, particularly when they were living in patriarchal societies such as Iran, might show a different psychosocial profile from abused women in modern societies who have easier access to formal help. The present results confirmed both the propositions, however, it needs further replication for generalizability.

Implementation of mental health programs under ongoing threat and violence, particularly in high conflict areas, is a new phenomenon, arising from the fact that pathological consequences of violence occurrences constrain victims into vicious cycles of violence. NET was specifically developed to be adaptable to people in situations of chronic and ongoing war and torture. In the present thesis, for the first time, the feasibility and efficacy of NET under chronic and ongoing IPV has been shown. We found that abused women with continuous exposure to IPV enormously benefitted from NET. NET reduced symptoms of numbing and avoidance, the two coping mechanisms that usually develop under chronic violence and are involved in further re-victimization. Therefore, in addition to IPV-related symptoms' reduction, we proposed that mental health interventions, such as NET, in the context of ongoing IPV results in IPV reduction. Future research is needed to investigate such an effect, and compensate for the apparent lack of research in this field.

Finally, the present thesis, in line with previous arguments, highlighted the gap between standard diagnostic definitions of traumatic stressors, and actual experiences and subjective perceptions of most severe disturbing incidents among victims of chronic, intimate violent relationships. In this regard, the present thesis confirmed that, from abused women's point of view, psychological abuse, and chronicity and continuity of violence occurrences were as disturbing as physical and sexual violence, while the former is absent from international standard diagnostic classifications. Therefore, reconsideration of current implicit and explicit beliefs and practices in the field of IPV in favor of actual needs and condition of abused women, is advisable.
6 References


Comparison


Myrick, A. C., & Green, E. J. (2014). Establishing safety and stabilization in traumatized youth:


