EFFICACY OF NARRATIVE EXPOSURE THERAPY AMONG TRAUMATIZED WOMEN VICTIMS OF HUSBAND'S VIOLENCE

SAMEENA HUMAYUN KHAN

Reg. 41-FSS/PHDPSY/F-14

DR. MAMOONA ISMAIL LOONA

ASSISTANT PROFESSOR

Department of Psychology

Faculty of Social Sciences

International Islamic University Islamabad

2021

Accession No. IH25398

616.85
SN

Narrative therapy -- Disorder

EFFICACY OF NARRATIVE EXPOSURE THERAPY AMONG TRAUMATIZED WOMEN VICTIMS OF HUSBAND'S VIOLENCE

Submitted to the Department of Psychology (Female Campus), International Islamic University Islamabad
in partial fulfilment of the requirements
for the award of degree of

PhD

IN

PSYCHOLOGY

By

SAMEENA HUMAYUN KHAN
Registration No. 41-FSS/PHDPSY/F14

Department of Psychology

Faculty of Social Sciences

International Islamic University Islamabad

2021

CERTIFICATION

This is certified that we have read the thesis submitted by Ms. Sameena Humayun Khan, bearing Registration No. 41-FSS/PHDPSY/F14. It is our judgment that this thesis is of sufficient standard to warrant its acceptance by International Islamic University, Islamabad, for the degree of Ph.D in Psychology.

Committee:

External Examiner-I
Prof. Dr. M. Anis Ul Haque,
Department of Psychology
NUML, Islamabad

External Examiner-II
Prof. Dr. Shazia Khalid
Department of Psychology
National University of Medical Sciences, Rawalpindi

Internal Examiner
Dr. Asghar Ali Shah
Assistant Professor,
Department of Psychology,
International Islamic University,
Islamabad

Supervisor
Dr. Mamoona Ismail Loona
Assistant Professor,
Department of Psychology,
International Islamic University,
Islamabad

Chairperson
Department of Psychology,
International Islamic University,
Islamabad

Dean
Faculty of Social Sciences,
International Islamic University,
Islamabad

DECLARATION

I, **Ms. Sameena Humayun Khan**, Registration No. **41-FSS/PHDPSY/F14** student of **PhD** in the subject of Psychology, session **2014-2021**, hereby declare that the matter printed in the thesis titled "Efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence" is my own work and has not been printed, published and submitted as research work, thesis or publication in any form in any University, Research Institution etc in Pakistan or abroad.

Sameena

Signatures of Deponent

30-08-2022

Dated:

RESEARCH COMPLETION CERTIFICATE

Certified that the research work contained in this thesis titled: Efficacy of Narrative Exposure Therapy among Traumatized Women Victims of Husband's Violence has been carried out and completed by Ms. Sameena Humayun Khan, Registration No. **41-FSS/PHDPSY/F-14** under my supervision.

30-08-2022

Date

Supervisor

Dr. Mamoona Ismail Loona

Assistant Professor,

Department of Psychology,

International Islamic University, Islamabad

Dedicated to

all those women who have shown resilience and strength in front of violence and devoted their lives to stop violence against women.

Acknowledgement

First and foremost, I would like to thank Allah Subhana-hu- wa-Taala,as it was impossible to complete this work without His consent and help.

I would like to acknowledge the following people for their support and contribution to my work and I am grateful to them for their moral support.

- My supervisor, Dr. Mamoona Ismail Loona, for the time, energy, and effort she devoted to help and guide me through this process.
- The experts from different institutions for their help in the translation of questionnaires.
- All the people who helped in data collection for studies.
- I am also grateful to all the women who participated in this research and showed courage to speak about a very sensitive issue of their valuable responses and assisted in broadening the knowledge about the topic. At the same time, it will help in devising some indigenous preventive and effective intervention strategies to stop and treat domestic violence in Pakistani society.
- I am very thankful to Dr. Muhammad Tahir Khalily, Dr. Asghar Ali Shah, and Dr. Mazhar Iqbal Bhatti for their thoughtful suggestions and guidance to complete this study.
- All the faculty members of the Psychology Department, Female Campus, IIUI, for their moral support.
- I would also like to thank Dr. Salma Batool for her constant help and guidance in the completion of my study.

- I would also like to acknowledge the support of my family members. I appreciate the great support from my sisters Sayema, Sarwat, and Fauzia and my brother Bilal for their motivation and comic relief that was necessary during this work.
- Above all my beloved daughter Sara who encouraged me at every step of my project. Completion of my PhD work represents a huge milestone and we have so much to be pleased for and to look forward together.

Sameena Humayun Khan

List of Tables

List of Figures

List of Appendices

List of Abbreviations

ANOVA	Analysis of Variance
APA	American Psychological Association
CDC	Centre for Disease Control and Prevention
CEDAW	The Convention for Eradication of all kinds Discrimination Against Women
DBT	Dialectical Behavioral Therapy
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition
EPT	Emotional Processing Theory
ICRW	International Centre for Research on Women
IPV	Intimate Partner Violence
KDVSS-U	Karachi Domestic Violence Screening Scale Urdu version
MBSR	Mindfulness Based Stress Reduction
NET	Narrative Exposure Therapy
NGOs	Non-Governmental Organizations
PBRS	Personal Beliefs and Reactions Scale
PTCI	Posttraumatic Cognitions Inventory
PTSD	Posttraumatic Stress Disorder
VAW	Violence Against Women
WAS	World Assumptions Scale
WHO	World Health Organization

Abstract

The present study was designed to check the efficacy of Narrative Exposure Therapy (NET) in women victims of violence committed against women by their husbands with Posttraumatic Stress Disorder in Pakistan. The study was completed in three phases. In the first phase, assessment tools such as Posttraumatic Checklist for DSM-5 (PCL-5) and Posttraumatic Cognitions Inventory (PTCI) were translated into Urdu by using the back translation method. In the second phase, a pilot study was carried out to establish psychometric properties of the translated scales. Results of test-retest reliability ($p< .01$) showed that the translated versions of the scales were psychometrically satisfactory and appropriate to be used for Pakistani population. Screening out of women victims of husband's violence having PTSD was also done during this phase. Out of 800 forms given to the research participants, 683 forms were returned. The incomplete forms were not included in the study. Six fifty six women were approached for the screening purpose (*N=656).* Three ninety five (60%) of women were identified as "abused" and 261 (39.8%) were identified as "non-abused". The current study also assessed an overall prevalence of violence perpetrated by husbands against wives. It was found out that all three forms of abuse (physical, psychological and sexual) were reported by women. The percentage of psychological abuse was the highest (83%). Association of some of the sociodemographic factors with the occurrence and prevalence of husband's violence in Pakistan was also examined during the second phase of the study. Results indicated that sociodemographic factors such as women's better education, husband's better education, husband's professional status, and better family income have negative correlation with violence at $p<.001$. Whereas, husband's age, years of marital relation and number of children have significant positive association with violence committed by husbands at $p<.05$. Age of women

participants did not have significant correlation with violence. After identifying women victims of husband's violence, the researcher also screened out 100 women victims of husband's violence who were having PTSD *(N=100)* to be included in the main the study. The third phase was the main study. It was a quasi-experimental research which included a sample composed of two groups: a treatment group who received Narrative Exposure Therapy and a control group who received general counseling and psychoeducation. Initially, 100 women victims of husband's violence with PTSD participated in the study; however, 40 participants in the treatment group and 35 participants in the control group completed the recommended package of sessions. Results of the study confirmed that there was a significant ($p < .05$) positive correlation between husband's violence and PTSD symptoms. Results also showed that PTSD has significant ($p< .05$) positive correlation with Negative Cognitions. All types of abuse (physical, psychological and sexual abuse) were found to be significantly ($p< .05$) positively correlated with PTSD. Similarly, negative cognitions have significant ($p< .05$) positive correlation with physical abuse and psychological abuse whereas, it has non-significant positive correlation with sexual abuse. Multiple regression analysis was carried out to assess violence committed by husbands against their wives as a predictor of PTSD and Posttraumatic Cognitions among women victims of husband's violence. The results showed that physical abuse, psychological abuse and sexual abuse significantly predict PTSD and Posttraumatic Cognitions among women victims of husband's violence ($p < .001$). The present study also examined the mediating role of Posttraumatic Cognitions related to the self and world that can form as a result of experiencing the trauma of violence and PTSD among women victims of husband's violence. Support was found for posttraumatic cognitions as partially mediating the relationship between husband's violence and PTSD ($p < .001$). Statistics from repeated

measures ANOVA indicated that in a treatment group, participants' scores on PCL-5 and PTCI were significantly ($p< .05$) decreased during the three assessments. Therefore, it can be concluded that Narrative Exposure Therapy was more effective than general counseling and psychoeducation for PTSD. The overall findings of the study indicated the prevalence of husband's violence i.e. 60% among women victims which shows the gravity of the problem in Pakistan. The evidence demonstrated that NET leads to significant reductions in PTSD symptomology, to the point where most of the participants no longer met the PTSD criteria. NET appears to be efficacious in offering a brief and practical approach in different cultural settings which is easy for counselors, clinicians and therapists to learn, allowing a large number of traumatized victims to be treated.

Keywords: Narrative Exposure Therapy, Husband's Violence, Posttraumatic Stress Disorder, Posttraumatic Cognitions

INTRODUCTION

Chapter 1

Introduction

The family is generally associated with a safe haven where people seek affection, protection, security, and shelter. However, research suggests that it is also a place that fosters some of the most heinous types of abuse committed against women and girls and puts their lives in danger (Yodanis & Godenzi, 1999; Lawrence & Spalter-Roth, 1996; Buvinic et. al, 1999). Husbands, boyfriends, fathers, fathers-in-law, stepfathers, brothers, uncles, sons, or other relatives who are, or have been, in positions of confidence, trust, affection, and control commonly commit domestic violence (Morrison & Orlando, 1999; Garcia-Moreno, 1999; Poppe, 1999). The majority of abuse in domestic realm is against women is carried out by men. Women are often subjected to a cycle of violence that expresses itself in a variety of ways during their lives. In societies where son preference is practiced, a girl may be the victim of sex-selective abortion or female infanticide even before she is born (Mitra, 1999). Forced malnutrition, lack of access to medical care and education, incest, female genital mutilation, early marriage, and forced prostitution or bonded labor are all examples of violence against girls throughout their childhood (World Health Organization, 1999). They continue to suffer as abused, assaulted, and even killed by their intimate partners or husbands in their adult lives (Ellsberg et. al, 1999). Other forms of violence against women include forced pregnancy, abortion or sterilization, and harmful cultural norms like dowry related violence, sati (the burning of a widow on her husband's funeral pyre), honor killings. Widows and elderly women may also be abused later in life (Fikree & Bhatti, 1999; Martin et. al, 1999; Jewkes et. al, 2000).

Violence by intimate partner or husband is a global issue that affects millions of women each year. Beyond geographical, cultural, religious, social, and economic conditions, it is a violation of woman's human rights. It's an epidemic that affects women all over the world in different degrees and forms. Women abuse has a sound social, cultural, and psychological foundation, as well as deteriorating physical, emotional, social, and financial consequences. It also affects their children, families, and society as a whole, despite the fact that it has direct effects on women. "One out of every five women has been subjected to violence in intimate relationship, and 35 percent of women have been subjected to physical or emotional violence throughout the world" (Garcia-Moreno, Heise, Jansen, Ellsberg, & Watts, 2005).

A recent study conducted by Sardinha and colleagues (2022) developed global, regional, and country estimates, based on data from WHO Global Database on Prevalence of Violence Against Women. The findings suggested that globally 27% of ever-partnered women aged 15-49 years are estimated to have experienced physical or sexual, or both, intimate partner violence in their lifetime. This violence starts early, affecting adolescent girls and young women. Regional variations exist, with low-income countries reporting higher lifetime compared with high-income countries.

In the South Asian region, where one out of three women experiences physical or sexual violence from her partner/husband, the incidence of violence is higher (Garcia-Moreno, 2013). Several hospital- based reports confirm that psychological abuse by husbands affect 43 percent to 97 percent of ever married females and that one third of ever married females reproductive aged 15 to 49 years are subjected to physical assault in Pakistan (Ali, Asad, Morgen, & Krantz, 2011; Zakar, 2012). In a similar study, the

researchers examined the relationship between intimate partner violence and unintended pregnancy among young women in South Asia using Demographic and Health Survey data from India, Bangladesh and Nepal. Thirty-eight percent of the respondents in India, 52% in Bangladesh and 28% in Nepal reported having experienced physical or sexual violence by their partners and husbands. The findings indicate that intimate partner violence is a risk factor for unintended pregnancy among adolescents and young adult married women (Anand, Unisa & Singh, 2016).

Violence, in some cultures, is regarded as a regular or daily practice which does not have any effect on women's health (Arriaga & Oskamp, 1999). Because of patriarchal social systems, the societal devaluation of women, husband's dominating and controlling position in the marital relationship, religious doctrine and lack of culturally competed laws and policies, its widespread prevalence and acceptance is justified (Ayub, 2000; Mumtaz, Mitha , & Tahira, 2003; Niaz, 2003).

Females from all walks of life, all social classes, races, ethnicities, religious groups, developed and developing countries and all ages have been victims of abuse. Extensive research has proved that domestic abuse is the common form of violence committed against women. Violence carried out against women by an intimate partner/husband or by other family members is referred to as "domestic" abuse. Because there is "a little chance of being punished for that abusive behavior", increased prevalence rates are reported by almost all cultures. Males are allowed to use even physical power against females because retaliation is least expected. Physical violence is more common in lower socio-economic groups than in educated middle and upper classes as reported by a research. In the educated

middle and upper classes, psychological abuse was shown both verbally and non-verbally (Shah. 2003).

Women are more vulnerable to be victims of violence because of their weaker and lower social status. Because of the abuse perpetrated by a man with whom she must share her life, a woman's sense of insecurity develops. A breach of a person's physical protection is likely to have most devastating emotional consequences. Women who leave their wed-lock are considered burdens in all cultures and the state and families prohibit them from doing so because of social stigma, lack of alternatives and loss of children. These women often face lack of support from the police who consider domestic violence a private issue and counselors who often encourage women to be traditional wives (Hassan, 1995).

For some women, violence committed against them by their husbands can put their lives at risk, but it is more likely to result in physical injuries, immune deficiencies, disturbed sleep, and gastrointestinal issues. A study conducted by Naz and Malik (2018) examined the effects of domestic violence on psychological well-being of 100 violence survivor women in Punjab, Pakistan. Results showed that the survivors of sexual and physical violence had most impaired psychological well-being as compared to other forms of domestic violence survivors.

Depression, low self-esteem, psychological distress, and posttraumatic stress disorder are all mental health issues linked to husband's violence (Bogat, Levendosky, Theran, von Eye, & Davidson, 2003). According to American Psychiatric Association (2013), posttraumatic stress disorder is a condition characterized by intrusive reliving of the traumatic event, avoidance and emotional numbing as well as symptoms of hyper-arousal which may develop in certain people following a traumatic incident. A traumatic

incident may be defined as an event that causes feelings of fear, helplessness, or horror as result of a threat to life or physical safety and survival.

A strong association between violence in marital relationship and PTSD has reported by various studies: the more forms of violence committed against women by intimate partner/husband such as physical, sexual, or psychological abuse, the higher the PTSD symptoms experienced (Basile, Arias, Desai, & Thompson, 2004). Depressive symptoms, somatic complaints, and PTSD symptoms were also found to be higher in pregnant women who reported a history of violence perpetrated against them by their husbands and sexual coercion when compared to those who did not, at a hospital in India (Varma, Chandra, Thomas, & Carey, 2007). In a similar study, when compared to non-abused controls, physically and psychologically abused women manifested more symptoms of PTSD, depression and anxiety, as well as suicidal thoughts (Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburoea, & Martinez, 2006).

Women are more likely to develop PTSD due to the nature of abusive act. When sexual assault occurs in combination with other forms of husband brutality, the risk for PTSD and other severe mental health conditions rises. Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburoea, & Martinez (2006) noted that just as violence committed against women by their husbands is linked to PTSD, similarly, higher levels of depression and suicidal attempts are linked to sexual abuse.

Many PTSD theories have suggested that certain interpersonal mechanisms such as interpretation of the cause and reason behind the trauma, attribution of the self-blame, and perception of the world as dangerousness place, affect a trauma victim's cognitions and beliefs. There is a clear connection between posttraumatic cognitions and posttraumatic

stress disorder as proposed by available literature (PTSD; Ehlers, Ehring, & Kleim, 2012). Posttraumatic cognitions distinguish people with and without PTSD is also supported by several similar findings (Dumore, Clark, & Ehlers, 1997; Ehlers, Glucksman, 2006; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999).

Positive changes in posttraumatic cognitions were found to predict subsequent improvements in PTSD (although a reverse relationship was not found) reported by Kleim and colleagues (2013) indicating that PTSD symptoms can be reduced by improving dysfunctional cognitions. Subsequently, for the understanding of causes, maintenance, and treatment of PTSD, certain factors that form and modify posttraumatic cognitions having significant implications are crucial to be identified.

After reviewing literature, it was felt necessary by the researcher to find out the connection between negative cognitions and PTSD as highlighted by previous researches. Directly assessing negative cognitions determines not only what negative cognitions an individual may have after experiencing trauma but can also show change in negative cognitions through the course of treatment. Thus, considering the significance of dysfunctional beliefs in PTSD, the current study aimed to translate and validate the posttraumatic cognitions inventory in Urdu to be used in the samples of traumatized individuals. Currently, the Posttraumatic Cognitions Inventory (PTCI) is the preferred measure among clinicians and researchers because it assesses negative cognitions specifically related to PTSD (Foa, Ehlers, Clark, Tolin & Orsillio, 1999) instead of cognitions related to a wide range of symptoms in traumatized individuals such as World Assumptions Scale (Janoff-Bulman, 1989) and the Personal Beliefs and Reactions Scale (Resick, Schnicke, & Markway, 1991). The PTCI assesses negative cognitions about the

world, self, and self-blame. The higher the scores, the more posttraumatic cognitions are experienced. Across various samples of trauma, the inventory has revealed satisfactory psychometric properties.

Attempts to lessen symptoms of trauma have proved to be effective. Many psychotherapeutic interventions have gained empirical support for treating PTSD symptoms in adults. One such example of an evidence-based treatment for PTSD is Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2005) in which, while focusing on the stressful life events, the client makes a chronological narrative of his/her life story with the help of a therapist. The scattered details of the traumatic events would be converted into a meaningful narrative over the course of a predetermined number of 90 minute sessions, typically about 4-12. The client is motivated to narrate these events while reliving them without losing the contact with the present. The therapist connects these mnemonic representations to episodic data such as time and place (cold memory) by using permanent reminders such as the feelings and physiological reactions that result from activation of (hot) memories. The process of uncovering the traumatic events related to the past continues through imagined exposure until the patient shows visibly decreased level of fear and other related feelings. The therapist, in this way, is both cooperative and directive when eliciting the narrative in order to retrieve all the hidden information of the traumatic event in detail. The testimony of survivors of domestic or organized abuse can be noted and used for documentation.

Due to rise in the incidence rate of violence committed by husbands against their wives and the resulting distress in women victims of husband violence initiated the current study investigation into the treatment aspect of the issue. The unique aspect of the current

study was to examine whether NET would be effective in treating traumatized women victims of husband violence in Pakistani context.

Literature Review

Due to the complexity of the issue, understanding women abuse is a difficult task. To explain the phenomenon, several hypotheses, based on different theoretical perspectives, have been proposed. According to research reports from countries all over the world, violence against women in varying degrees and forms still exists depending upon that culture and society. Since it has serious physical, psychological, social and emotional implications, this issue needs to be addressed on priority basis.

Before recounting various aspects violence committed against women around the world, it seems imperative to define and describe the term violence. The word violence is a Latin word- violare meaning to violate. The review of definitions of violence in different dictionaries revealed that violence has been defined primarily by its features like exertion of physical power to violate, to show aggressive behaviors, intense destructive actions, unjust exercise of power, consequent injury/suffering and as an expression of unconstructive feelings.

The Centre for Disease Control and Prevention (CDC) defines violence as injury inflicted by deliberate means (Saltzman, Fanslow, Mc Mahon & Shelley, 2002). The definitions of violence clearly rely on the common understanding of violence according to which hitting, pushing, stabbing, injuring, or inflicting physical pain by any other means are violent behaviors.

The above-mentioned definitions of violence are very narrow in the sense because they refer to actual infliction of bodily harm or abuse. However, if we re-examine the

meaning of the word violence in its Latin origin to violate it automatically broadens the definition of violence by focusing on the outcome of violence which is violation whether physical harm is involved or not (Perkins-McIntosh, 2008).

Violence is present in all societies around the world in various forms and at multiple levels. At the personal level, individuals display certain physical, verbal, emotional and sexual abuse of others. The examples of such violence are harassment, assault, torture, domestic abuse, child sexual abuse, rape, murder etc. Violent activities are sometimes carried out at group or institutional level e.g. robbery, dacoits, terrorist attacks, bomb-blasts, ethnic conflicts, wars etc. The expansion of technology has resulted in development of advance methods of committing violence. Threat of nuclear weapons and increased media coverage of terrorist activities has made violence global (Jarvis, 2008).

Nature and Extent of Various Forms of Violence against Women around the World

Nearly, in all societies of the world, women have been exposed to various forms of domestic abuses. Research studies and reports on violence against women provide detail account of the nature and extent of violence committed against women around the globe. The reports published by Amnesty International, first in 2004 and later in 2008 provide shocking data about the incidence and types of violence committed against women in different countries of the world (Amnesty International, 2004; Amnesty International, 2008). Violence committed by husbands against their wives is not only practiced in less developed societies of the world but equally prevalent in more advanced countries including American and European countries. According to Amnesty International report (2004) murder and abduction of hundreds of women and girls were reported in different states including Mexico and Central America. The Canadian government statistics also

verified the rise in death rates in women due to violent acts against them. Some studies also indicated rise in rates of femicides by intimate partners (Miller, 2004; Vigdor & Mercy, 2006). These statistics suggest that women around the globe face various acts of violence and discriminatory practices which gravely hamper their growth and development in the society.

According to 2004 report, women were the major victims of discrimination and poverty in Asia-Pacific. The most prevalent form of human rights violation in this region include spousal violence, female infanticide, cultural and traditional forms of violence, women trafficking and inadequate laws. The report published in 2008 was even more alarming which stated that gender-based violence, including sexual brutality, remained a threat for women and girls in Asia-Pacific. In China, rates of reported cases of domestic violence in 2008 was greater than before, however, the cause for increased number of cases was attributed to the courage of women to report abuse. In Pakistan, acid-throwing, domestic violence, rape and honor killings are still on rise. 183 women were assassinated in "honor killings" from January to October 2008 in the province of Sindh only.

A recent estimate showed that 30% women are subjected to physical violence by their intimate partner which makes it a proportion of 1 in every 3 (who have experienced violence). The occurrence of violence can be elucidated by the frequencies which showed that the violence experienced by women from their intimate partners: 23.2% violence against women by the partner is estimated in high income regions while from Western Pacific to East Mediterranean region violence ranges from 24.6% to 37% respectively. In South East Asian region, 37.7% women were subjected to violence by their spouse (WHO, 2019).

A global estimate in 2017 indicated that the proportion of the prevalence of violence against women that resulted in deaths or signified as murders, were more from either the spouse or other family members in domestic sphere. The estimate showed that among 87,000 women who were murdered in 2017, more than half of the proportion of about 50-58% were either exterminated by their spouse or some family member. Another estimate also elucidated that 137 women in every day across the world are murdered by their family members. Furthermore, a report by United Nations Office on Drugs and Crime (UNODC) made evident that women who were killed in 2017 were either killed by intimate or non-intimidate partner (United Nations Office on Drugs and Crime, 2019).

Sexual brutality remained prevalent in Morocco, Chad, Sierra Leone, Uganda and various other regions. These victims of sexual abuse were not even provided with any satisfactory medical, psychological and legal aid. Domestic violence is very much prevalent in whole society regardless of socioeconomic and cultural backgrounds. More than one third of women were physically abused and out of every four women one woman had been sexually abused at some point in her life. 60 percent of murder cases were related to Intimate Partner Violence (IPV).

One of the study carried out in East Africa reported that in East Africa, near to one-third of women experience violence by their intimate partners and husbands. Women's education, residence, sex of household heads, current pregnancy, husband drinks alcohol, attitude towards wife-beat, husband controlling behavior, and women's decision-making autonomy were the major determinants of intimate partner violence
(Kebede, Adisu, Weldesenbet & Tusa, 2022). Likewise, Anolue and Uzoma (2017) in a study concluded that violence by intimate partner or husband is a pervasive problem in

Nigeria with a prevalence of 56% in this study. Various factors particularly financial constraints, incitement, alcoholism and substance abuse were contributing factors in cases of intimate partner violence. Intimate partner violence may appear as a single form or as multiple forms of abuse.

Wet-Billings and Godongwana (2021) identified intimate partner violence as a risk factor for hypertension outcomes among young women in South Africa. Results showed that 68% of women with hypertension experienced physical intimate partner violence. The odds of hypertension were increased if young women experience physical or sexual intimate partner violence. The study also suggested that efforts to reduce hypertension outcomes in the country should include intimate partner violence awareness and assistance.

The impact of intimate partner violence on empowerment of Armenian women of reproductive age group was explored in a study by Kabir and Khan (2019). The study revealed that women with no empowerment are more likely to experience intimate partner violence compared to those who are empowered in Armenian society.

Women's Vulnerability to Violence in Pakistani Society

Pakistani women are vulnerable to different types of violence, primarily, because of their overall subordinate position in society. 48.1% of Pakistani population comprised of females. According to Shah (2003) overall women literacy rate is around 37%. Literacy rates are significantly higher in urban areas than in rural areas. 60% of women in urban areas are literate and 76% of men. In rural areas, the literacy rate for female is 25% and 53% for men. Percentage of women at administrative and managerial positions is only 4% (United Nations, 2000). According to Population Association in Pakistan (2002), female

labor force participants is 15.4% and percentage of women in agricultural labor force is 66.3%.

There are certain traditions, customs, thoughts and ways of living in this society which allow and perpetuate women's secondary status. Generally, people follow traditional lifestyles and women are often dependent on men who abuse them. Pakistani society is based on strong stereotyping of gender roles. A girl in Pakistan is taught from very beginning that she should be very passive, obedient and polite especially with her husband. Women in general develop very strong emotional attachment with their husbands for all kinds of support including emotional, financial and social support. Earlier research in other parts of the world has also shown that emotional involvement and financial dependency increase the vulnerability of women (Denmark et al., 2006). Acceptance of violence committed against women by their intimate relatives in our society is one of the major contributing factor. The misery of the situation can be estimated by the fact if same acts are carried out against some other resident of the country or an unfamiliar person that would be punished but in case when men commit them against their sisters, daughters and wives, they are often acceptable.

Other than this, misinterpreted religious teachings communicate to common people that women are low-grade by nature and traditional lifestyles practically promote such beliefs. The malformed political and legal infrastructure of a country is not able to provide justice to sufferers. As a result, girls and women in Pakistan are still experiencing higher levels of discrimination and maltreatment. Women are insecure in their own homes and face domestic and cultural forms of violence like wife abuse, acid throwing, stove-burning, honor killings, exchange marriages, vani and bride price etc. According to Human Rights

Commission of Pakistan (2003), the subordination of women is so much tolerated that women themselves accept husband violence as routine practice. This insecurity and discrimination is not only faced by housewives who are totally dependent on their husbands but it has been observed that working women also experience it. In rural areas women work in cotton, rice and wheat fields with minimal benefits. Many women activists and Non-Governmental Organizations (NGOs) in the region raised voices on rights of agricultural women. The distressing point is that many rural areas in Pakistan, contributions of women are not even recognized and acknowledged.in urban metropolitan cities like Karachi, poor women have no choice except to work as domestic servants or as low-paid workers in textile and garment industries. Girls who have completed education up to high-level school often work at minimal salaries in small private schools or as clerks in government sector. Highly educated women are employed at some better positions in various organizations but many of these women often face sexual harassment at their workplaces and spousal violence in their homes. These working women also face discrimination by traditional religious leaders, who always put an obstacle in front of them by misinterpretation of religious teachings. They raise various objections against women who are studying, doing office jobs or involved in any type of productive work.

The most prevalent forms of violence committed against women included domestic violence, husband violence, stove-burning, sexual assault, acid throwing and various traditional practices like exchange marriages, honor killings, vani or sawara etc. (Human Rights Watch, 1999).

Honor killing is also commonly practiced in Pakistan. Honor killing is carried out in the name of family "honor" to punish the victims as they have dishonored tribal or cultural norms and mostly women are targets because of their sub-ordinate status.

Human Rights Commission of Pakistan, Human Rights Watch and women activists consistently reported that most of the Pakistani women face violence in their homes by their intimate partners. According to their estimates 70-95% of all women in Pakistan experience spousal abuse (Hassan, 1995; Human Rights Watch, 1999). A recent survey of more than 200 women living in refugee camp outside of Peshawar revealed that 79% of women were beaten by their husbands and 39% by other family members. 13.4% of women even believed that wife beating is the right of husbands (Ward, 2002). Roomani and colleagues (2016) examined the involvement of women in domestic violence against other women in the family. In-depth interviews were taken from married women who faced domestic violence. The conclusion of the study revealed that women were directly or indirectly involved in perpetuating domestic violence against other women in the family.

Being burned with fire at the hands of husbands or in-laws has tormented women in Pakistan and other South Asian countries for decades (The Mahbub ul Haq Human Development Centre, 2000). It was indicated that a wife's disobedience on minor tasks or suspicion of illicit relations were the most common reasons for such assaults (Human Rights Watch, 1999).

Forms of Violence Perpetrated by Husbands

Violence committed by husbands against their wives is not a new phenomenon. For centuries women have faced various forms of violence in their intimate relations but the problem was considered as non-existent because there was scarcity of research in this area.

As it was hidden behind the closed doors therefore it was not investigated for years (Gelles, 1974). However, reports published by World Health Organization confirmed the prevalence of wife abuse in everyday lives of women (WHO, 2002 & 2005).

Intimate Partner Violence (IPV) is also termed as domestic violence, wife-beating, spousal abuse, and battering and husband violence. Approximately 95% of victims are women and 95% of perpetrators are men (El-Bayoumi, Borum, & Haywood, 1998; Tjaden & Thoennes, 2000). Available literature has provided various descriptions for patterns of violence in marital relation. It has been reported that violence exists along a continuum from a single episode to ongoing battering. It has been recognized as an intentional behavior targeted to have control and power in relation (Almeida & Durkin, 1999).

Violence against Women (VAW) is defined as any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life, according to United Nations Resolution (1993). Violence manifests itself in three ways: physical abuse, psychological abuse and sexual abuse, according to this definition.

A review of definitions of intimate partner violence provided by Australian Medical Association (1998) and American Medical Association (1992) revealed that intimate partner violence is the domination, coercion, intimidation and victimization of one person by another person by the use of physical, sexual or emotional means. In most of the cases, it has been observed that this imposition of control is by male partners over female partners. It sometimes begins with direct use of force, like push or slap and at other times it be gins with mild psychological and emotional abuse and then systematic abolition of the victim's

confidence and self-esteem. Once the violence starts, it very often escalates. A push turns into a slap which turns into a punch and punch turns into kicks, stabs, burns and sexual abuse (Tjaden & Thoennes, 2000).

Physical Abuse. Slapping, punching, hitting, arm twisting, slashing, stabbing, strangling, burning, choking, kicking, attacks with an object or firearm, and murder are all examples of aggressive acts of violence. The most common act of violence faced by women in both developed and developing countries according to a multi-country study conducted by the World Health Organization in 2005, was being slapped by their partners. Most of the women interviewed from less developed countries reported that physical abuse experienced by them generally increase in its frequency and intensity over time. Tolman and Rosen (2001) examined the incidence of physical abuse in the sample by defining it as 'moderate physical violence' or 'severe physical violence'. 16.5% reported at least one physical threat from their intimate partners, 20.6% reported moderate physical abuse and 14.9% reported severe physical abuse in the past year. The lifetime prevalence rates were much higher as indicated by findings. 57.1% reported at least one physical threat, 57.5% reported moderate physical violence and 51% reported severe physical abuse in their lifetime. It involves cultural practices that are not favorable to women such as female genital mutilation, and wife inheritance (the process of transferring the widow and her property to the brother of her deceased husband).

Sexual Abuse. It is another way of exerting power and domination over a partner by imposing unwanted sexual acts or forcing sex with others, using threats, coercion, or physical force. A woman is very often denied of her basic right on her own body after marriage especially in South-Asian region and other under developed countries of the

world. According to a report published by World Health Organization (2005) in majority of settings, 10-50% of women reported sexual abuse by intimate partner. A qualitative study on women found that women's refusal to engage in sex also contribute to other forms of violence in marital relations (Dantas-Berger & Giffin, 2005).

Psychological Abuse. It includes a variety of emotional, verbal, social and even economically abusive behaviors committed very frequently against women. Verbal threats, name- calling, degradation, social isolation, economic isolation, and damage of personal property have been reported in abusive intimate relations. There is a common misperception that physical and sexual abuse are more fatal than psychological abuse. However, women themselves have frequently reported that they found it even harder to put up with psychological abuse and humiliation than the physical abuse (Follingstad et al., 1990; Cabrejos et al.,1998 as cited in Heise, Ellsberg & Gottemoeller, 1999). Psychologically abusive partner systematically attempts to control partner's thinking and behaviors. Literature has provided an outline of variety of behaviors placed under the category of psychological abuse. Isolation, debility, pathological jealousy, attacks, degradation, forced alcohol and drug use, brain washing, occasional indulgences and insults, are only a few examples. Isolation includes restricting the social contacts of partner and forcing her to stay at home, or only allowed to leave the house when accompanied with him. In some cases, she is even not allowed to phone her friends or family members thus moving her away from all her support system. A strong sense of isolation is developed in women when they are denied of their basic human rights of provision of funds, refusal to contribute financially, denial of food and controlling access to health care, employment, and other services etc. Induced debility involves forcing wife to do unwanted tasks and

get exhausted like unnecessary arguments, keeping her awake all night, forcing her to do all household tasks without any help. For women in many societies, there is no 'give and take' in the relationship and it is solely the duty of a woman to sustain the relationship, to look after the children and to make ends meet. Pathological jealousy and possessiveness means to keep check on the wife all the time, accusing her of having affair, controlling finances, convincing partner that actually it is all her mistakes or that she can't live without him. Threatening is a common type of psychological violence that is used to intimidate and dominate the wife. Degradation includes use of harsh words, bad language for her and her family and frequent taunting. Degradation like this has a negative effect on women's self-esteem. The women finally give up control of their worth to their abuser.

Emotional violence usually targets the victim's self-esteem, happiness, and self-sufficiency by making her accountable for all mis-happenings in their relationship. Women are blamed for abusive episodes and for days and weeks batterers frequently refuse to talk directly to their wives leaving them guessing about how they have displeased or insulted him (Loring, 1994).

Theoretical Perspectives on Husband's Violence

Many theoretical perspectives have been developed to explain the causes of violence against women. These include biological and genetic explanations as well as theories which attribute its causes to poverty, socialization, and even women themselves. Domestic violence is so prevalent and complex venture that no single theory can adequately explain various dimensions of this phenomenon. Factors like ideology of power and control, social, cultural and individual characteristics have been taken into account in this review to describe violence against women.

Power and Control Factor. Domestic abuse is said to revolve around issues of power and control. Men who beat their wives have particular sensitivity to issues of masculine control in terms of marital power structure, personality, sex-role adherence and peer-group affiliation (Coleman & Straus, 1986). Abusive and violent behavior against women has been primarily explained in terms of "need to maintain power and control" (McClelland, 1975; Dutton & Strachan, 1987). Salient factors that have been identified in wife abuse as well as in attempts to compensate for deficits in power outside the home include attempts to exercise or maintain control over decision-making, social relations, family finances and partner's freedom of movement (Frieze & Browne, 1989). Earlier research carried out in West showed that structurally wife abuse is more common when the husband's educational and professional status places him in a lower position than the wife (Pagelow, 1984; Frieze & Browne, 1989). One of the perspectives maintained that the advent of industrial revolution in the 18th century also brought privatization of domestic relationship. Women were left in intense sense of physical isolation and segregation in household. Women served in the household chores but were not paid and their efforts went

unnoticed (Dobash & Dobash, 1979). According to Russell (1982) differentials in patriarchal family represents and perpetuates the dominance of husband over his wife. The husband is paid for his work but there was and still no value of wife's work which places the husband in financial and psychological control of the family. This is also considered as the origin of wife abuse. Glies-Sims (1983) held the view that power is the common factor under all societal differentials. Women, on average have less influence in society than men and as a result, they have less opportunities to combat or stop abuse violence and less options to flee when this happens. According to Jacobson and Gottman (1998) the main factor in wife beating is controlling the wife and any tactic used to obtain control is justified by the abuser. This view was also supported by results of a study conducted by Rosales and colleagues (1999) in Nicaragua that husbands had high scores on marital control scale also physically abused their wives more frequently than low scorers.

Social Perspective. Social norms concerning marriage, economic conditions and social policies are thought to be related to explain the phenomenon of marital violence. After reviewing a bulk of literature on domestic violence, it was found that responses to domestic violence are influenced by societal norms and practices in almost all societies. The family is considered a private place where outsiders are not allowed to interfere even in the serious matters. Violence against women is usually committed by males who are strict and believe in the patriarchal dominance of the family (Bowker, 1983). A study conducted by Pattison (1985) demonstrated that certain social components are common to all types of violence: aggressive family communication styles; financial constraints; male dominance; acceptance of violence or lack of effective social norms; couple or family isolation, in addition to drug and alcohol dependence.

Another theory which explains the phenomenon of abusive relationship is social learning theory. This theory is largely based on the Bandura's work that stresses the notion that physical and psychological assault is a 'conditioned and learned response' for both the victims and perpetrators. Bandura (1973) assumed that the social conditions actually determine the incidence, type, circumstances and target of abusive behaviors. Men learn to be aggressive and abusive since their childhood through the process of socialization while women learn helplessness over the course of their adult abusive relationship as held by social learning theorists.

Social exchange theory is derived from learning theory perspective. This theory maintains that abusive behavior takes place when rewards are raised and punishments are avoided. Violence will continually be used as a method of control by violent partners as long as the price for being violent does not offset the rewards (Gelles & Cornell, 1985). According to Sonkin and Durphy (1985) use of violence in home by men is effective because it enables them to win arguments and maintain control.

Psychological Perspective. Individual traits of abusive males and abused females that contribute towards development of abusive marital relation were the subject matter of early psychological theories. Potential for anger, low self-esteem and a tendency towards sexual jealousy are considered to be personality characteristics of husbands which are associated with wife abuse. The researchers found that anger was the key emotion in the psychological profile of both husbands and wives (Maiuro et al., 1988). Available research shows that most psychological theories interpret violence committed by husbands as a result of an individual perpetrator's psychopathology such as borderline personality disorder or anti-social personality disorder, anxious attachment style during childhood, witnessing or

experiencing violence, and/or other psychological problems, such as impulsivity and managing anger, low self-worth, and inability to trust in relationships due to the fear of intimacy (Babcock,et al., 2000; Carden, 1994; Dutton, 1988, 2000; Fonagy et al., 2000; Holtzworth-Munroe & Stuart, 1994). Other scholars supporting psychological theories blame victim's characteristics such as desire to be abused or exerting excessive pressure on their partners for instigating violence (Babcock et al., 1993; Kaufman, 1992; Walker, 1992). These ideas have been criticized for overlooking the social context (Beecham, 2009), placing males' violence in a depoliticized and individualized matter, thus ignoring it as a social problem for females (Pagelow, 1992; Mullender, 1996). The common cause of domestic abuse in Pakistani families was described by Hayyat (2002). He wrote that in Pakistani society males have a tendency to develop a controlling and governing attitude molded in a self-image of being an all powerful and commanding person. It is commonly held view that man is the only one who knows what is best for family members especially females. When he fails to impose his views, he resorts to violence, without even realizing that he is committing a crime and breaking religious sanctions and societal norms and values. The female victims develop a sense of inferiority and inadequacy; based on misconception that good wife is one who accepts everything in her relationship as a part of her fate which further aggravates the violence.

Feminist Perspective. The center of feminist theory of violence against women is cultural and structural power differences between men and women. Many individual and interpersonal processes work together to interpret societal and cultural factors to individual level, including behaviors justifying male dominance and superiority over females and strict standards of gender-specific actions. Moreover, men are socialized to be violent and

dominating in interpersonal relationships. Peers and authority figures promote aggression and superiority over women. Violence against women is not sanctioned by social institutions and domestic violence against women is also observed in the home or by the media. The patriarchal system, according to Feminist theory, is blamed for women's subordination. In a study, Felix and Paz-Ingente (2003) found that men and women have been socialized in such a way to think and act in a patriarchal structure. Males are taught to be hostile, dominating, and in charge of females, throughout history and literature while females are taught to be obedient, reliant on males and willing to make sacrifices for the sake of their family, husband and children.

In their interviews with 109 women who had been assaulted, Dobash and Dobash (1979) reported that men used coercion, isolation, and psychological tactics to dominate them. They stated that violence was a result of a culture that was embodied in historical laws about male ownership and marriage, as well as existing gender roles and systems that ensured male superiority over females.

Although contemporary feminist theories acknowledge the occurrence of intimate partner violence perpetrated by females, they also emphasized the empirical evidence that in heterosexual relationships, men are the primary perpetrators (Johnson, 2008, 2011). Such perspectives, in particular, look at the effects of male supremacy and strict gendered socialization on the execution of power and control (Zavala, 2007) when a man's masculinity is challenged, the use of violent acts and forced control is more likely to occur (Anderson, 1997). As a result, this approach provides a clear image of violence in marital relations as it emphasizes the study of both physical and non-physical violence as well as

the social, economic, cultural and power components that influence male dominance and places females in a submissive, obedient and under privileged group.

Cultural Perspective. It is believed that set of laws and cultural values determine the attitudes and behaviors of individuals in any society. Gender-based violence is also thought to be encouraged by cultural institutions, beliefs and customs practiced in various societies of the world. Levinson (1989) highlighted the role of a culture and customs in violence against women and Count, Brown and Campbell (1992) reviewed 14 cultures in this regard. They discovered that wife beating was present and severe in different cultures ranging from very common to almost non-existent. They concluded that punishing wives by physical force was accepted and even considered essential in some societies and slight interference was allowed by outsiders. In other societies with low levels of violence, family and community were allowed to intervene in marital conflicts.

Hassan (1995) stated that both men and women in the family have dynamic power relationships that promote women abuse. It can be concluded that violence against women is caused by more than just men, but also by cultural norms in which often mothers-in-law and sisters-in-law promote and endorse wife abuse in domestic sphere (Rabbani, 1999). Physical abuse of women is often accepted as a reaction to a woman failing to behave in accordance with predetermined gender norms and not viewed as a serious matter for which effective criminal justice responses are needed (Ali et al., 2011; Masood, 2005). Wife beating is currently considered as a normal practice and a family matter that should be kept inside the four walls of the house, rather than a violation of human rights. (Babur, 2007; Masood, 2005; Niaz, 2003; Shaikh, 2003). Violence against women usually remains unnoticed because traditional gender roles, social norms, patriarchal and cultural practices

and religion are used to justify the use of violence against women (Ali et al., 2011; 2013; Fikree et al., 2005; Hassan, 1995; Masood, 2005; Niaz, 2004). The status of women in Islam is usually combined with patriarchal cultural norms which is misinterpreted and results in the encouragement of violence against those who are dependents (Niaz, 2003). In a study by Macey (1999), it was observed that Pakistani Muslim men living in United Kingdom, justified violence against women in the name of Islam and women saw it as a source of power and control.

Violence against wives is a function of the belief, fostered in cultures, that men are superior and that women they live with are their possessions or property that they can treat as they wish and as they consider appropriate

Marriage is generally viewed as a contract between families rather than a contract between two individuals in Pakistani society (Zaidi & Shuraydi, 2002).

In the rural and tribal areas of Pakistan, in particular, women are unable to marry without the consent of their male family members (Hassan, 1995; Masood, 2005; Niaz, 2003; Pardhan, 2009). Literature has shown that women whose marriages are based on certain customs and traditional practices such as dowry system, vulvar (marriage of women with opponent party to settle disputes), bride price and exchange marriages are at a greater risk of violence committed against them by their husbands (Schuler et al., 1996; Rao, 1997; Jewkes et al., 1999).

Marital Perspective. Dissatisfaction with relationship, the couple's power relationship and couple conflict style are marital factors that are closely related to the violence within a marriage. Women who are negatively judged by their husbands because of husband's dissatisfaction with wife or with their relationship are at a greater risk of violence and

aggressive behaviors. In a study by Rosenbaum and O'Leary (1981) found that couples with low marital satisfaction are involved in marital abuse. It was found that violence tends to escalate in families where husband had lower status than his wife (Hournung et al., 1981; Straus & Gelles, 1990). Higher frequency of violence was reported where the power structure is a matter of disagreement inmale-dominant and female-dominant couples. The extent of violence rises when the dissatisfied couples and couples with abusive relationship use less effective conflict management strategies. In a study Loyld (1990) noted that rational problem-solving, discussion or negotiation to resolve conflicts were less likely employed by violent couples. High levels of anger, verbal attacks and physical violence heightened the conflicts.

Family System Perspective. Theorists of family system perspective view the family as a complex entity in which behavior of each member is influenced by the actions and responses of other members of the family (McCue, 2008). These theorists emphasized interactions and relationships within the family, communication styles and problem solving strategies of couples to understand each member's behavior. Family system theorists proposed that any disparity in the family raises the chances for the dominant spouse, either a man or a woman, using violence (Beecham, 2009; Gelles & Straus, 1988; Straus, 2009). They also used to criticize the feminist theorists for addressing only patriarchy and ignoring the effects of sociodemographic variables such as income, unemployment, and age on the incidence of family violence (Gelles, 1993; Gelles & Straus, 1988; Straus, 2007).

This perspective has been highly criticized for failing to address the context in which violence against wives occurs (Laing & Humphreys, 2013), gender disparity, and placing a joint blame for the assault on both the abused and the abuser (Beecham, 2009; Stubbs,

2007; Walker, 2009; Whitchurch & Constantine, 1993). A feminist scholar, Johnson (1995, 2008, 2011) noted that both feminist theory and family system theories appear to be contradictory but two different forms of marital violence must be considered for better understanding i.e. 'situational couple violence' (arising out of conflict as emphasized by family system theory) and 'intimate terrorism' and 'violent resistance' (originated in power and control in relationships).

It can be concluded from the above discussion that the researchers' general consensus seems to suggest that no single theory can accurately explain the scope and complexity of this phenomenon of violence committed by husbands against their wives.

Husband's Violence and Posttraumatic Stress Disorder

One of the most common mental health problems linked to husband's violence has been identified as posttraumatic stress disorder (Golding, 1999). According to Woods (2000), women who have been exposed to violence in intimate relationship face both persistent threats and physical injuries as a consequence of continuing violence as well as repeated occurrence of trauma through physical, psychological and sexual abuse. PTSD is an effective response to abnormally high levels of trauma and stress, according to Goldberg and colleagues (1990). Similarly, women experiencing PTSD symptoms after exposure to violence should not be considered to have a prior mental health problem; rather a natural reaction to events involving high levels of fear and danger are exhibited by these women (Goldberg et al., 1990).

PTSD is an anxiety disorder marked by the presence of symptoms after exposure to a highly stressful incident (APA, 2000). There are eight key requirements for diagnosing PTSD, according to Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

a) An individual has been subjected to a traumatic incident in which he or she witnessed, encountered, or faced an event or events involving real or threatened death, serious injury, or a danger to one's or other's physical integrity and the person's reaction was extreme fear, helplessness, or horror;

b) The person consistently re-experiencing the traumatic event in one or more forms (e.g. frequent and disturbing memories of the event, frequent distressing dreams of the event);

c) Avoiding consistently the trauma-related stimuli and numbing of emotions (not present before the trauma) in three or more ways (e.g. attempts to avoid thoughts, emotions or conversations related to trauma, limited expression of affect, sense of foreshortened future);

d) Negative changes in cognitions and mood that are linked to the traumatic event(s) in the two or more ways, for example, failure to recall important details of the traumatic event, consistent and exaggerated negative thoughts about oneself, others, or the world, persistent negative emotional state, significantly decreased interest in daily activities and lack of general responsiveness;

e) Persistent symptoms of hyper- arousal (not present before the trauma) in two or more ways (e.g. disturbed sleep, irritability, anger outbursts, and lack of concentration);

f) The duration of the disturbance (symptoms in Criteria B, C, D, and E) lasts for one month;

g) Clinically significant impairment in social, occupational, or other important areas of functioning is caused by the disturbance;

h) The impairment is not caused by the physiological effects of a drug (e.g. medication, alcohol) or another medical disorder.

Coker and colleagues (2005), Fedovskiy, Higgins, and Paranjape (2008), Kemp and colleagues (1995) and O'Campo et al., (2006) in their studies showed that women who have exposed to violence by an intimate partner or husband have a higher risk of developing PTSD than women who have never experienced assault.

Woods and colleagues (2008) investigated the connection between violence in marital relationship, PTSD and physical health issues in a diverse group of women seeking help from domestic violence organizations. The findings indicate that all forms of violence i.e. physical, emotional, sexual, threats of abuse, and homicide risk were positively linked to PTSD and to a variety of negative health outcomes such as chronic pain, cardiovascular, respiratory, gastrointestinal, musculoskeletal.

Physical Abuse and PTSD. A significant positive correlation between severity of physical abuse and PTSD has been reported by numerous studies. For example, Housekamp and Foy (1991) found that the degree and intensity of experiencing physical abuse in an intimate relationship have significant correlation with severity of the symptoms of PTSD. In a similar study Kemp, Rawlings and Green (1991) found that the severity of physical abuse and frequency of violent episodes were both significantly linked to PTSD. Even when accounting for length of time and nature of the assault experienced, subjective level of distress, also known as individual perception of the violence, was found to be the strongest predictor of PTSD (Kemp et al., 1991). This study adds to the existing body of knowledge by implying that physical abuse has a strong psychological dimension. This

psychological dimension, or how women view abuse, has a potential to have a profound effect on mental health of women.

A connection between different types of husband's violence and PTSD was found by Babcock, Roseman, Green and Ross (2008). Physical and psychological abuse were found to be positively associated with PTSD symptoms; but only physical abuse appeared to be a significant predictor of PTSD as shown by regression analysis. Similar findings were noted by Kemp and colleagues (1995) indicating that PTSD was substantially higher in women who had been physically abused than in women who had only been verbally abused. Physical violence seems to play an important role in the development of PTSD, according to these findings.

Woods (2000) found that in an abusive relationship, a higher risk of homicide was linked to increased symptoms of PTSD. It also examined women who had left the abusive relationship two years back. Woods called this sample of women as 'post-abused.' Results showed that PTSD symptoms such as intrusive memories and avoidance were still experienced by 44-66 percent of post-abused women. According to this report, women who have been subjected to physical abuse by their husbands were at increased risk of developing PTSD even after the violence has ended. These findings provide evidence for the relationship between physical violence and PTSD symptoms.

Psychological Abuse and PTSD. Threats to both physical and psychological well-being, threats to physical independence, isolation from family, lack of social support, and frequent attempts to both insult and/or humiliate the victim are all common examples of psychological abuse (Follingstad & DeHart, 2000; Pico-Alfonso, 2005). An essential feature of psychological abuse is social isolation since it helps the abuser to assert more

influence and power over the victim by also keeping her more reliant on the abuser for social contact, financial support, and other types of information (Baldry, 2003). Victims of abuse live in a state of persistent fear and forced to constantly monitor their surroundings for signs of abuse as studied by Kaysen et al. (2003). Women are more likely to develop PTSD as result of being in a constant state of terror, danger, and risk. The effects of persistent psychological trauma on women's mental and physical health have been examined by a variety of studies. According to a study by Coker and colleagues, psychological abuse is just as harmful as physical abuse for women victims of marital violence (Coker et al., 2005).

When compared to physical and sexual forms of violence, Pico-Alfonso (2005) reported psychological abuse as the strongest predictor of PTSD. Similarly, even when compared to severity of physical violence, the degree of psychological abuse proved to be the significant predictor of fear. Physical and psychological violence were found to have a strong relationship indicating that it is not easy to separate both types of abuse into unique and distinct features since they are inherently interconnected. Psychological abuse was found to be the sole cause of PTSD symptomatology while examining both physical and psychological abuse by Pico-Alfonso and colleagues (2006) in a later study.

After controlling physical violence, Arias and Pape (1999) observed that psychological violence was a strong predictor of PTSD. Baldry (2003) noted similar results that after accounting for the consequences of psychological violence, physical abuse was no longer a major contributor to multiple psychological symptoms.

Sexual Abuse and PTSD. When compared with physical and psychological forms of abuse, sexual abuse in a marital relationship has received less attention. Sexual abuse,

according to Bonomi, Anderson, Rivara and Thompson (2007) raises the likelihood for physical, mental and social stress in women victims of violence. Sexual violence, according to these researchers, causes additional damage to trust and protection, in addition to those caused by physical and psychological violence. According to the observations of Garcia-Linares and colleagues (2005), one third of women who had been physically abused by their partner/husband had also been subjected to sexual abuse. Severity of physical violence is likely to increase for women who are sexually assaulted. The results indicate that focusing on one type of abuse, such as physical abuse, does not adequately reflect women's experiences of victimization. Therefore, while examining the effects of violence, it is necessary for investigators to also study different types of violence, the severity of violence, and mixed forms of violence.

When Krupnick and colleagues (2004) analyzed various forms of violence and their resulting effects on women's mental health, their results confirmed the existing findings. When compared to women who encountered physical abuse, the findings revealed that sexual assault posed the greatest threat for developing mental health problems; particularly, the lifetime prevalence of PTSD appeared to be the highest in the sexually assaulted women victims of violence.

Temple et al. (2007) conducted a same study and found out that women who have experienced sexual abuse by their partners/husbands are more likely to encounter frequent episodes of sexual violence which could increase their risk of developing PTSD. These women are constantly frightened and scared, uncertain when the next episode of violence will take place. Women victims of violence could be more likely to have PTSD as a result of this persistent danger.

After accounting for physical abuse intensity, Bennice, Resick, Mechanic, and Astin (2003) reported that severity of sexual violence explained a significant portion of the difference in PTSD. According to these researchers, women who have witnessed sexual assault in an intimate relationship have more chances of suffering from PTSD. Pico-Alfonso and colleagues (2006), on the other hand, found that while other forms of violence were taken into consideration, sexual violence was not the only and significant predictor of PTSD. More research into the effects of sexual abuse as well as other forms of marital violence is needed according to these researchers.

Overall, these observations are vital since they demonstrate the seriousness of sexual violence in an intimate relationship. These findings have shown the traumatic nature of sexual violence and the need for more in-depth research, programs, and strategies for women who are victims of such violence.

Demographics, husband's violence and PTSD

A variety of factors at different levels of woman's life, and within different contexts have been related to domestic violence globally. These factors include various individual factors (education level, financial autonomy, level of empowerment, previous history, etc.), partner factors (communication with partner, employment status of partner, etc.), and factors related to immediate social context (inequalities in mobility, economic power, autonomy, etc.).

Keeping in view the significance of the impact of sociodemographic variables and their association with husband's violence perpetrated against women. the current study also aimed at exploring the relationship between sociodemographic factors and husband's violence. Several studies throughout the world have been conducted to explore the

association between intimate partner violence and its sociodemographic correlates. A study was designed by Garg and colleagues (2019) to estimate the magnitude of domestic violence overall, and its subtypes among pregnant women in Delhi, India. The study also found the associated sociodemographic determinants of domestic violence among subjects. The findings revealed overall prevalence of domestic violence to be 29.7% with emotional and verbal type of violence being the most common type. Caste, religion, literacy status of the study subjects, and occupational status of spouses were reported as significant correlates affecting the causation of domestic violence among the subjects.

A recent study was conducted in Gilgit-Baltistan, Pakistan (Hussain, Hussain, Zahra & Hussain, 2020) to assess the prevalence of domestic violence, associated risk factors, and its impact on women's mental health in Gilgit-Baltistan, Pakistan. The results showed that married women in Gilgit-Baltistan reported higher levels of domestic violence (88.8%), psychological (69.4%), physical (37.5%) and sexual (21.2%) violence. Abused women reported lower levels of mental health, psychological well-being, general positive affect and life satisfaction. They also reported higher levels of psychological distress, anxiety, depression, and loss of emotional / behavioral control as compared to no-abused women. Risk factors behind domestic violence were identified as poverty, the influence of in-laws, second marriage, step children, forceful intimate relationship, husband's irresponsibility, addiction and handicapped children.

A number of intervening variables can have an effect on the relationship between violence committed against women by their husbands and PTSD. Professional status, for instance, has been linked to both husband's violence and PTSD. According to some reports,

women who are unemployed have greater number of chances for developing PTSD and other mental health issues as compared to employed women (Jones et al., 2001).

Kimberling et al. (2009) explored the connection between physical and psychological abuse, PTSD, and unemployment rates in a study. Psychological abuse and PTSD were found to be the most important predictor of unemployment. Similarly, women were unemployed were also more likely to experience symptoms of PTSD and both physical and psychological violence. Zink and Sill in 2004 observed that women who have been victims of abuse are more likely to be unemployed for a number of reasons, including physical injuries, psychological trauma, finding protection from the abuser, and the abuser's dominating behavior. Abusers can interfere with a woman's ability to work in a variety of ways, according to Swanberg and Logan (2005). For instance, the abuser can make threatening phone calls to the woman's work place, chase them at work, ruin the woman's work clothes, or physically harm and create hurdles when women try to go to their job. These findings indicate that women who have been abused face significant obstacles to their jobs. Women who are victims of violence are more likely to experience loneliness and lack of social support if they are unemployed. As a result, these women are at a higher risk of suffering from mental health problems.

Age, level of education, number of children are examples of other intervening factors to consider. Higher education and older age have been shown as protective factors in rising resiliency in women survivors of marital abuse (Coker et al., 2005). Humphreys and colleagues (2001) noted that more educated and older women experience less psychological issues as compared to younger and less educated females. Since women are more vulnerable to violence committed by their husbands in their teens and early twenties,

age may act as a protective factor. Thus, women in older age may be less susceptible to experience extreme violence and psychological disorders associated with violence. It has been observed that women who have more children are more likely to suffer from PTSD and violence (Jones et al., 2001).

Understanding the association between Negative Cognitions and PTSD

Negative cognitions refer to dysfunctional thoughts and beliefs individuals may have about themselves and the world. Many theoretical models (Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Janoff-Bulman, 1989) support the key role of dysfunctional thoughts in the etiology and maintenance of PTSD. The theory of shattered assumptions (Janoff-Bulman, 1989; 1992) explains that PTSD develops because basic assumptions and beliefs individuals have are "shattered" after they experience a trauma. According to the emotional processing theory (EPT; Foa & Riggs, 1993; Foa & Rothbaum, 1998), PTSD develops and is maintained when there is a failure of the natural recovery process. The natural recovery process requires the ability to process the memory and implement adaptive behavioral strategies through disconfirming negative cognitions by encountering corrective information in daily life. Finally, the Ehlers and Clark (2000) cognitive model of PTSD describes how PTSD develops, is maintained, and persists over time. Despite knowing the fact that the trauma has long gone, individuals still experience constant fear and danger because of negative judgement of the traumatic incident and/or its aftermaths and incorrect encoding of the traumatic memory. Each theory, over time, has added to our understanding of negative cognitions and its role in PTSD.

Understanding the association between trauma type (e.g., sexual assault) and negative cognitions is important because not everyone who experiences a trauma develops

the same negative cognitions. Research consistently shows that negative cognitions differ based on the trauma experienced; individuals who experience an interpersonal trauma have more severe negative cognitions than individuals who experience a non-interpersonal trauma (Cromer & Smyth, 2010; Foa, Ehlers et al., 1999; Müller et al., 2010; Startup, Makgekgenene, & Webster, 2007; Su & Chen, 2008). As negative cognitions are affected by trauma type, it is important to understand so that we know which negative cognitions may be of particular focus during treatment.

Research has clearly defined the connection between PTSD and distorted thoughts: individuals diagnosed with PTSD have more severe negative cognitions than individuals who do not have PTSD (Agar, Kennedy, & King, 2006; Beck et al., 2004; Daie-Gabai et al., 2011; Foa, Ehlers et al., 1999; Matthews, Harris, & Cumming, 2009; Müller et al., 2010; Pérez Benítez, Zlotnick, Gomez, Rendón, & Swanson, 2013; Startup et al., 2007; Su & Chen, 2008; van Emmerik et al., 2006). Even when comparing individuals with differing PTSD diagnostic criteria (e.g., without PTSD, subthreshold, or with PTSD), individuals with PTSD had the most severe negative cognitions and non-significant difference was reported in other diagnostic categories (Beck et al., 2004; Foa, Ehlers et al., 1999; van Emmerik et al., 2006). However, the association between distorted cognitions regarding self-blame and PTSD diagnosis is unclear. For example, some studies found an association in victims of abuse (Foa, Ehlers et al., 1999) and victims of accidents and natural disasters (Sun & Chen, 2008), while other studies did not find this association in samples of motor vehicle accidents (Beck et al., 2004) and victims of accidents (Matthews et al., 2009). There is a significant association between negative cognitions and PTSD diagnosis and thus the

current study seeks to examine and extend these findings to a larger number of women victims of abuse committed against them by their husbands with PTSD.

Evidence has revealed a robust positive association between negative cognitions and PTSD severity in cross-sectional studies (Blain, Galovski, Elwood, & Meriac, 2012; Buodo, Novara, Ghisi, & Palomba, 2012; Carek, Norman, & Barton, 2010; Constans et al., 2012; Daie-Gabai et al., 2011; Foa, Ehlers et al., 1999; Su & Chen, 2008; van Emmerik et al., 2006).

Among traumatized individuals, the level of PTSD severity is mostly influenced by how severe their negative cognitions are about themselves (not including self-blame) and the world (Agar et al., 2006; Beck et al., 2004; Bryant & Guthrie, 2005; Bryant & Guthrie, 2007; Buodo et al., 2012; Cromer & Smyth, 2010; Field et al., 2008; Moser, Hajcak, Simons, & Foa, 2007; Müller et al., 2010; Startup et al., 2007). Further, it was found that higher dysfunctional thoughts about the self are the strongest predictor of severe PTSD over and above other variables such as gender, depression, and other negative cognitions (Blain et al., 2012; Bryant & Guthrie, 2005; Bryant & Guthrie, 2007; Field et al., 2008; Moser et al., 2007; Startup et al., 2007). However, the link of negative cognitions with self-blame, trauma type, and PTSD severity is unclear. Among individuals with non-interpersonal traumas, there is a weak or non-significant association between self-blame negative cognitions and PTSD severity (Beck et al., 2004; Field et al., 2008). Yet, this relationship exists in interpersonal trauma samples (Foa, Ehlers et al., 1999; Müller et al., 2010; Startup et al., 2007).

A longitudinal research has also indicated a robust association between negative cognitions and PTSD severity in samples of firefighters (Bryant & Guthrie, 2005; Bryant

& Guthrie, 2007), injury survivors (O'Donnell, Elliot, Wolfgang, & Creamer, 2007), and mixed trauma survivors (Shahar, Noyman, Schnidel-Allon, & Gilboa-Schechtman, 2013). In particular, distorted beliefs related to the self are the strong determinants of having severe PTSD over time. In sum, a clear connection is found between negative cognitions and PTSD. However, further testing of this relationship is warranted to better understand and improve our knowledge about how negative cognitions impact PTSD severity over time.

Assessing Negative Thoughts and Beliefs

Although the theoretical models highlighting the role of negative cognitions in PTSD may differ, there is one general commonality: negative cognitions appear to be a fundamental factor in the etiology, maintenance, and persistence of PTSD. It is necessary to examine how negative cognitions are assessed. Directly assessing negative cognitions determines not only what negative cognitions an individual may have after experiencing a trauma, but can also show change in negative cognitions through the course of treatment. Measures, such as World Assumptions Scale (WAS; Janoff-Bulman, 1989), the Personal Beliefs and Reactions Scale (PBRS; Resick, Schnicke, & Markway, 1991), and the Posttraumatic Cognitions Inventory (PTCI, Foa, Ehlers, Clark, Tolin, & Orsillo, 1999), are needed in order to empirically test theories such as, theory of shattered assumptions (Janoff-Bulman, 1989; 1992), emotional processing theory (Foa & Riggs, 1993; Foa & Rothbaum, 1998), and the cognitive paradigm of PTSD (Ehlers & Clark, 2000).

Posttraumatic Cognitions Inventory (PTCI, Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) is currently the preferred assessment tool for capturing the various aspects of

negative cognitions that are specifically related to PTSD. It consists of Negative Cognitions about Self, Negative Cognitions about the World, and Self-Blame subscales.

Negative thoughts about the self: Incompetence and lack of control. Negative beliefs regarding one's incompetency and decreased self-control have found to be significant in the assessment of functioning after exposure to trauma. "I am a weak person" and "If I think about the trauma, I will not be able to handle it," are PTCI items that measure negative self-beliefs. PTSD, anxiety, and depression have been linked to these thoughts implying that that this particular type of dysfunctional thinking is associated with multiple negative emotions (Beck, Coffey, Palyo, Gudmundsdottir, Miller, & Colder, 2004).

Self-blame. Dysfunctional beliefs about self can lead to feelings of responsibility and self-blame. Many items in the inventory such as "The event happened because of the way I acted," are used to measure such cognitions.

Negative thoughts about the world: Danger. Perceptions regarding the dangerousness of the outside world are among the thoughts and beliefs that emerge after a traumatic incident. The items in PTCI such as "The world is a dangerous place" and "You can never know who will harm you," can be used to assess these cognitions. These beliefs have been related to PTSD, anxiety and depression indicating that they are not specific to any single unpleasant feeling. It appears natural that certain negative emotions such as fear, anger, depression and unhealthy coping styles such as social isolation, insistence on carrying a weapon when leaving the house and so on may be related to generalized feelings of threat and danger.

Narrative Exposure Therapy: A short-term treatment for Traumatic Stress Disorder

Schauer, Neuner, and Elbert (2002) introduced an evidence-based therapy for multiple traumas triggered by domestic, sexual, organized violence or assault, conflict, natural disasters, or war called Narrative Exposure Therapy (NET). The Narrative Exposure Therapy is based on Testimony Therapy and Cognitive Behavioral Therapy and it explores the same psychological etiology used by other exposure therapies namely the modification of the autobiographical memory dysfunction and the fear response habituation.

The goal of NET, at its most basic level, is to make the process of altering fragmented autobiographic memories about the traumatic incident into a meaningful narrative much easier. Distressing emotions are evaluated in a supervised manner during the process of emotional recovery.

The client is engaged in constructing a chronological narrative of his/her life, directed by the therapist, with a particular emphasis on the time and place of trauma. During this process, the therapist will ask the client to explain in depth their observations, thoughts, emotions and all physiological responses to the tragic event while maintaining a relation to the present. Constant reminders are given in terms of the fact that the reactions being discussed by the client are connected to a period of traumatic incident. The therapist documents this this description as a necessary condition for the composing of the autobiography. In conventional exposure intervention, the therapist instructs the clients to reflect on the most stressful incident of their lives. On the on the hand, NET focuses on all traumatic incidents assuming that in complex trauma, people have experienced similar extreme forms of multiple traumas. As a consequence, concentrating on any one of these

traumas might not be practical or even therapeutic. This also aims to improve an individual's sense of personal identity throughout his or her life even through the most distressing life events. After the biography is formed, the therapist and the client revisits it to obtain a clearer picture of interactions as well as actions and cognitions that are experienced as a reaction.

Basis of Narrative Exposure Therapy. Human perception is generally believed to be influenced by perceptions of arousing events that have happened in the past, and is also thought to be influenced by encountering the stimulus directly. The memory is not just a snapshot of the historic incidence but a dynamic composition of the real event and the meaning assigned to it particularly in the case of traumatic event. This affects person's memories, feelings and behavioral responses to the extent that the person might experience severe and persistent discomfort, even if the danger is in no longer present. This, in turn, causes the development of hot and cold memories. When recalled by a person, the term "cold memories" refers to recollections that are meaningful, true, organized, significant and does not cause severe discomfort. Cold memories are specific to various events that happened in a person's life and are arranged in various phases, each phase being more specific than the previous one. "Hot memories," on the other hand, are traumatic, distressing, scattered and unrelated to the actual event. Another negative feature of such memories is their proclivity for being activated by sensory or environmental cues which then stimulates the person's fear response to a stimulus that have already occurred in the past. NET aims at rearranging and restructuring of a fragmented representation of memory from the person's life history, therefore improving the coding of the declarative autobiographical memory (cold memories) and assigning a temporal and spatial meaning

to traumatic events. The traumatic incidents are repeated until the individual's arousal level is considerably decreased. This does not imply that the significance of traumatic event's meaning is ignored, rather, it is modified in a manner that helps the person to interpret the incident more realistically and respond to it in a less distressing way (Schauer, Neuner & Elbert, 2002)

Structure of Narrative Exposure Therapy. Sessions of Narrative Exposure Therapy can take place at least once a week, with no more than a fortnight between them. Each session is normally 60-120 minutes long. The session begins with psychoeducation which entails providing information about the procedure and purpose of the therapy. Followed that the client gives his or her informed consent to the therapist. The lifeline is formed in the first session. This is done with the help of a rope that represents the client's life from birth to the present. To represent the future, a part of the rope is left uncoiled. The person then narrates his/her life history in a chronological order. On the lifeline, symbols such as flowers for pleasant events and stones for unpleasant or stressful events are used to depict life events. This first activity is crucial for establishing a relationship between the therapist and the client as well as for determining the number of sessions needed. Following that, with a special emphasis on the traumatic incidents, the person's life story is narrated. When explaining the episodes of trauma, the person is advised to begin by giving a general background of the event while considering an environmental, physical, cognitive and behavioral perspective in view. The real incident is then investigated in detail with the therapist guiding the patient to engage himself/herself in the description for a period of time considered long enough to enable habituation while keeping a link between past and present. After exposure to the incident, the patient is asked to continue telling the story of

his/her life until the arousal is visibly reduced, so that the session can be ended at that point. The therapist, between the sessions, compiles the narrative and finds the areas that need to be explored further. The narrative is read to the client at the start of the next session which acts as another opportunity for disclosure. It may take multiple sessions and narrations for the person to have a reduced response to the incident. This process continues until the next traumatic event appears on the lifeline. Therapy will end with a special focus on the hopes and expectations after all traumatic events have been addressed and a complete testimony from the individual has been obtained. For legal proceedings and history purposes, the patient is provided with a copy of testimonial (Schauer, Neuner & Elbert , 2002)

Rationale of the study

Within their families and in their homes where women and children should be safest, they are often in great danger. For most of the women and children, 'home' is a place where they are exposed to organized violence and abuse perpetrated by someone they should trust. Victims are both physically and psychologically harmed. From the fear of more consequences, they are not able to make their own choices, express their own views or secure themselves and their children. The persistent threat of violence denies their human rights and robs them of their livelihood. Domestic violence refers to violence perpetrated by husband or members of the family, regardless of where it occurs or in what manner.

There has been an increased focus on the issue of violence inflicted by the husbands on their wives throughout the world as it is a serious and pervading issue for both the individuals and the wider community. As highlighted by the research on its frequency and prevalence, the global dimensions of this violence are startling. The current study also

explored the association of sociodemographic factors with husbands' violence keeping in view their significance in the causation of husband's violence. Various studies have highlighted the importance of sociodemographic correlates in husband's violence. For example, Ali, Asad, Morgen, and Krantz (2011) conducted a study on a sample of women living in urban areas of Karachi to assess the nature and extent of various types of wife abuse and their relationship with sociodemographic variables. It was found by the study that self-reported past year and lifetime prevalence of physical violence was 56.3 percent and 57.6 respectively; for sexual assault, the figures were 53.4 percent and 54.4 percent, and for psychological abuse the figures were 81.8 percent and 83.6 percent. Likewise, Bano, Zafar and Rahat (2021) in a study reported that around 10% of ever-married females aged between 15-49 years in Pakistan had experienced intimate partner violence during pregnancy in lifetime. The women who were in poverty, uneducated, unemployed experienced higher violence by intimate partner. Intimate partner violence during pregnancy was significantly associated with residence in rural areas, having husbands who were unemployed and consumed alcohol.

No society can claim to be free of such violence, the only distinction between countries and regions is in the patterns and trends that prevail. Historically, females remained victims of violence all over the world in general and Pakistan in particular. According to survey conducted by Sheikh (2000) on the prevalence and types of domestic abuse carried out by husbands, 100 percent of males admitted to "ever screaming or yelling" at their wives even while pregnant. Thirty two percent of males confessed slapping their wives, and 77 percent admitted to ever engaging with them in coercive sex with them. Rabbani, Qureshi and Rizvi (2008) concluded in a study that in Pakistan, family structure,

lack of legal assistance, gender discrimination and inequality, women's social status and their financial dependency on the male family members are significantly correlated with family violence.

The family is considered a private place where outsiders are not allowed to interfere even in the serious matters. Violence against women is usually committed by males who are strict and believe in the patriarchal dominance of the family. As it was hidden behind the closed doors therefore it was not investigated for years and there is a scarcity of empirical data about the issue of non-reporting of the violence perpetrated by husbands. As a result, girls and women in Pakistan are still experiencing higher levels of discrimination and maltreatment. Women are insecure in their own homes and face domestic and cultural forms of violence like wife abuse, acid throwing, stove-burning, honor killings, exchange marriages, vani and bride price etc.

Pakistan does not have a literature which shows the involvement of women in domestic violence against women. This is an indication which shows that society keep a blind eye to this issue. This is the reason that despite of growing awareness and discourse on the issue, the issue remains in the society and this could be one of the reasons behind the under reporting of the issue. If the issue is to be rooted out, there is a great need that female to female violence should be given equal importance as the male to female violence has always been given.

The overall scope of this research is broad in a sense that its main focus is on identification and intervention of intimate partner violence which has eclipsed the lives of many women in Pakistan. Vindya and colleagues (2001) stressed that there is a need for

more researches on women and gender relations in South-Asian countries because progress in this region is closely associated with women development. This research comprised of three distinct studies with special emphasis on identification and prevention of family violence against women will be a noteworthy contribution.

Alpert et al (2002) expressed that in view of high incidence rate and impacts of abuse on physical, psychological and sexual health of women, it is expected that nearly every healthcare professional may come across domestic abuse during his or her professional life. Previous research has identified that women were very frequently visit to hospitals for their problems related to abuse but they did not disclose presence of abuse in their marital relations nor did healthcare providers commonly ask them about that possibility (Sagot, 2005). Similar kinds of problems are faced by women in Pakistan who frequently tolerate violence in their marital lives. There is a strong need to devise tools and interventions to identify violence committed by husbands against their wives. Public interest and awareness about the issue has risen as a result of efforts and work done by non-governmental organizations, print and electronic media in Pakistan.

This research will be a noteworthy contribution in the field of research on husband inflicted violence against women in South-Asian region. Being a Pakistani woman and living in a traditional society, the researcher has noticed that women in this society have always been considered as subordinate or inferior. Women face all forms of violence by their husbands. Their sufferings continue in form of short-term and long-term impacts on physical and psychological well-being. Being a student of psychology, the researcher strongly believe that it is her professional and moral duty to work on this important issue

which has indented the lives of many Pakistani women. It is an attempt to improve everyday living of women in our society.

The current study particularly targeted the hidden and forgotten dilemma of violence against women committed by their husbands. While reliable statistics are hard to come by, studies estimate that women around the world experience between 20 and 50 % of physical abuse at the hands of their husbands or family members. Intimate partner violence itself a traumatic experience and existing body of knowledge confirmed PTSD, emotional numbing, and other psychiatric symptoms among women who face wife abuse.

An alarming increase in the occurrence and the hazardous effects of husband's violence initiated the current study to examine the therapeutic aspect of issue. The unique aspect of the current study was to examine whether Narrative Exposure Therapy will be effective in treating traumatized women victims of intimate partner violence. Although a numerous researches have demonstrated the prevalence of PTSD among natural disaster survivors such as those of an earth quake, tsunami, hurricane and typhoon, very few have examined PTSD among women victims of violence within intimate relationship. So far, the current research will be the first in Pakistan to examine the efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence. The researcher hopes that the results of the study will be helpful in many ways. Narrative Exposure therapy will be provided to women victims of intimate partner violence which will help them recover from the Posttraumatic Stress Disorder.

The findings of the study will be valuable for counselors, mental health professionals, psychotherapists and social workers working with women victims of

intimate partner violence by providing relevant information. The study will also encourage researchers to investigate NET as well as other psychotherapies in the field of family violence. Generally, it will play an important role in adapting, developing and using NET in Pakistani context. Examining intimate partner violence against women sensitively from various aspects, the current study will hopefully highlight the discrepancies across the studies and fill the research gaps. Above all, as its core objective, the research findings will definitely contribute to address the issue of violence inflicted on women by their husbands in a distinct way.

The goal of present research was integrating psychological rehabilitation of trauma survivors with issues of human rights and dignity on social, academic, and political levels. Therefore, it is of utmost importance to listen to the voices of women on issues particularly related to females. The present study was planned in such a way that it allows full expression to their wide range of experiences from their perspective by giving "voice" to women. At the same time, this research is also written such that it is available to engage members of general public. Since story-telling and narration are practices shared among all of humankind and NET can be tailored to any culture, therefore, NET was selected to be tested in the present study by the researcher.

Objectives

1. To investigate the association between violence committed by husbands against their wives, posttraumatic stress disorder and negative cognitions.
2. To evaluate the efficacy of Narrative Exposure Therapy among traumatized women victims of husbands' violence.
3. To examine the differences on the basis of sociodemographic variables with violence committed by husband.

METHOD

Chapter-II

Method

Research Design

The current study was a Quasi-Experimental Control Group Pretest-Posttest design with intra and inter group comparisons over time. Current study was completed in the following three phases:

Phase I consisted of the following steps:

Step I: Translation of the instruments into Urdu language.

Step II: Pilot Testing of translated instruments.

Step III: Cross-Language Validation of translated instruments.

Step IV: Establishing Psychometric properties of Urdu Scales.

Phase II was based on the following steps:

Step I: Screening out of traumatized women victims of husband's violence.

Step II: Exploring the relationship and differences between sociodemographic variables and husband's violence.

Step III: Pilot study to examine efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence.

Phase III: Main Study: Examining efficacy of Narrative Exposure Therapy on a larger sample of traumatized women victims of husband's violence.

Phase I

Step I: Translation of Scales. Step I was carried out to translate PTSD Checklist for DSM-5 (PCL-5) and Posttraumatic Cognitions Inventory (PTCI) into Urdu.

Instruments

PTSD Checklist for DSM-5 (PCL-5). PCL-5 was developed by Weathers, Litz, Keane, Palmieri, Marx and Schnurr in 2013 to assess 20 symptoms of PTSD based on DSM-5 criterion. The PCL-5 has multiple uses such as monitoring symptom change during and after the treatment, screening individuals with PTSD and making provisional diagnosis.

The checklist consists of four domains of PTSD given by DSM-5: Re-experiencing, Avoidance, Negative alterations in cognition and mood and Hyper- arousal. The total score indicates the seriousness of the symptoms that can be calculated by adding the scores for 20 items. The scores range from 0-80. These scores range between 0 to 5 on a Likert scale where 0= Not at all to 4= Extremely. Higher scores represent higher severity. For making provisional diagnosis, the cut-off score is 38. For observing change in symptoms over time, 10-point change is required to be considered a clinically significant change in symptoms (see Appendix-H)

Posttraumatic Cognitions Inventory- PTCI. Posttraumatic Cognitions Inventory (PTCI) developed by Foa and Ehlers (1999) was used in the present research to assess posttraumatic cognitions in women victims of husband's violence. PTCI consists of 33 statements about negative cognitions scored on Likert-type ranging from 1 (*totally disagree*) to 7 (*totally agree*). The scores range from 33-231. PTCI has three subscales measuring Negative Cognitions about the Self, Negative Cognitions about the World, and

Self-Blame. Higher scores represent higher levels of dysfunctional thoughts (see Appendix-I).

Procedure

Translation into Urdu Language. Translations were produced by six bilingual translators, who have target language as their mother language. Experts were briefed about the rationale of the research. Two of the translators were psychologists while the other four were native speakers of the target language. It was requested to the translators to concentrate on conceptual rather than literal elements while translating the statements. They were also asked to propose alternatives to items which they observed as irrelevant to Pakistani culture.

Committee Approach. Six members of the committee cautiously examined the translations and identified the discrepancies between the original version and the translated version. The committee selected the most suitable and relevant translations done by the experts.

Back Translation. Back-translation is just one of the ten steps in the questionnaire translation process. In short, these are:

1) preparation;

2) forward translation, done simultaneously by two independent translators;

3) forward translation reconciliation, whereby the forward translations are compared and merged into one by either one of the forward translators or an independent translator;

4) back-translation, done independently by two translators who do not have access to the source text;

5) back-translation review, performed by an expert who compares the back translations with the original text, identifies discrepancies and discusses with the translator who did the reconciliation if any changes need to be made;

6) harmonization, whereby back translations of a number of language versions are compared to achieve a consistent approach in addressing translation issues;

7) pilot testing on a small group of subjects;

8) review of pilot testing results and finalization;

9) proofreading; and

10) final report, that documents all the steps of the translation process for the client (Wild et al 2005).

In the present study four independent translators (n=4) blind to the original English version translated the target language version of the instruments back to English. Conceptual, rather than literal translation of the items was the focus of translation.

Committee Approach. A group of five bilingual experts (n=5) critically examined and finalized the items from back translation. The following criteria must be considered in selecting the bilingual experts (Hambleton & Patsula, 1999):

a) Proficiency in both languages.
b) Familiarity with both cultures.
c) Proficiency in the subject matter tested, and
d) Item writing expertise.

The details about the qualification of experts are given below:

1. One Associate Professor in English from Islamabad College for Girls, F-6/2, Islamabad.
2. Two Assistant Professor in Psychology from International Islamic University, Islamabad.
3. Two Assistant Professors in English from The University of Haripur, KPK.

The members after having consensus on the accuracy and appropriateness of the statements decided that adaptation was not required for any statement.

Step II: Pilot Testing of Translated Scales

Objective

Step-II was carried out to examine the clarity and relevance of the translated scales in the clinical sample.

Sample

Twenty psychiatric patients with Posttraumatic Stress Disorder (N=20) including males (n=13) and females (n=07) were presented the Urdu translated versions of PTSD Checklist for DSM-5 (PCL-5) and Posttraumatic Cognitions Inventory-PTCI. The sample was taken from different government and private hospitals of Islamabad and Rawalpindi (see Appendix-A). To determine test-retest reliability, the scales were again administered to the same respondents after 2 weeks.

Results

Table 1

Alpha Reliability Coefficients and Test-Retest Reliability of PTSD Checklist for DSM-5 and Posttraumatic Cognitions Inventory (N=20)

Scales	No. of Items	α	*r*
PTSD Checklist for DSM-5	20	0.85	0.77
Re-experiencing	5	0.79	0.76
Avoidance	2	0.75	0.69
Cognition/Mood	7	0.80	0.73
Arousal	6	0.70	0.74
Posttraumatic Cognitions Inventory	33	.0.83	0.76
Self	21	0.77	0.70
World	7	0.64	0.71
Self-Blame	5	0.71	0.66

Note. $^{**}p < .01$

Table 1 indicates the findings that the reliability of PCL-5 was 0.85 and PTCI was 0.83. Test- retest reliability was also established. The results showed that there was a significant correlation (r = 0.77, $p < .01$ and r = 0.76, $p < .01$ for PCL-5 and PTCI respectively) between the two administrations of the scales. Test-retest reliability of subscales was also calculated which indicates that all subscales of both the scales have significant correlation.

The findings revealed that respondents had no difficulty in answering the statements. All the statements in the translated scales were found to be appropriate and relevant to Pakistani culture by the respondent

Step III: Cross Language Validation of translated scales. For cross-language validation following objectives were formulated:

Objectives

1. To determine cross language validation of PTSD Checklist for DSM-5 (Weathers et al., 2013) and Posttraumatic Cognitions Inventory-PTCI ((Foa et al., 1999).
2. To establish Test-Retest reliability of Urdu versions of PCL-5 and PTCI.

Sample

A sample of (N=300) married women aged 18-50 years was recruited from various residential areas of Islamabad and Rawalpindi to determine psychometric properties of the research instruments.

Procedure

The participants were split into Group1 and Group 2. There were 150 (n=150) participants in each group. The original English inventory was given to Group 1, while translated Urdu version was given to Group 2. After a two- week period, the same sample of respondents were tested again but this time in a different way with Group 1 and Group 2 being split into groups 1a and 1b and 2a and 2b respectively, each group consisting of 75 respondents. The original English inventory was given to groups 1a and 2a, while the Urdu translated version of the inventory was given to groups 1b and 2b. Following figure explains the procedure of group division and administration.

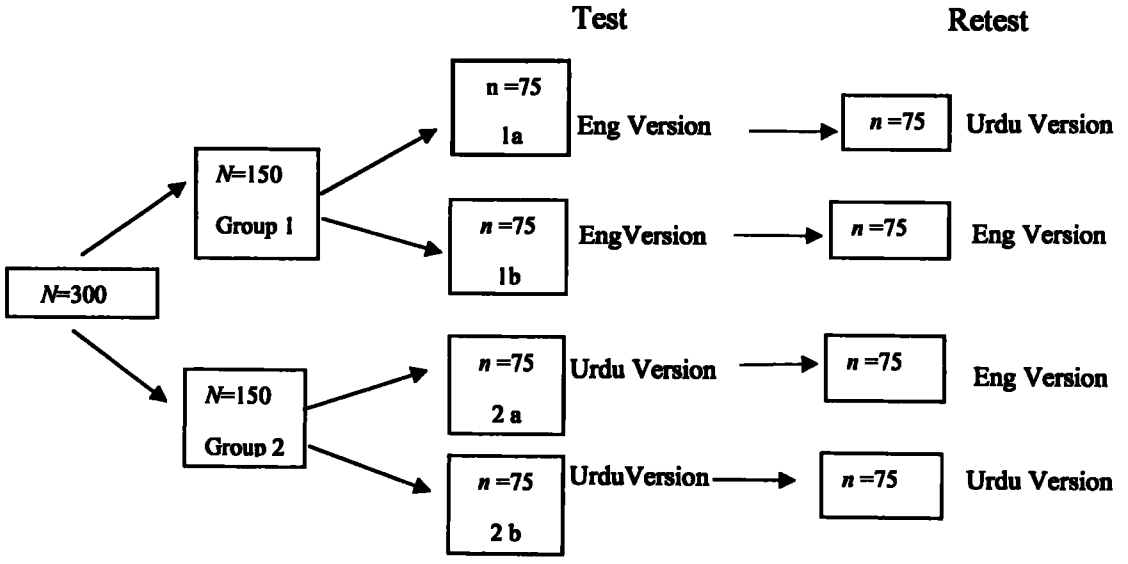


Figure 1: The figure represents the distribution of sample for step - III

Procedure

The data was collected from 300 married women living in Islamabad, Rawalpindi and Haripur. The researcher briefly explained the main objectives of the study to the respondents. Volunteers were recruited for the present research after taking their consent. Confidentiality of information was ensured to the participants by the researcher. They were requested to select the best suitable option after going through the instructions carefully. The respondents completed the task in approximately 20 minutes.

Results

Table 2

Cross Language Validation and Test-Retest Reliability of PTSD Checklist for DSM-5 (N=300)

Groups	*n*	1st Administration	2nd Administration	*r*
I	75	English	English	.70
II	75	English	Urdu	.69
III	75	Urdu	Urdu	.73
IV	75	Urdu	English	.72

***p<.01*

Table 2 indicates significant correlation (*p<.01*) between PTSD Checklist for DSM-5 Urdu and English versions which ranges from .73 (Urdu to Urdu) to .70 (English to English).

Table 3

Cross Language Validation and Test-Retest Reliability of Posttraumatic Cognitions Inventory (N=300)

Groups	*n*	1st Administration	2nd Administration	*r*
I	75	English	English	.65
II	75	English	Urdu	.79
III	75	Urdu	Urdu	.82
IV	75	Urdu	English	.68

***p*<.01*

Table 3 indicates significant correlation (*p*<.01) between Posttraumatic Cognitions Inventory (PTCI) Urdu and Posttraumatic Cognitions Inventory (PTCI) English versions. The correlation coefficient ranges from .82 (Urdu to Urdu) to .65 (English to English).

Step IV: Establishment of Psychometric Properties of Urdu scales

Objective

To determine psychometric properties of Urdu version of the instruments.

Sample

To determine psychometric properties, the instruments were given to 300 married women. The data was collected from different residential localities of Islamabad, Rawalpindi and Haripur. The age of the participants ranged from 18-50 years.

Instruments

Psychometric properties of the following scales were estimated:

1. Urdu version of PTSD Checklist for DSM-5 (PCL-5)
2. Urdu version of Posttraumatic Cognitions Inventory (PTCI).

Procedure

A permission letter was issued on the behalf of Department of Psychology, International Islamic University, Islamabad for data collection (Annexure-A). The respondents were briefed about the purpose of the research. They were asked to follow the instructions about the questionnaire carefully. Convenient sampling technique was used for data collection. Participants were thanked by the researcher for their cooperation after completing the questionnaires.

Results

Table 4

Psychometric Properties of PCL-5 Urdu version and PTCI Urdu version (N=300)

					Range			
Scales	k	*M*	*SD*	α	Potential	Actual	Skew	Kurt
PCL-5	20	41.62	11.03	.83	80	64	-.021	-.89
Re-experiencing	5	17.1	6.3	.80	20	14	-.056	-1.50
Avoidance	2	9.46	1.21	.70	8	5	.08	1.20
Cognition/Mood	7	29.51	5.47	.82	28	21	-.211	-1.21
Arousal	6	18.81	7.81	.79	24	20	.065	1.60
PTCI	33	208.7	6.38	.80	231	210	.29	1.36
Self	21	62.80	14.35	.81	147	128	.29	1.22
World	7	19.81	8.92	.76	49	37	-.063	-1.80
Self-Blame	5	17.71	6.80	.65	35	29	.069	1.98

Note. PCL-5= Posttraumatic Stress Disorder Checklist for DSM-5, PTCI= Posttraumatic Cognitions Inventory

Table 4 shows mean and standard deviation of Posttraumatic Stress Disorder Checklist (PCL-5) and Posttraumatic Cognitions Inventory (PTCI). The reliability analysis for each measure was carried out using Cronbach Alpha. PCL-5 has a reliability coefficient of 0.83 which is quite satisfactory. The reliability coefficient of the subscales of PCL-5 were also calculated which came out to be 0.80 for Re-experiencing, 0.70 for Avoidance, 0.82 for Cognition/Mood and 0.79 for Arousal. The reliability coefficient of PCTI is 0.80. The reliability coefficient for the subscales of PTCI was 0.80 for Self, 0.76 for World and 0.65 for Self-Blame. Overall, both scales have satisfactory index of reliability.

Table 5

Item Total Correlations of Urdu Version of PTSD Checklist for DSM-5 (N=300)

Item No.	Corrected Item Total Correlation
1	.45
2	.35
3	.60
4	.40
5	.51
6	.37
7	.38
8	.49
9	.34
10	.38
11	.38
12	.40
13	.59
14	.44
15	.36
16	.42
17	.38
18	.45
19	.43
20	.31

Table 5 indicates item-total correlations for 20 items of PCL-5 Urdu version. It is clear from the results that there is a positive correlation between all the items of the scale and the total score.

Table 6

Item Total Correlations of Urdu Version of Posttraumatic Cognitions Inventory (N=300)

Item No.	Corrected Item Total Correlation
1	.35
2	.40
3	.42
4	.40
5	.43
6	.35
7	.33
8	.43
9	.31
10	.32
11	.38
12	.42
13	.43
14	.36
15	.33
16	.42
17	.36
18	.41
19	.45
20	.37
21	.39
22	.35
23	.35
24	.34
25	.37

Continued.....

Item No.	Corrected Item Total Correlation
26	.39
27	.33
28	.36
29	.41
30	.38
31	.35
32	.40
33	.40

Table 6 indicates item-total correlations for 33 items of PTCI Urdu version. It is clear from the results that there is a positive correlation between all the items and the total score of the scale and measuring the same construct.

Discussion

Keeping in view the main purpose of the current research that is to examine the efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence, it was decided by the researcher to translate and validate PTSD Checklist for DSM-5 (Weathers et al., 2013) and Posttraumatic Cognitions Inventory (Foa et al., 1999) for screening out traumatized women victims of husband's violence. After reviewing literature, it was noticed by the researcher that the positive relationship between PTSD and negative cognitions is logical; as increase in PTSD symptoms may lead to higher levels of negative cognitions in individuals which could in return may affect the outcome of therapeutic intervention. The researcher also found out that in Pakistan, there are very few studies conducted on the evaluation of thoughts and beliefs that are developed after a traumatic event. In addition, testing and evaluation efforts in this field are currently facing a serious shortage. As a result, the aim of this study was to translate and validate Posttraumatic Cognitions Inventory (Foa et al., 1999) into Urdu language to identify and restructure dysfunctional beliefs so that the efficacy of narrative exposure therapy could be enhanced.

The research was carried out in three different phases. Six bilingual experts independently translated the questionnaires into Urdu language in phase I. Four different experts worked on the back translation. Committee members finalized the statements and no differences between the translated and original inventories were found by the committee members. The final translated version of PCL-5 and PTCI were also administered to the clinical sample to check clarity and relevance of the content. The results indicated that participants have no difficulty in understanding the statements. Cross language validation

and psychometric properties of the scales were assessed on a larger sample 300 married females who were divided into four groups in step III. The results showed appropriate and satisfactory psychometric properties yielded by the instruments (see Table 4). Analysis of consistency (Table 2 & 3) and item-total correlations (Table 5 & 6) indicated that the instruments measure what they claim to measure (Anastasi & Urbane, 1997).

According to the findings of this research, the translated Urdu version of the scales can be used as a sound base for developing local instruments. The present study suggested that in future studies, items of PCL-5 and PTCI can be expanded and modified while taking into account the cultural background of Pakistan. On the basis of overall results, it can be said that both scales have been translated accurately and cross language validity has been established satisfactorily. The instruments are ready to use in a variety of settings including clinical setting with confidence.

Phase II: Phase II of the study consisted of the following steps:

Step I: Screening out women victims of husband's violence with PTSD and exploring the relationship and differences between sociodemographic variables and husband's violence.

Step II: Pilot Study to examine the efficacy of NET among women victims of husband's violence with PTSD.

Step I: Screening out women victims of husband's violence with PTSD and exploring the relationship and differences between sociodemographic variables and husband's violence.

Objectives

Following objectives were formulated for this phase:

- To screen out women victims of husband's violence with Posttraumatic Stress Disorder for therapeutic intervention.
- To assess overall prevalence of violence committed against women by their husbands.
- To explore the differences on the basis of sociodemographic variables in abused women.
- To find out relationship between sociodemographic variables and husband's violence.

Hypotheses

Following assumptions were formulated about the findings of the present study:

1. Higher rates of violence will be reported by women in younger age than older women as measured by Karachi Domestic Violence Screening Scale (KDVSS-U).
2. Husbands belonging to older age groups will more likely to commit violence against their wives as compared to younger group.
3. Women with low level of education will face more violence committed by husbands as compared to highly educated women.
4. Husbands with low level of education will inflict more violence as compared to highly educated husbands.
5. Housewives would more likely to report violence committed by husbands as compared to working women.
6. Employed husbands would less likely to commit violence against their wives as compared to unemployed husbands.
7. Husbands with higher income will inflict less violence as compared to husbands with low level of income.
8. Husband inflicted violence will be high in later years of marriage as compared to early years.
9. Husband inflicted violence will be high in women with more children as compared to women with less number of children.
10. Higher rates of abuse will likely to be reported by women who live in joint families as compared to women living in nuclear families.

Sample

For the screening purpose, data was collected from various government and private healthcare services centers, hospitals and residential localities of Islamabad, Rawalpindi and Haripur. Purposive sampling technique was used for the present study. Only those women were included in the sample who were currently in a marriage and experiencing violence by their husbands with age range from 19-55 years. Widowed, separated and divorced women were excluded from the sample. A total 800 of forms were distributed among women for the current study. Forms with incomplete information were rejected by the researcher. The entire sample therefore consisted of 656 women belonging to various age groups, socioeconomic classes, educational qualifications, both joint and nuclear families with a wide range for years of marital relation and number of children (See Table 7 & 8).

Operational Definitions of Demographic Variables

Following categories of demographic variables were established to conduct analysis and present findings of the study:

Age: Age groups were combined into four categories for the current study.

Very Young Group: 16 years to 25 years; Younger Group: 26 years to 35 years;

Middle Group: 36 years to 45 years; Older Group: 46 years and above

Educational Levels: Categories were combined for both husband's and wife's educational levels.

Lower Educational Levels: Illiterate and Primary

Middle Educational Levels: Secondary, Matric and Intermediate

Higher Educational Levels: Graduate, Master and Professional

Employment Status for Women:

Non-Professional Status: Housewives

Professional: Paid Employee

Employment Status for Husbands:

Employed and Unemployed

Family Monthly Income: Family Monthly Income was divided into five categories:

10,000 – 25,000

26,000 – 41,000

42,000 – 67,000

68,000 – 83,000

84,000 & above

Number of Children:

Less Number of Children: 3 or less than 3 children

More Number of Children: 4 children and above

Years of Marriage: Years of marriage were combined to form following categories for the present study:

1 – 5 years; 6 – 10 years;

11 – 15 years; 16 – 20 years;

21 – 25 years; 26 – 30 years;

31 years and above

Instruments

Demographic Data Sheet. The researcher prepared Demographic Data Sheet (Annexue-E) to obtain information about socio-demographic characteristics of the participants and/or their husbands. Socio-demographics such as age, length of marriage, number of child(ren), whether living in a joint or a nuclear family, education level, employment status, income and religion were included in the demographic data sheet.

Karachi Domestic Violence Screening Scale- Urdu version. The scale comprised of 35 items with five subscales exploring the incidence of physical abuse, psychological abuse, and sexual abuse. The scale also measures characteristics of the abuser and characteristics of the victim (Annexure-I).

For all items there was a 4-point rating scale with options of "Never", "Sometimes", "Often" and "Most of the time". The scoring range on each item is 0 to 3, corresponding to minimal and maximal domestic abuse being faced by the victim. The total score range of KDVSS is from 0 to 105. The cut-off score on KDVSS-U is 30. The total score is obtained by adding scores on all the subscales (Hassan & Malik, 2009).

PTSD Checklist for DSM-5 (PCL-5)- Urdu Version. PCL-5 was developed by Weathers, Litz, Keane, Palmieri, Marx and Schnurr in 2013 to assess 20 symptoms of PTSD based on DSM-5 criterion. The PCL-5 has multiple uses such as monitoring symptom change during and after the treatment, screening individuals with PTSD and making provisional diagnosis.

The checklist consists of four domains of PTSD given by DSM-5: Re-experiencing, Avoidance, Negative alterations in cognition and mood and Hyper- arousal. The total score

indicates the seriousness of the symptoms that can be calculated by adding the scores for 20 items. The scores range from 0-80. These scores range between 0 to 5 on a Likert scale where 0= Not at all to 4= Extremely. Higher scores represent higher severity. For making provisional diagnosis, the cut-off score is 38. For observing change in symptoms over time, 10-point change is required to be considered a clinically significant change in symptoms (see Appendix-J)

Posttraumatic Cognitions Inventory-Urdu Version. Posttraumatic Cognitions Inventory (PTCI) developed by Foa and Ehlers (1999) was used in the present research to assess posttraumatic cognitions in women victims of husband's violence. PTCI consists of 33 statements about negative cognitions scored on Likert-type ranging from 1 (*totally disagree*) to 7 (*totally agree*). The scores range from 33-231. PTCI has three subscales measuring Negative Cognitions about the Self, Negative Cognitions about the World, and Self-Blame. Higher scores represent higher levels of dysfunctional thoughts (see Appendix-L).

Procedure

As a part of the study, the screening of women victims of husband's violence was done. Authority letter was taken from parent department to collect information. Data was collected from different healthcare services centers, hospitals, schools, colleges and universities and also from residential areas of Rawalpindi, Islamabad and Haripur. Key informants in different residential areas of Rawalpindi, Islamabad and Haripur were identified and with their help the researcher personally visited to collect data from women victims of husband's violence. Participants were given brief introduction regarding the

nature, objectives and importance of the study. The participants were given the booklet of the questionnaires containing demographic data form, domestic violence screening test and information related to traumatic experiences. Brief instructions regarding the completion of questionnaires were given to the participants and the willing participants were requested to sign the informed consent. Participants were asked to remain confident as the information was only used for research purpose. The researcher addressed the queries of the participants before, during and after completion of scales. After completing the scales, the researcher initially scanned the questionnaires to identify the missing responses, either intentionally or unintentionally. If any question was left blank, the researcher requested to complete the questionnaire. There were no time constraints to answer the questionnaires. After identifying the targeted sample (*N= 395)*, the researcher also screened out 100 women victims of husband's violence who were having PTSD (*N= 100)* to be included in the main study. These women were selected after taking their consent to participate till the completion of the study. At the end, the researcher thanked the participants for providing valuable information.

Results

Table 7

Age, Education and Professional Status of wives and husbands (N=656)

Demographics	*n*	Percentage	Demographics	*n*	Percentage
Age of Wives			Age of Husbands		
16-25 years	176	26.8%	16-25 years	40	6.1%
26-35 years	226	34.4%	26-35 years	186	28.4%
36-45 years	202	30.8%	36-45 years	340	51.8%
46 years & Above	52	7.9%	46 years & Above	90	13.7%
Education level of Wives			Education level of husbands		
*Low	160	24.4%	Low	90	13%
**Middle	366	55.8%	Middle	355	54%
***High	130	19.8%	High	211	32%
Professional Status of Wives			Professional Status of Husbands		
Housewives	456	69.5%	Unemployed	51	7.7%
Paid Work	200	30.5%	Employed	605	92%

Note: Education = * Illiterate and Primary, ** Secondary, Matric & Intermediate, *** Graduate, Master and Professional

Table 7 reveals basic demographic characteristics of women who took part in the study and the characteristics of their husbands. The larger categories of demographic characteristics are merged into smaller ones in order to make comparisons.

Table 8

Family Income, Years of Marital Relation, No. of Children and Family System (N=656)

Demographics	*n*	Percentage	Demographics	*n*	Percentage
Family Monthly Income			Number of Children (M=3.0)		
10,000-25,000 Rs			0 Child		
26,000-41,000 Rs	263	40.1%	1 Child	79	12.0%
42,000-67,000 Rs	230	35.0%	2 Children	68	10.4%
68,000-83,000 Rs	101	15.4%	3 Children	112	17.0%
84,000 & above	41	6.2%	4 Children	198	30.2%
	21	3.2%	5 Children	66	10.1%
			6 Children & Above	52	8.0%
				81	12.3%
No. of Years of Marriage			Family System		
(M=13 Years)			Nuclear Family		
1-5 Years			Joint Family	388	59.1%
6-10 Years	159	24.2%		268	40.8%
11-15 Years	237	36.1%	Religion		
16-20 Years	107	16.3%	Muslim		
21-25 Years	85	13.0%	Non-Muslim	654	99%
26-30 Years	32	5.0%		2	3%
31 Years & Above	26	4.0%			
	10	1.5%			

Table 8 illustrates that most of the women have low levels of income (*N*= 263). Most of the women (*N*= 237) had 6-10 years of marital relations. 59% women were living in nuclear families. The number of children ranged from 0 to 6 and above. Since Pakistan is a Muslim country, therefore, majority of the participants were Muslims by religion (99%).

Table 9

Frequency and percentages of women identified as Abused and Non-Abused in this study sample assessed by Karachi Domestic Violence Screening Scale Urdu Version (N= 656)

	N	*%*
Women who scored above 3 on KDVSS-U (Abused)	395	60
Women who scored 3 or below 3 (Non-Abused)	261	39.8

Note. KDVSS-U = Karachi Domestic Violence Screening Scale- Urdu Version

Table 9 indicates that 60 % of women were identified as "abused" and 39.8% of women as "non-abused".

Table 10

Correlation between sociodemographic variables and husband's violence (N= 395)

Violence as assessed by KDVSS-U	Pearson *R*	*p*-value
Participants' Age	.047	.484
Participants' Husband Age	.096	.044
Participants' Education	-.351	.000
Participants' Husband Education	-.263	.000
Participants' Professional Status	.087	.104
Participants' Husband Profession	-.291	.000
Levels of Family's Monthly Income	-.228	.000
Years of Marriage	.00	.023
Number of Children	.135	.009

*$p<.05$; **$p<.001$

Table 10 indicates correlation between husband's violence and sociodemographic variables. The computed values of correlation show that women's better education, husband's better education, husband's professional status, and better family income have negative correlation with violence at $p<.001$. Whereas, husband's age, years of marital relation and number of children have significant positive association with violence committed by husbands at $p<.05$. Age of women participants did not have significant correlation with violence.

Table 11

Age wise differences in abused women on KDVSS-U (N=395)

	Very young group (n=88)		Younger group (n= 147)		Middle group (n= 132)		Older group (n= 28)		
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*(3,128)
Abuse as assessed by KDVSS-U	24.6	4.39	23.6	3.28	26	5.63	22	4.77	1.66
Physical Abuse	3.56	4.36	3.11	3.98	2.76	3.63	2.86	3.54	
Psychological Abuse	18.23	3.21	19.33	1.93	19.33	8.85	17.31	4.76	
Sexual Abuse	4.15	4.47	4.78	4.65	4.29	3.90	4.55	4.67	

Note: Age Groups: Very Young Group= 16 years to 25 years; Younger Group= 26 years to 35 years; Middle Group= 36 years to 45 years; Older Group= 46 years and above.

Table 11 shows number of abused women in different age groups with mean, S.D. and *F* value. Results indicate non-significant mean differences for abuse in different age groups with $F(3,128)=1.66, p = .272$. The value of Ω_2 was non-significant.

Table 12

Differences in women abuse on the basis of husband's age as assessed by KDVSS-U (N=395)

	Very young group (n= 25)		Younger group (n= 93)		Middle group (n= 219)		Older group (n= 58)		
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(3,121)*
Abuse as assessed by KDVSS-U	23	4.55	22.6	3.91	25.9	5.50	23	5.78	2.3
Physical Abuse	3.58	3.23	3.41	4.12	3.97	3.77	3.34	3.21	
Psychological Abuse	17.09	14.23	18.31	15.21	19.77	7.98	17.56	15.27	
Sexual Abuse	4. 45	4.15	4.01	3.96	4.90	4. 10	3.87	4.01	

Note: Age Groups: Very Young Group= 16 years to 25 years; Younger Group= 26 years to 35 years; Middle Group= 36 years to 45 years; Older Group= 46 years and above.

Table 12 indicates non-significant mean differences for abuse in different age groups of husbands of abused women with $F(3,121)= 2.3$. $p=.110$. The value of Ω_2 was also non-significant.

Table 13

Education wise differences in abused women as assessed by KDVSS-U (N= 395).

	Lower Educational Level (*n*=93)		Middle Educational Level (*n*=210)		Higher Education (*n*=92)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*F(2,102)*	η_2
Abuse as Assessed by KDVSS-U	36	6.21	26.5	4.56	18	6.23	20.5***	.61
Physical Abuse	4.89	4.24	3.50	4.36	3.02	3.43		
Psychological Abuse	18.96	6.38	15.25	5.08	13.90	3.50		
Sexual Abuse	4.90	4.87	3.87	3.23	3.01	3.20		

Note. .Education: Lower educational level= Illiterate & Primary; Middle Educational level= Secondary, Matric &Intermediate; Higher Education= Graduate, Master & Professional.

Table 13 revealed mean, standard deviation and *F*- values for comparison of differences between educational levels of women with abuse. Results indicated significant mean differences across different educational levels of women with violence committed against them by their husbands with $F(2,102)= 20.5, p<.001$. Findings showed that women with lower educational level scored higher on abuse as compared to other two groups. The value of η_2 was .61 (> .50) which indicated moderate effect size.

Table 14

Education wise differences in husbands of abused women as assessed by KDVSS-U (N= 395).

	Lower Educational Level (*n*=101)		Middle Educational Level (*n*=205)		Higher Education (*n*=89)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*F(2,102)*	Ω_2
Abuse as Assessed by KDVSS-U	36	6.54	28	4.09	17	4.65	36.3***	.58
Physical Abuse	4.90	4.16	3.21	4. 01	3.49	3.09		
Psychological Abuse	19.77	18.29	16.70	3.50	18.56	2.40		
Sexual Abuse	4.94	4.54	4.29	4.22	3.60	3.12		

Note..Education: Lower educational level= Illiterate & Primary; Middle Educational level= Secondary, Matric &Intermediate; Higher Education= Graduate, Master & Professional.

Table 14 revealed mean, standard deviation and *F*- values for comparison of differences between educational levels of husbands of abused women with violence. Results indicated significant mean differences across different educational levels of husbands of abused women with violence committed against them by their husbands with $F(2,102)= 36.3, p<.001$. Findings showed that women whose husbands were less qualified scored higher on abuse as compared to other two groups. The value of Ω_2 was .58 (> .50) which indicated moderate effect size.

Table 15

Differences between housewives and professional abused women on KDVSS-U (N= 395)

	Housewives (n= 212)		Professionals (n= 183)						
	M	*SD*	*M*	*SD*	*t* (393)	*P*	95% *CI* *LL*	*UL*	Cohen's *d*
Abuse as assessed by KDVSS-U	26	5.11	24	3.28	1.91	.057	29.1	54.7	0.21

Note: CI=Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

Table 15 indicates non-significant mean differences of women's professional status with husband's violence with $t\ (393)=1.91,\ p > .05$. Findings showed that housewives exhibited slightly higher scores on abuse ($M=26,\ SD=5.11$) compared to women in different professional status ($M=24,\ SD=3.28$). The value of Cohen's d was 0.21 (<0.50) which indicated small effect size.

Table 16

Differences in abuse between women on the basis of employment status of husbands on KDVSS-U (N= 395)

	Unemployed (n= 61)		Employed (n= 334)				95% CI		
	M	*SD*	*M*	*SD*	*t* (393)	*P*	*LL*	*UL*	Cohen's *d*
Abuse as assessed by KDVSS-U	40.2	11.52	28.1	5.76	23.6	.000	31.9	64.2	0.49

Note. CI=Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit.

Table 16 indicates the differences in professional status of husband with abuse against wives. The results show significant mean differences with *t (393)=23.6, p<.001.* Findings showed that women whose husbands were unemployed exhibited higher scores on abuse (*M=40.2, SD=11.52)* compared to women whose husbands were employed (*M=28.1, SD=5.76).* The value of Cohen's *d* was 0.49 (< 0.50) which indicated moderate effect size.

Table 17

Differences on the basis of monthly family income in abused women on KDVSS-U (N= 395).

	10,000-25,000 (n= 144)		26,000-41,000 (n= 119)		42,000-67,000 (n= 68)		68,000-83,000 (n= 39)		84,000 & above (n= 25)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(4,112)*	D_2
Abuse as assessed by KDVSS-U	36	8.22	22	5.63	19.5	4.54	16.1	4.03	14.2	3.35	11.2***	.66
Physical Abuse	5.86	4.19	3.34	3.40	3.02	4.14	3.27	3.90				
Psychological Abuse	18.82	6.37	15.65	5.01	14.21	3.11	11.67	2.33				
Sexual Abuse	4.92	4.09	3.37	2.99	3.66	3.21	3.32	3.11				

Note. KDVSS-U: Karachi Domestic Violence Screening Scale-Urdu

Table 17 revealed mean, standard deviation and *F*- values for differences on the basis of monthly family income with husband's violence in abused women. Results indicated significant mean differences across different monthly income levels of abused women with $F(4,112)= 11.2,\ p<.001$. Findings showed that women with low monthly income level scored higher on abuse as compared to other two levels. The value of D_2 was .66(> .50) which indicated moderate effect size.

Table 18

Differences on the basis of years of marriage in abused women on KDVSS-U (N= 395).

	1-5yrs (n= 106)		6-10 yrs (n= 102)		11-15 yrs (n= 61)		16-20yrs (n= 69)		21-25 yrs (n= 23)		26-30 yrs (n= 22)		31 &Above (n= 12)		
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(6,118)*
Abuse as assessed by KDVSS-U	24	6.40	26	5.19	26	3.87	28	4.18	25	6.79	27	4.33	26	3.14	1.91

Note. KDVSS: Karachi Domestic Violence Screening Scale-Urdu

Table 18 revealed mean, standard deviation and *F*- values for comparison of differences on the basis of years of marriage with husband's violence in abused women. Results indicated non- significant mean differences across different years of marital relations and violence by husband with $F(6,118)= 1.91$, $p=0.266$. Findings showed that years of marriage did not have any relation with abuse. The value of η_2 was also non-significant.

Table 19

Differences in abused women on the basis of number of children on KDVSS-U (N= 395)

	0 Child (n= 73)		1 Child (n= 50)		2 Children (n= 62)		3 Children (n= 90)		4 Children (n= 55)		5 Children (n= 36)		6 & above (n= 29)			
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(6,127)*	D_2
Abuse as assessed by KDVSS-U	21	3.71	22	4.38	24	5.34	26	5.51	29	4.87	22	4.47	27	6.40	1.86***	.56

***p<.001

Table 19 revealed mean, standard deviation and *F*- values for comparison of differences on the basis of number of children and husband's violence in abused women. Results indicate significant mean differences across different groups in relation to number of children in abused women with *F(6,127)= 1.86, p= .096*. Findings showed that women having four or more children scored higher on abuse as compared to women with less number of children. The value of D_2 was .56 (> .50) which indicated moderate effect size.

Table 20

Differences on the basis of family system in abused women on KDVSS-U (N= 395).

	Nuclear Family (n=235)		Joint Family (n= 160)						
							95% CI		
	M	*SD*	*M*	*SD*	*t* (393)	*P*	LL	UL	Cohen's *d*
Abuse as assessed by KDVSS-U	36.1	7.20	26.5	4.87	3.4	.008**	32.6	60.22	0.32

**$p < .01$

Table 20 indicates significant mean differences on the basis of type of family system with husband's violence in abused women with $t\ (393) = 3.4,\ p < .01$. Findings showed that women from nuclear family system exhibited higher scores on abuse ($M=36.1,\ SD=7.20$) compared to women from joint family system ($M=26.5,\ SD=4.87$). The value of Cohen's *d* was 0.32 (<0.50) which indicated small effect size.

Table 21

Prevalence of overall husband's violence, physical abuse, psychological abuse, and sexual abuse as assessed by Karachi Domestic Violence Screening Scale Urdu Version (N= 395)

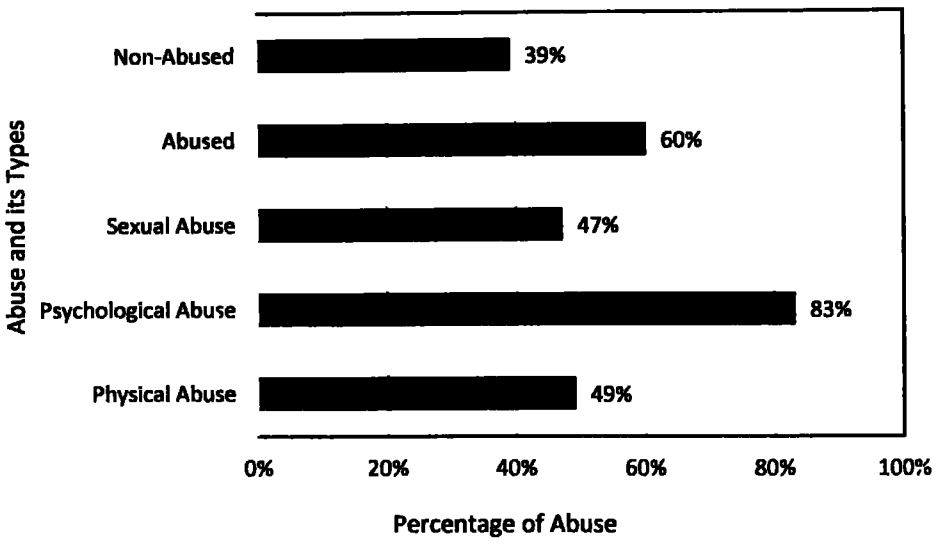
Abuse as assessed by KDVSS-U	*n*	Percentage of abuse
Overall Abuse	395	60%
Physical Abuse	196	49%
Psychological Abuse	328	83%
Sexual Abuse	188	47%

Note. KDVSS-U = Karachi Domestic Violence Screening Scale- Urdu Version

Table 21 illustrates prevalence of overall abuse committed by husbands against their wives as assessed by scores on KDVSS-U and its subscales. Husband's violence was reported by 60% of women on KDVSS-U. It also shows that physical abuse, psychological abuse, and sexual abuse were also reported by women. The percentage of psychological abuse was the highest (83 %) among three types of abuse against women by their husbands.

Figure 2

Prevalence Rate of Abuse by Husbands against Their Wives



Discussion

Several studies conducted in different parts of the world have investigated association of sociodemographic factors with family violence (Coker et al., 2000; Martin et al., 2002). The present study was conducted to identify some of the demographic variables and their association with violence against women committed by their husbands. The study was also conducted to estimate the prevalence of husband's violence in the study sample.

Violence in marital relations is much prevalent in many societies of the world as indicated by various studies (Campbell, 2002; Krug, 2002). One half of the 456 women were killed by their intimate partners and few of them were also seen by domestic violence advocates during the year before these women were killed but service providers were unable to catch signs of their increased exposure to domestic violence as reported by Campbell (2004) in a national study of homicide women. These statistics were reported by a developed country and alarming enough to raise concerns about the situation in less developed countries like Pakistan.

In the present study, 656 women were selected from Islamabad, Rawalpindi and Haripur and an effort was made to include women from lower, middle and upper socioeconomic classes to represent the sample. These women were asked to complete Demographic Data Sheet prepared by the researcher and Karachi Domestic Violence Screening Scale (KDVSS-U). Comparisons were made between abused and non-abused women to examine the association of demographic variables with husband's violence against wives in the present study. 60% of women were identified as "Abused" and 39.8% as "Non-Abused." These statistics indicate overall high prevalence of marital violence

experienced by women. The prevalence rates of all types of abuse by an intimate partner/husband i.e. physical, psychological and sexual in this study falls within the range of rates reported in studies from all over the world. 29% to 62% of women experienced violence by their intimate partners or husbands, according to WHO multi-country study on Women's Health and Domestic Violence against Women (2005). Rabbani and colleagues (2008) conducted a study in Karachi city in which they interviewed 102 married women and found 92% of women were facing violence by their husbands every week and every day of their lives.

In this study, few hypotheses were formulated to identify association between sociodemographic factors and husband's violence against their wives. The statistical analysis of the data of the current research showed that some of the results were in line with the hypotheses while some of the findings did not support the hypothesis of this study.

Age and violence committed against women by their husbands

It was assumed on the basis of previous literature that younger age of couples might associate with marital abuse (Coker, et al., 2000; Vest et al., 2002). It was reported by several studies that as the age of couple increases, violence in marital relations tend to decrease (Papadakaki et al., 2009; Burazeri et al., 2005). However, the results of the present study did not support significant differences of women age with violence against them by their husbands. The review of the demographic characteristics of the research participants revealed that most of the women (37%) belonged to the age category of 26-35 years. Comparisons can be made while there are sufficient number of women in each category (Table 7). The mean score of women on Karachi Domestic Violence Screening Scale (KDVSS-U) did not indicate significant differences which was also supported by ANOVA

test (Table 11). Women age was not associated with abuse against wives as shown by Pearson correlation (r =.047; p = .48). Most of the women in Pakistan do experience some degree of abuse by their husbands as observed by Human Rights Watch (1999). Irrespective of their age, women are vulnerable to violence perpetrated against them by their husbands as shown by this study. 'Continue living with abusive marital relations' is in accordance with previous other studies. For example, Ho (1990) in South-Asian region found significant association between family violence and traditions of sufferings, perseverance and accepting one's fate and men's traditional dominance in women. One reason, as noted by Ho (1990), for prevalence of this violence in marital relations among women of all age groups could be the fact that women in South-Asian region are less likely to dissolute the marriage and keep on suffering as victims of violence by their husbands.

The analysis of demographic characteristics of husband's age revealed that majority of women (55 %) had husbands in age range of 36 to 45 years. Husband's age was correlated with abuse at p< .05 as shown by Pearson Correlation (Table 10). The mean score of women who have husbands in this age category was slightly higher (M=28.9 vs. M= 23). The difference was non-significant at p = .11 which indicates that violence committed by husbands against wives is not significantly associated with any specific age of husband (Table 12).

Education and violence committed against women by their husbands

Results of the current study support the hypothesis of relationship between education and violence against wives. Most of the women in this study had "middle level" of education. The middle level of education referred to women who had completed 8-12 years of education. There was a sufficient number of participants in 'lower group' and

'high group' to make the comparisons possible. Correlation coefficient index revealed significant negative correlation between women's educational level and violence by husbands (r = -.351; p< .001) (Table 10). The scores on mean differences showed that women with low education level scored higher on KDVSS (M= 36) as compared to women with high education level (M= 18). Significant differences were also supported by One-way ANOVA at p< .001 (Table 13). These findings are in line with other studies conducted by Romans and colleagues (2007) showing an association between sexual and physical violence in marital relations and low educational level. Coker and colleagues (2002) found that low levels of education and income have been identified as the strongest risk factor for being victimized by intimate partner/husband because women with low educational levels are not able to earn income and eventually are not in a position to support themselves and their children.

Educational qualification of husbands was found to be negatively associated with violence against wives committed by their husbands (r = -.263; p< .001). The results of the mean scores indicated that women who had husbands with lower educational levels had higher mean scores (M=39) as compared to women whose husband had higher educational levels (M= 17). The difference was also found to be significant at p< .001 by One-Way ANOVA (Table 14). A study conducted by Mayda and Akkus (2004) on Turkish females reported the same results that the possibility of perpetrating or tolerating marital violence was influenced by formal education of either a husband or a wife.

Professional Status and Husband's Violence against Women

Professional status of women would be associated with husband's violence as hypothesized by this study. Overall higher percentage of women were found in

'Housewives' category as compared to the category of 'Professionals.' Significant relationship between professional status of women and abuse was not supported by Correlation coefficient index (Table 10). Similarly, comparison of mean scores and t-test did not demonstrate significant mean differences in both groups (Table 15). Both working women and housewives are equally vulnerable to be abused by their husbands according to this study. These results show that while higher education and income may give professional women an opportunity to leave a toxic relationship, but they do not completely remove the risk of being abused by husbands. These findings were also supported by previous research. For instance, Morash, Bui and Santiago (2000) recommended that despite of making women more financially independent to eliminate the risk being abused, rather, culture-specific beliefs about male supremacy must be rejected.

It is generally observed that women usually continue to live in abusive marital relation because of stigma attached to divorce in our society. Just to avoid the stigma of divorce, many women with strong socioeconomic backgrounds, self-sufficient compromised with abusive husbands for years. Moreover, in our society, women who are able to support themselves financially, cannot live without their husbands in their separate houses on their own. Different types of psychological and social stresses are faced by women who decide to live in that way. In a case study of Indian women, Mitra (2002) did not find any relationship between status-based differentials (education and employment) of husband and wife and violence in marital relations.

Husband's professional status was divided into two categories of 'employed' and 'unemployed' in order to find out differences in husband's professional status and violence against wives. It was assumed that husbands who are employed will less likely to inflict

violence on their wives as compared to unemployed husbands. Negative correlation was found between husband's professional status and abuse against wives (r = -.291; p<.001). The comparison of mean scores also indicated significant differences. Husbands with employment showed lower mean scores on abuse (M= 28.1) as compared to unemployed husbands (M= 40.2). t-test also supported significant difference at p<.001 (Table 16).

The association of husband's education as well as professional status with violence committed by husbands against their wives is significant and clear. In Pakistan and other South Asian countries, women's vulnerability to abuse is highly dependent on their husband's personal and social characteristics as compared to their own. Similar evidence was reported by Mitra (2002) in a case study of Indian women. She observed that regardless of their own educational level and financial status, most of the women were suffering from marital violence. She further added that most of these women had husbands with low educational qualifications and poor financial status. This inequality of power and control gives rise to gender discrimination in education and financial resources which in turn resulted in increased rates of violence against women in some societies. In order to highlight the need of educating and empowering females of the country, numerous researchers in the Western countries have investigated the relationship between employment status, economic status and violence in intimate relations (Lambert & Firestone, 2000; Farmer & Tiefenthaler, 2003). They observed that the incidence of family violence reduces when women's employment status, income and external financial support equals or exceeds that of their partners.

Family Income and Husband's Violence against Wives

Family income would be linked to violence inflicted by husbands against their wives as hypothesized by the present study. On the basis of approx. monthly family income, five levels of income were formulated. The findings of this study showed that monthly income had negative relationship with violence against women by their husbands at $p<.001$. The comparison of mean scores indicated that women who had low levels of monthly income had higher mean scores as compared to women who had moderate and above than moderate levels of monthly income at $p<.001$(Table 17).

Years of Marriage and Husband's Violence against Wives

It was hypothesized in the current study that years of marriage would be associated with husband's violence against wives. Findings of the study indicated that correlation coefficient showed positive correlation between years of marriage and husband's violence against wives at $p<.05$. However, the comparison of mean scores and One-Way ANOVA did not find any significant difference (Table 18). Women were asked to report life time prevalence of violence, therefore women with different number of years of marriage reported if they experienced violent marital relations which could be the reason for this non-significant difference. According to Mitra (2002), it is necessary to highlight the need to address the issue of violence in marital relations as soon as it appears as these violent acts which appeared in the early years of marriage i.e. within the first six months, were not infrequent but a vicious cycle of abuse.

Step II: Pilot Study to examine the effects of Narrative Exposure Therapy among traumatized women victims of husband's violence.

Objectives

Following objectives were formulated for pilot testing the efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence:

1. To explore the relationship between husband's violence, PTSD and negative cognitions.
2. To examine differences on PTSD and posttraumatic cognitions in women victims of husband's violence after Narrative Exposure Therapy (NET) in treatment group.
3. To examine differences on PTSD and posttraumatic cognitions in women victims of husband's violence in control group after general counseling and psychoeducation.

Hypotheses

1. Physical abuse, psychological abuse, and sexual abuse of the women by their husbands have positive correlation with PTSD and negative cognitions.
2. Significant differences will likely to occur in scores of PTSD and negative cognitions in pretest assessments and posttest assessments of women victims of husband's violence in treatment group.
3. Non- significant differences will likely to exist in scores of PTSD and negative cognitions in pretest-posttest assessments of women victims of husband's violence in control group.

Research Design

The current study was a quasi-experimental control group pretest-posttest research design with intra and inter group comparisons over time. The intervention was carried out in one group (treatment group) and the outcomes were compared in regard to each participant over different periods within the same group as well as between the treatment and control/comparison groups.

Sample

Twelve participants were selected for pilot study (N= 12) to examine the effectiveness of NET among traumatized women victims of husbands' violence. The sample consisted of two groups: treatment group (n = 6) who received NET and a comparison/control group (n = 6) who did not receive NET based on the following criteria:

Inclusion criteria

Women who were married and living with their husbands at the time of interview, women who were experiencing husband's violence, agreed to take part in the study and complete the study, women between the ages of 18-50 years, had higher scores on PTSD Checklist for DSM-5 and they scored higher on Posttraumatic Cognitions Inventory were included in the study sample.

Exclusion criteria

Women who were unable to read Urdu by themselves, widow, unmarried, divorced, separated women and women suffering from any acute medical and psychiatric illness were not included in the study.

Operational Definitions

Husband's Violence. Throughout the present study, the definition of intimate partner violence given by Schecter and Edleson (1999) was followed: "a pattern of coercive behaviors, including physical, sexual, and emotional abuse, as well as economic coercion, that adults use against their intimate partners to gain power and control in that relationship. This violence is mostly perpetrated by men against women partners," (Schecter & Edleson, 1999). Violence committed against women by their husbands was operationalized in terms of Karachi Domestic Violence Screening Scale-Urdu version (Hassan & Malik, 2009).

Posttraumatic Stress Disorder (PTSD). Posttraumatic stress disorder (PTSD) is an anxiety disorder in which a person experiences significant distress, intense fear and horror following a traumatic incident. Diagnostic and Statistical Manual of Mental Disorders (DSM-5) characterizes the common symptoms of PTSD as re-experiencing or reliving of the distressing event, persistent avoidance of any cues of the incident, emotional numbing, hyper-arousal and alterations in cognitions and mood (American Psychiatric Association, 2013). It is operationalized in terms of Posttraumatic Checklist for DSM-5 (Weathers, Litz, Keane, Palmieri, Marx & Schnurr, 2013).

Posttraumatic Cognitions. Negative cognitions refer to dysfunctional thoughts and beliefs individuals have about themselves and the world. Many trauma theories postulated that traumatic incidents produce changes in the thoughts and beliefs of the victims and these changes are considered as key features in emotional reaction to the traumatic incident. Negative or dysfunctional thoughts were operationalized in terms of Posttraumatic Cognitions Inventory (Foa, Ehlers, Clark, Tolin & Orsillo, 1999).

Instruments

Demographic data sheet was used to gather personal information of respondents and their husbands. It obtained information regarding age, education level, professional status, years of marriage, income, family structure, religion, etc. (Annexure D).

Following instruments were used in the current study:

Karachi Domestic Violence Screening Scale- Urdu version (Hassan & Malik, 2009). The scale comprised of 35 items with five subscales exploring the incidence of physical abuse, psychological abuse, and sexual abuse. The scale also measures characteristics of the abuser and characteristics of the victim (Annexure-E).

For all items there was a 4-point rating scale with options of "Never", "Sometimes", "Often" and "Most of the time". The scoring range on each item is 0 to 3, corresponding to minimal and maximal domestic abuse being faced by the victim. The total score range of KDVSS is from 0 to 105. The cut-off score on KDVSS-U is 30. The total score is obtained by adding scores on all the subscales (Hassan, 2009).

Urdu version of PTSD Checklist for DSM-5. (PCL-5; Weathers, Litz, Keane, Palmieri, Marx & Schnurr, 2013) . PCL-5 was developed to assess 20 symptoms of PTSD based on DSM-5 criterion. The PCL-5 has multiple uses such as monitoring symptom change during and after the treatment, screening individuals with PTSD and making provisional diagnosis.

The checklist consists of four domains of PTSD given by DSM-5: Re-experiencing, Avoidance, Negative alterations in cognition and mood and Hyper- arousal. The total score

indicates the seriousness of the symptoms that can be calculated by adding the scores for 20 items. The scores range from 0-80. These scores range between 0 to 5 on a Likert scale where 0= Not at all to 4= Extremely. Higher scores represent higher severity. For making provisional diagnosis, the cut-off score is 38. For observing change in symptoms over time, 10-point change is required to be considered a clinically significant change in symptoms (see Appendix-H)

Urdu version of Posttraumatic Cognitions Inventory- PTCI. Posttraumatic Cognitions Inventory (PTCI) developed by Foa and Ehlers (1999) was used in the present research to assess posttraumatic cognitions in women victims of husband's violence. PTCI consists of 33 statements about negative cognitions scored on Likert-type ranging from 1 (*totally disagree*) to 7 (*totally agree*). The scores range from 33-231. PTCI has three subscales measuring Negative Cognitions about the Self, Negative Cognitions about the World, and Self-Blame. Higher scores represent higher levels of dysfunctional thoughts (see Appendix-I).

Ethical Considerations

Ethical Review Board, Department of Psychology, IIUI, Ethics Committee along with head of the institutes granted their approval. In addition, the research respondents gave their informed consent and were guaranteed privacy and confidentiality of their data

Procedure

The pilot study employed a pretest-posttest design to assess the impact of Narrative Exposure Therapy (NET) among women victims of husbands' violence experiencing

PTSD. The intervention consisted of 12 weekly 1-hour sessions. Each session followed a structured format (Table 22). Authority letter was taken from parent department to collect information (see Appendix-A). To ensure voluntary participation, the researcher provided contact information only after ascertaining that those potential participants who actually wanted to participate in the study. The researcher then contacted the participants to review the inclusion criteria and invite them to the study. Participants were given a detailed introduction regarding the nature, objectives and importance of the study. Informed consent (see Appendix-C) was taken by all the respondents. Throughout the research process care was taken to make it consistent with ethical guidelines and principles. The respondents were given complete assurance that their information would be kept strictly confidential. Treatment program was completed in twelve weeks with twelve sessions. A total of 12 women participated in the pilot study. Six women were selected for treatment group and 6 were selected for control group. The participants in control group did not receive the therapy. They were only given general counseling and psycho education. Participants were assessed through psychological tools before therapy, middle of the therapy and just after the therapy. At the end of the treatment, differences between the treatment and control group were directly attributed to the effect of the treatment through posttest measures. The researcher also thanked the participants for providing valuable information and for participating in the study till its completion.

Table 22

Overview of Narrative Exposure Therapy Sessions

Steps	Sessions	Description
Step 1 Diagnosis Psychoeducation	1	Establishment of the therapeutic contract; establishment of therapeutic goals; evaluation of the participant's expectations; trust-building. Establishment of clear psychiatric history and correct diagnosis of PTSD.
	2	Psychoeducation about violence; consequences of violence-mood disorders, anxiety, PTSD. Explanation of the therapeutic procedure.
Step 2 Lifeline Start of narration	3	Construction of lifeline for mapping the history of violence beginning at birth and continuing through the first traumatic event; gradual exposure to the traumatic memories.
	4	Activating the "Hot" memory by asking direct questions and feedback of observation.
	5	Habituation Exposure session
Step 3 Re-reading of the narrations	6 &7	Cognitive Restructuring Diary Keeping
	8 & 9	Monitoring parallel processes during NET by the therapist. Re-reading of written narratives from previous sessions to the participant.
	10	Building of awareness about emotional and cognitive changes by the participant Self-protection strategies
Step 4 Testimony/Signing of documents	11	Preparation of the final draft.
	12	Wrapping Up

Results

Table 23

Sociodemographic characteristics of Treatment and Control Group (N=12)

Baseline Characteristics	Treatment Group		Control Group		Full Sample	
	n	%	*n*	%	*n*	%
Age (M=32)						
16-25 Years	2	33.0	1	16.0	3	25.0
26-35 Years	3	50.0	3	50.0	6	50.0
36-45 Years	1	16.0	1	16.0	2	16.0
46 Years & Above	0	0.0	1	16.0	1	8.0
Education						
*Low	1	16.0	2	16	3	25.0
**Middle	3	50.0	2	16	5	41.6
***Higher	2	33.0	2	16	4	33.0
Years of Marriage (M=10 Years)						
1-5	2	33.0	3	50.0	5	41.6
6-10	3	50.0	2	33.0	5	41.6
11-15	1	16.0	1	16.0	2	16.0
16-20	0	0	0	0	0	0
21-25	0	0	0	0	0	0
26- 30	0	0	0	0	0	0
31 & above	0	0	0	0	0	0
No. of Children (M= 3)						
0 child	0	0	0	0	0	0
1 child	2	33.3	0	0	2	16.0
2 children	2	33.3	1	16.0	3	25.0
3 children	2	33.3	2	33.3	4	33.0
4 children	0	0	3	50.0	3	25.0
5 children	0	0	0	0	0	0
6 children & above	0	0	0	0	0	0
Professional Status						
Paid work	3	50.0	2	33.3	5	41.6
Housewife	3	50.0	4	66.6	7	58.3
Husband's Age						
21-30 Years	1	16.0	3	50.0	4	33.3
31-40 Years	3	50.0	2	33.3	5	41.6
41-50 Years	2	33.0	1	16.0	3	25.0
51Years & above	0	0	0	0	0	0

Continued...

Baseline Characteristics	Treatment Group		Control Group		Full Sample	
	n	%	*n*	%	*n*	%
Husband's Education						
*Low	1	16.0	0	0	1	8.3
**Middle	3	50.0	4	66.6	7	58.3
***High	2	33.0	2	33.0	4	33.3
Professional Status						
Employed	4	66.6	5	83.0	9	75.0
Unemployed	2	33.3	1	16.0	3	25.0
Family's Monthly Income						
10,000-25,000 Rs	1	16.0	2	33.3	3	25.0
26,000-41,000 Rs	0	0	1	16.0	1	16.0
42,000-67,000 Rs	2	33.3	1	16.0	3	25.0
68,000-83,000 Rs	2	33.3	2	33.3	4	33.3
84,000 & Above	1	16.0	0	0	1	8.3
Family Structure						
Joint	3	50.0	2	33.3	5	41.6
Nuclear	3	50.0	4	66.6	7	58.3
Residence						
Rural	2	33.3	1	16.0	3	25.0
Urban	4	66.6	5	83.0	9	75.0
Religion						
Muslim	6	100	6	100	12	100
Non-Muslim	0	0	0	0	0	0

Note: N= 12(n=6 for treatment group and *n=6* for control group). Participants were on average 32 years old; Education: Lower educational level= Illiterate & Primary; Middle Educational level= Secondary, Matric &Intermediate; Higher Education= Graduate, Master & Professional.

Table 24

Relationship between KDVSS, PCL-5 and PTCI for Treatment Group (n=6)

Variable	2	3
Karachi Domestic Violence Screening Scale	.40**	.39*
Posttraumatic Checklist-5	-	.44*
Posttraumatic Cognitions Inventory	-	-

*$p<.05$, **$p<.01$

Table 24 indicates that in the treatment group, KDVSS is significantly positively correlated with PCL-5 ($p<.01$) and PTCI ($p<.05$). Similarly, PCL-5 is also significantly positively correlated with PTCI ($p<.05$).

Table 25

Relationship between KDVSS, PCL-5 and PTCI for Control Group (n=6)

Variable	2	3
Karachi Domestic Violence Screening Scale	.65**	.37*
Posttraumatic Checklist-5	-	.28*
Posttraumatic Cognitions Inventory	-	-

*p<.05, **p<.01

Table 25 indicates that in the control group, KDVSS is significantly positively correlated with PCL-5 (p<.01) and PTCI (p<.05). Similarly, PCL-5 is also significantly positively correlated with PTCI (p<.05).

Table 26

Relationship between subscales of PCL-5 and PTCI for Treatment and Control Group (N=12)

	PTCI		
Variable	Negative Cognitions about Self	Negative Cognitions about World	Self-Blame
PCL-5			
Re-experiencing	.36*	.05	.07
Avoidance	-.18	-.26	.18
Negative alterations in cognition and mood	.39*	.21	.33*
Hyper-arousal	-.002	-.08	-.33*

*Correlation is significant at 0.05 level

Table 26 shows that there is significant positive correlation between Re-experiencing and Negative Cognitions about Self ($p<.05$). Results also show that Negative alterations in cognition and mood have a significant positive correlation with subscales of Negative Cognitions about Self and Self-Blame ($p<.05$), whereas Hyper-arousal has significant negative correlation with the subscale of Self-Blame (($p<.05$).

Table 27

Correlations between physical abuse, psychological abuse and sexual abuse, PTSD and Posttraumatic Cognitions in Treatment and Control Group (N=12)

Variable	Physical Abuse	Psychological Abuse	Sexual Abuse
Posttraumatic Stress Disorder	.61**	.44**	.31**
Posttraumatic Cognitions	.23*	.40**	.34

**$p<0.01$, *$p<0.05$

Table 27 illustrates that all types of abuse (physical, psychological and sexual) are significantly positively correlated with Posttraumatic stress disorder. Table also illustrates that Negative Cognitions have significant positive correlation with physical abuse and psychological abuse. Negative Cognitions have positive but non-significant correlation with sexual abuse.

Table 28

Pretest and posttest Mean and Standard Deviation of effect of NET on PTSD and Posttraumatic Cognitions in Treatment Group (n=6)

	Pre _Assessment		Post Assessment					
Variables	*M*	*SD*	*M*	*SD*	*t(5)*	*P*	*r*	*Cohen's d*
PTSD	71.66	1.03	43.33	2.25	24.13	.00	.46***	0. 26
Posttraumatic Cognitions	207.0	8.34	181.83	4.70	7.81	.00	.37***	0.98

***$p<.001$

Table 28 indicates mean comparison of effect of NET on PTSD and Posttraumatic Cognitions in treatment group. Findings indicated significant mean differences on PTSD with t (5) = 24.13, $p < .001$. Results showed that mean scores on PTSD in pre-assessment (M= 71.66, SD= 1.03) subsequently decreased in the post- assessment level (M= 43.33, SD= 2.25). Two sets of scores were significantly correlated (r= .46, p <.001). The value of Cohen's d was 0.26 (< 0.50) which indicated small effect size. Findings indicated significant mean differences on Posttraumatic Cognitions with t (5) = 7.81, $p < .001$. Results showed that mean scores on Posttraumatic Cognitions in pre-assessment (M= 207.0, SD= 8.34) subsequently decreased in the post- assessment level (M= 181.83, SD= 4.70). Two sets of scores were significantly correlated (r= .37, p <.001). The value of Cohen's d was 0.98 (> 0.80) which indicated large effect size.

Table 29

Pretest and posttest Mean and Standard Deviation of effect of general counseling and psychoeducation on PTSD and Posttraumatic Cognitions in Control Group (n=6)

	Pre Assessment		Post Assessment				
Variables	*M*	*SD*	*M*	*SD*	*t(5)*	*P*	*r*
PTSD	68.83	2.99	70.66	1.86	-1.80	.13	.56
Posttraumatic Cognitions	211.33	3.98	211.83	4.70	- .38	.71	.73

Table 29 shows mean, standard deviation and t-values for Posttraumatic Stress Disorder and Posttraumatic Cognitions across two levels of assessment. Results indicated non-significant mean differences in pre and post-assessment levels in control group. Value of Cohen's *d* was also non-significant. Findings revealed that general counseling and psychoeducation did not bring any significant reduction in Posttraumatic Stress scores and Posttraumatic Cognitions from pre-assessment to post-assessment.

Discussion

Violence committed by husbands against their wives is not a new phenomenon. For centuries women have faced various forms of violence in their intimate relations but the problem was considered as non-existent because there was scarcity of research in this area. As it was hidden behind the closed doors therefore it was not investigated for years (Gelles, 1974). However, reports published by World Health Organization confirmed the prevalence of wife abuse in everyday lives of women (WHO, 2002 & 2005).

Due to rise in the incidence rate of violence committed by husbands against their wives in Pakistan and the resulting distress in women victims of husband violence initiated the current study investigation into the treatment aspect of the issue. The current study was designed to examine whether NET would be effective in treating traumatized women victims of husband violence in Pakistani context. The main focus of the study was on the identification of the women victims of intimate partner violence/husbands' violence and providing them intervention for reducing the hazardous effects of this violence which has eclipsed the lives of many women in Pakistan. To achieve the main objective of the study i.e. examining the effectiveness of Narrative Exposure Therapy among women victims of husband's violence with PTSD, pilot study was conducted on a sample of 12 traumatized women victims of husband's violence after completing the screening process. The current study was a Quasi-Experimental Control Group Pretest-Posttest design. The intervention was carried out in one group (treatment group) and the outcomes were compared in regard to each participant over different periods within the same group as well as between the treatment and control/comparison groups. Six women were selected for treatment group (n = 6) and 6 were selected for control group (n = 6). The participants in control group did not receive the therapy. They were only given general counseling and psycho education.

The intervention consisted of 12 weekly 1-hour sessions. Each session followed a structured format (Table 22). Before starting NET sessions, pre testing was done on PTSD and posttraumatic cognitions and after completion of NET training post testing was done to assess the difference of pretest posttest severity levels of PTSD and negative cognitions. The first two sessions of NET consisted of diagnosis and psychoeducation in which participants were given information regarding identification of PTSD and negative thoughts (Insight of the problems as identified through pre testing. In third session, the agenda was construction of lifeline for mapping the history of violence beginning at birth and continuing through the first traumatic event; gradual exposure to the traumatic memories. Fourth and fifth sessions focused on activating the "Hot" memory by asking direct questions and feedback of observation, habituation exposure session. Sixth and seventh sessions were based on cognitive restructuring and diary keeping. The main focus was on how to dispute negative cognitions through rational thoughts. Re-reading of narratives by the therapist from the previous sessions to the participant was done in eighth and ninth sessions. Tenth session was based on building awareness about emotional and cognitive changes by the participant. Eleventh and twelfth sessions were therapy termination sessions in which final draft was prepared and signed by the participant and the therapist. Feedback was also obtained as what skills and strategies participants have practiced in previous sessions, with emphasis on application in real life regularly.

Results of the study indicated a positive association between all types of abuse (i.e. physical abuse, psychological abuse and sexual abuse) committed against women by their husbands and PTSD (Table 27). The prevalence of PTSD among women victims of intimate partner violence is frequently reported more than any other mental health

outcomes ranging from 45-84% (Houskamp & Foy, 1991; Kemp, Rawlings, & Green, 1991).

According to Woods (2000), as a result of continuing violence perpetrated by husbands and acute experiences of trauma may increase the risk of chronic threats and injuries among such women. Findings of this study add to the existing body of evidence that husband's violence has a positive link with negative cognitions. Results have clearly indicated that negative cognitions have significant positive correlation with physical and psychological abuse and positive but non-significant correlation with sexual abuse (Table 27).

The impact of Narrative Exposure Therapy was measured by comparing the presence of variations in PTSD diagnosis before and after therapy. Psychological evaluation has shown to play an important role in the healing process as it provides details about the severity of the effects of abuse. Findings of the study revealed that after implementing therapeutic intervention, posttest interventional scores on PTSD and posttraumatic cognitions were significantly lower when compared with pretest scores (Table 28). The techniques used in therapy proved to be effective in lessening the distress. The results also showed that there were no significant differences in control group from pretest to posttest assessments who did not receive NET (Table 29). The reason for these differences in treatment and control group may be attributed to the contribution of the healing aspect of narratives or story telling commonly practiced in every culture across the globe. Likewise, NET has been developed on the similar intention of healing individuals while integrating fragmented traumatic memories into a meaningful narrative.

Conclusion

NET is evidenced- based psychological intervention for the management of trauma and violence. NET has proved to be a method of psychological treatment that can be used for healing purpose as well as for directly contributing to the fight against violence and abuse. It can be concluded from the findings of the study that NET has shown efficacy for the treatment of women victims of husband's violence who were also experiencing PTSD. It can be used on the larger sample for main study.

Phase III: Main Study

Examining the Effects of Narrative Exposure Therapy among Traumatized Women Victims of Husband's Violence

Objectives

Following objectives were formulated to examine the efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence:

1. To find out the physical abuse, psychological abuse, and sexual abuse as predictor of PTSD.
2. To find out the physical abuse, psychological abuse, and sexual abuse as predictor of posttraumatic cognitions.
3. To determine the role of posttraumatic cognitions as mediators in relationship between husband's violence and PTSD among women victims of husband's violence.
4. To examine differences on PTSD and posttraumatic cognitions in women victims of husband's violence after Narrative Exposure Therapy (NET) in treatment group.
5. To examine differences on PTSD and posttraumatic cognitions in women victims of husband's violence in control group.

Hypotheses

1. Physical abuse, psychological abuse, and sexual abuse by husbands positively predicts PTSD among women victims of husband's violence.
2. Physical abuse, psychological abuse, and sexual abuse by husbands positively predicts negative cognitions among women victims of husband's violence.
3. Posttraumatic cognitions positively mediate between husband's violence and PTSD.
4. Significant differences will likely to occur in the scores on PTSD and negative cognitions in three assessments of women victims of husband's violence in treatment group.
5. Non-significant differences will likely to occur in the scores on PTSD and negative cognitions in three assessments of women victims of husband's violence in the control group after general counseling and psychoeducation.

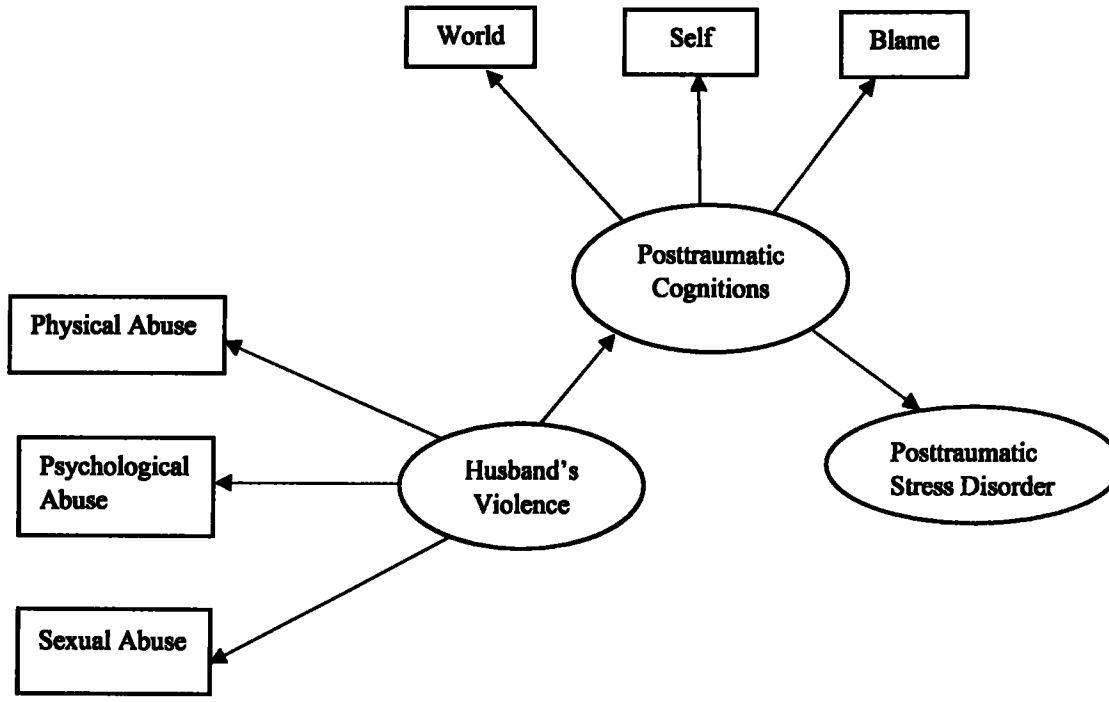


Figure 3 represents Proposed Mediational Model

Research Design

The current study was a quasi-experimental control group pretest-posttest research design with intra and inter group comparisons over time. The intervention was carried out in one group (treatment group) and the outcomes were compared in regard to each participant over different periods within the same group as well as between the treatment and control/comparison groups. The aim of the therapy was reducing symptoms of PTSD, and helping in restructuring negative thoughts in regard to experiencing husband's violence. Participants were assessed through psychological tools before therapy, middle of the therapy and just after the therapy.

Sample

One hundred participants were selected for the group that received NET (treatment group) and a comparison group that did not receive NET (control group) based on the following criteria:

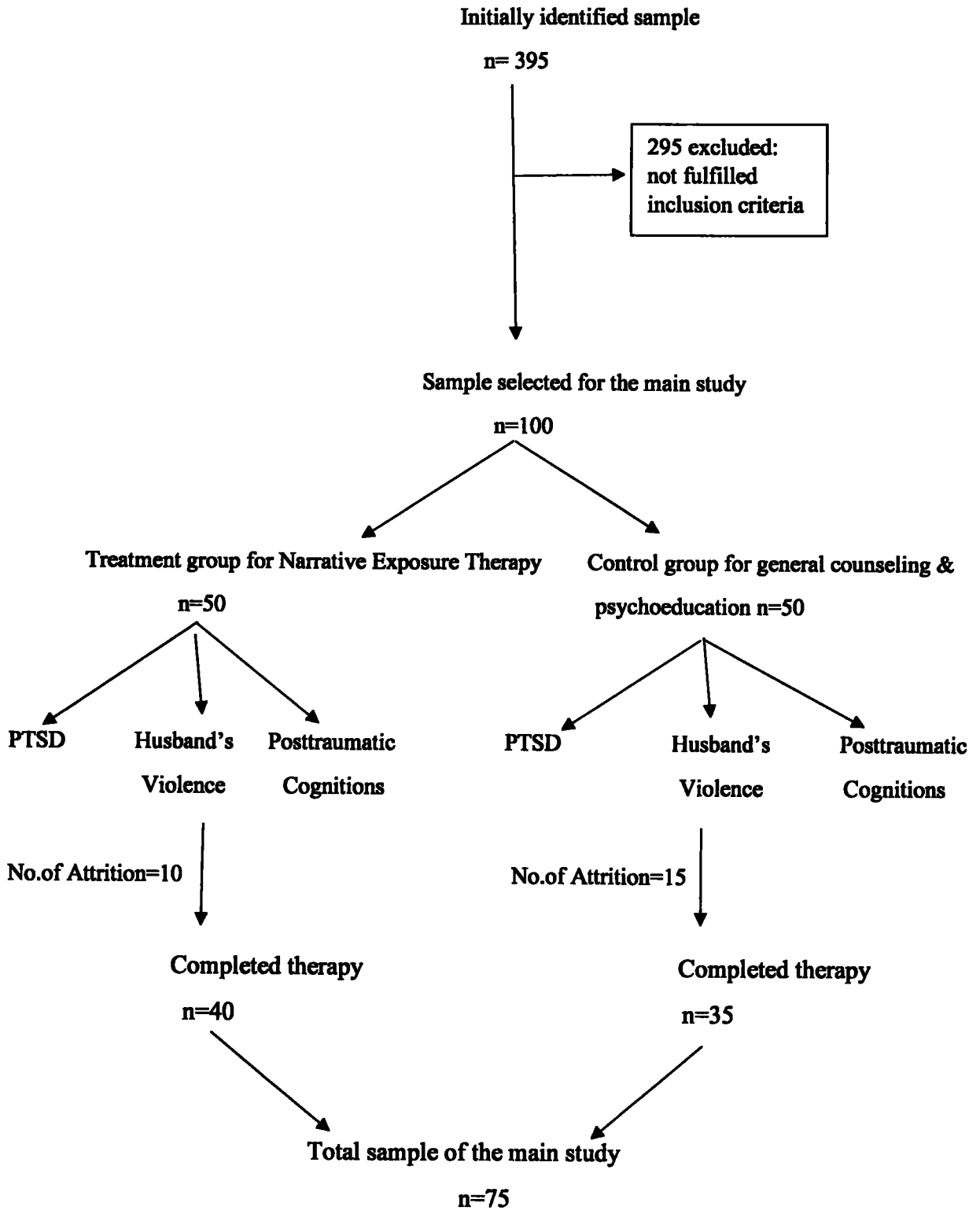
Inclusion criteria

Women who were married and living with their husbands at the time of interview, women who were experiencing husband's violence, they agreed to take part in the study and complete the study, women between the ages of 18-50 years, had higher scores on PTSD Checklist for DSM-5 and they scored higher on Posttraumatic Cognitions Inventory were included in the study sample.

Exclusion criteria

Women who were unable to read Urdu by themselves, widow, unmarried, divorced, separated women and women suffering from any acute medical and psychiatric illness were not included for this study.

Figure 4: Sample Flow Sheet for the Main Study



Operational Definitions

Husband's Violence. The definitions provided in the literature usually include current or former spouses and non-marital partners like dating partners. However, the focus of the current study was violence within a marital relationship and also keeping in view the cultural context of Pakistan and for the purpose of definitional clarity, it was decided that the term 'husband' instead of 'intimate partner' would be used in the present research.

Throughout the present study, the definition of intimate partner violence given by Schecter and Edleson (1999) was followed: "a pattern of coercive behaviors, including physical, sexual, and emotional abuse, as well as economic coercion, that adults use against their intimate partners to gain power and control in that relationship. This violence is mostly perpetrated by men against women partners," (Schecter & Edleson, 1999). Violence committed against women by their husbands was operationalized in terms of Karachi Domestic Violence Screening Scale-Urdu version (Hassan & Malik, 2009).

Posttraumatic Stress Disorder (PTSD). Posttraumatic stress disorder (PTSD) is an anxiety disorder in which a person experiences significant distress, intense fear and horror following a traumatic incident. Diagnostic and Statistical Manual of Mental Disorders (DSM-5) characterizes the common symptoms of PTSD as re-experiencing or reliving of the distressing event, persistent avoidance of any cues of the incident, emotional numbing, hyper-arousal and alterations in cognitions and mood (American Psychiatric Association, 2013). It is operationalized in terms of Posttraumatic Checklist for DSM-5 (Weathers, Litz, Keane, Palmieri, Marx & Schnurr, 2013).

Posttraumatic Cognitions. Negative cognitions refer to dysfunctional thoughts and beliefs individuals have about themselves and the world. Many trauma theories postulated that traumatic incidents produce changes in the thoughts and beliefs of the victims and these changes are considered as key features in emotional reaction to the traumatic incident. Negative or dysfunctional thoughts were operationalized in terms of Posttraumatic Cognitions Inventory (Foa, Ehlers, Clark, Tolin & Orsillo, 1999).

Instruments

Following instruments were used in the current study:

Socio Demographic Sheet. It was used to gather personal information of respondents and their husbands. It obtained information regarding age, education level, professional status, years of marriage, income, family structure, religion, etc. (Annexure D).

Karachi Domestic Violence Screening Scale- Urdu version (Hassan & Malik, 2009). The scale comprised of 35 items with five subscales exploring the incidence of physical abuse, psychological abuse, and sexual abuse. The scale also measures characteristics of the abuser and characteristics of the victim (Annexure-E). For all items there was a 4-point rating scale with options of "Never", "Sometimes", "Often" and "Most of the time". The scoring range on each item is 0 to 3, corresponding to minimal and maximal domestic abuse being faced by the victim. The total score range of KDVSS is from 0 to 105. The cut-off score on KDVSS-U is 30. The total score is obtained by adding scores on all the subscales (Hassan, 2009).

Urdu version of PTSD Checklist for DSM-5. (PCL-5; Weathers, Litz, Keane, Palmieri, Marx & Schnurr, 2013). PCL-5 was developed to assess 20 symptoms of PTSD based on DSM-5 criterion. The PCL-5 has multiple uses such as monitoring symptom change during and after the treatment, screening individuals with PTSD and making provisional diagnosis. The checklist consists of four domains of PTSD given by DSM-5: Re-experiencing, Avoidance, Negative alterations in cognition and mood and Hyper-arousal. The total score indicates the seriousness of the symptoms that can be calculated by adding the scores for 20 items. The scores range from 0-80. These scores range between 0 to 5 on a Likert scale where 0= Not at all to 4= Extremely. Higher scores represent higher severity. For making provisional diagnosis, the cut-off score is 38. For observing change in symptoms over time, 10-point change is required to be considered a clinically significant change in symptoms (Appendix-H)

Urdu version of Posttraumatic Cognitions Inventory- PTCI. Posttraumatic Cognitions Inventory (PTCI) developed by Foa and Ehlers (1999) was used in the present research to assess posttraumatic cognitions in women victims of husband's violence. PTCI consists of 33 statements about negative cognitions scored on Likert-type ranging from 1 (*totally disagree*) to 7 (*totally agree*). The scores range from 33-231. PTCI has three subscales measuring Negative Cognitions about the Self, Negative Cognitions about the World, and Self-Blame. Higher scores represent higher levels of dysfunctional thoughts (Appendix-I).

Ethical Considerations

Ethical Review Board, Department of Psychology, IIUI, Ethics Committee along with head of the institutes granted their approval. In addition, the research respondents gave their informed consent and were guaranteed privacy and confidentiality of their data

Procedure

The researcher attended training workshops of Narrative Exposure Therapy by a senior clinical psychologist who was trained in the Narrative Exposure Therapy and attended accredited workshops. After getting training, the intervention was implemented on women who were victims of husband's violence with PTSD. Authority letter was taken from parent department to collect information (Appendix-A). Participants were given a detailed introduction regarding the nature, objectives and importance of the study. Informed consent (see Appendix-C) was taken by all the respondents. Throughout the research process care was taken to make it consistent with ethical guidelines and principles. The respondents were given complete assurance that their information would be kept strictly confidential. Treatment program was completed in twelve weeks with twelve sessions (Table 22). The participants were randomly assigned to treatment and control group (*N=100)*. Fifty women were contacted to attend all the sessions but only 40 women attended all the sessions in treatment group. Participants having less than six sessions were not included in the sample. There were four women who participated in six therapeutic sessions and three women participated only in three sessions while the remaining three women discontinued the therapy after attending initial two sessions. The participants in control group did not receive the therapy. They were only given general counseling and psycho education. There were

35 women who completed general counseling and psychoeducation sessions within twelve weeks. The researcher tried her best to contact the women who left the study but it was not possible because of the incomplete information provided by the participants. However, the researcher managed to contact some of the participants who left the therapy prematurely. The reasons for dropping out of the therapy as reported by the participants included lack of familial support, child care, education level, low income and unemployment, physical constraints such as time and distance forced the participants to drop out of the therapy. Some other factors were also observed by the researcher which contributed to the dropout rate. These factors were lack of commitment on the part of the participants, lack of motivation to be treated, self-help behavior of the participants, anxiety about disclosing one's feelings and personal experiences and last but not the least, social stigma which continues to prevent people to seek mental health care interventions. At the end of the treatment, differences between the treatment and control group were directly attributed to the effect of the treatment through posttest measures.

RESULTS

Chapter-III

Results

Table 30

Sociodemographic characteristics of Treatment and Control Group (N=75)

Baseline Characteristics	Treatment Group		Control Group		Full Sample	
	n	%	*n*	%	*n*	%
Age (M=32)						
16-25 Years	13	32.5	10	28.6	23	30.6
26-35 Years	12	30.0	15	42.9	27	36.0
36-45 Years	14	35.0	9	25.7	23	30.7
46 Years & Above	1	2.5	1	2.9	2	2.7
Education						
*Low	6	15.0	8	22.9	14	18.7
**Middle	18	45.0	19	54.3	37	49.3
***Higher	16	40.0	8	22.9	24	32.0
Years of Marriage (M=10 Years)						
1-5	5	12.5	3	8.6	8	10.7
6-10	15	37.5	10	28.6	25	33.3
11-15	9	22.5	12	34.3	21	28.0
16-20	7	17.5	8	22.9	15	20.0
21-25	3	7.5	1	2.9	4	5.3
26- 30	1	2.5	1	2.9	2	2.7
31 & above	0	0	0	0	0	0
No. of Children (M= 3)						
0 child	0	0	0	0	0	0
1 child	2	5.0	1	2.9	3	4.0
2 children	14	35.0	5	14.3	19	25.3
3 children	12	30.0	12	34.3	24	32.0
4 children	5	12.5	8	22.9	13	17.3
5 children	5	12.5	6	17.1	11	14.7
6 children & above	2	5.0	3	8.6	5	6.7
Professional Status						
Paid work	17	42.5	13	37.1	30	40.0
Housewife	23	57.5	22	62.9	45	60.0
Husband's Age						
21-30 Years	4	10.0	0	0	4	5.3
31-40 Years	11	27.5	10	28.6	21	28.0
41-50 Years	6	15.0	17	48.6	23	30.7
51Years & above	19	42.5	8	22.9	25	33.3

Continued...

Baseline Characteristics	Treatment Group		Control Group		Full Sample	
	n	%	*n*	%	*n*	%
Husband's Education						
*Low	5	12.5	6	17.1	11	14.7
**Middle	19	47.5	19	54.3	38	50.7
***High	16	40.0	10	28.6	26	34.7
Professional Status						
Employed	39	97.5	34	97.1	73	97.3
Unemployed	1	2.5	1	2.9	2	2.7
Family's Monthly Income						
10,000-25,000 Rs	3	7.5	1	2.9	4	5.3
26,000-41,000 Rs	3	7.5	3	8.6	6	8.0
42,000-67,000 Rs	9	12.5	11	25.7	20	17.3
68,000-83,000 Rs	6	15.0	11	22.9	17	18.7
84,000 & Above	19	37.1	9	21	28	9.3
Family Structure						
Joint	27	67.5	21	60.0	48	64.0
Nuclear	13	32.5	14	40.0	27	36.0
Residence						
Rural	7	17.5	2	57.0	9	12.0
Urban	33	82.5	33	94.3	66	88.0

Note: N= 75(n=40 for treatment group and *n=35* for control group). Participants were on average 32 years old; Education: Lower educational level= Illiterate & Primary; Middle Educational level= Secondary, Matric &Intermediate; Higher Education= Graduate, Master & Professional.

Table 30 illustrates demographic characteristics of women who participated in this study. The mean age of the participants is 32 years and most of them completed education up till Matric. Most of them are housewives. Twenty eight percent are with family income of above 68,000 rupees. Most of them live in a joint family system. The mean years of marital relation is 10 years and mean number of children is three.

Table 31

Psychometric properties of Scales of Three levels of assessment for Treatment Group (n=40)

Scales	Pre-Test				Mid-Test			Post-Test		
	M	*SD*	Range	α	*M*	*SD*	α	*M*	*SD*	α
KDVSS-U	89.03	3.07	0-105	.69	91.3	3.18	.75	88.01	3.04	.77
PCL-5	70.25	2.66	0-80	.70	70.7	3.01	.69	61.23	3.81	.71
PTCI	205.8	6.42	33-231	.82	204.5	5.97	.80	190.56	6.43	.82

Note: KDVSS-U=Karachi Domestic Violence Screening Scale-Urdu; PCL-5=Posttraumatic Stress Disorder Checklist for DSM-5; PTCI= Posttraumatic Cognitions Inventory.

Table 31 shows the alpha coefficients on three assessments of the KDVSS-U, PCL-5 and PTCI for the treatment group. The results indicate that all the scales used in this study are internally consistent with satisfactory alpha coefficient reliability.

Table 32

Psychometric properties of Scales of Three levels of assessment for Control Group (n=35)

Scales	Pre-Test				Mid-Test			Post-Test		
	M	*SD*	Range	α	*M*	*SD*	α	*M*	*SD*	α
KDVSS-U	87.97	4.58	0-105	.71	90.20	3.35	.73	90.58	3.55	.73
PCL-5	70.67	2.60	0-80	.71	71.88	2.43	.71	70.26	1.93	.70
PTCI	212.32	4.22	33-231	.78	210.08	5.38	.80	210.41	4.78	.82

Note: KDVSS-U=Karachi Domestic Violence Screening Scale-Urdu; PCL-5=Posttraumatic Stress Disorder Checklist for DSM-5; PTCI= Posttraumatic Cognitions Inventory.

Table 32 shows the alpha coefficients on three assessments of the KDVSS-U, PCL-5 and PTCI for the control group. The results indicate that all the scales used in this study are internally consistent with satisfactory alpha coefficient reliability.

Table 33

Relationship between KDVSS, PCL-5 and PTCI for Treatment Group (n=40)

Variable	2	3
Karachi Domestic Violence Screening Scale	.50**	.33*
Posttraumatic Checklist-5	-	.42*
Posttraumatic Cognitions Inventory	-	-

*p<.05, **p<.01

Table 33 indicates that in the treatment group, KDVSS is significantly positively correlated with PCL-5 (p<.01) and PTCI (p<.05). Similarly, PCL-5 is also significantly positively correlated with PTCI (p<.05).

Table 34

Relationship between KDVSS, PCL-5 and PTCI for Control Group (n=35)

Variable	2	3
Karachi Domestic Violence Screening Scale	.56**	.29*
Posttraumatic Checklist-5	-	.38*
Posttraumatic Cognitions Inventory	-	-

*p<.05, **p<.01

Table 34 indicates that in the control group, KDVSS is significantly positively correlated with PCL-5 (p<.01) and PTCI (p<.05). Similarly, PCL-5 is also significantly positively correlated with PTCI (p<.05).

Table 35

Relationship between subscales of PCL-5 and PTCI for Treatment and Control Group (N=75)

	PTCI		
Variable	Negative Cognitions about Self	Negative Cognitions about World	Self-Blame
PCL-5			
Re-experiencing	.26*	.07	.07
Avoidance	-.12	-.18	.12
Negative alterations in cognition and mood	.28*	.16	.23*
Hyper-arousal	-.005	-.05	-.23*

*Correlation is significant at 0.05 level

Table 35 shows that there is significant positive correlation between Re-experiencing and Negative Cognitions about Self ($p<.05$). Results also show that Negative alterations in cognition and mood have a significant positive correlation with subscales of Negative Cognitions about Self and Self-Blame ($p<.05$), whereas Hyper-arousal has significant negative correlation with the subscale of Self-Blame (($p<.05$).

Table 36

Correlations between physical abuse, psychological abuse and sexual abuse, PTSD and Posttraumatic Cognitions in Treatment and Control Group (N=75)

Variable	Physical Abuse	Psychological Abuse	Sexual Abuse
Posttraumatic Stress Disorder	.53**	.54**	.38**
Posttraumatic Cognitions	.33*	.46**	.25

**$p<0.01$, *$p<0.05$

Table 36 illustrates that all types of abuse (physical, psychological and sexual) are significantly positively correlated with Posttraumatic stress disorder. Table also illustrates that Negative Cognitions have significant positive correlation with physical abuse and psychological abuse. Negative Cognitions have positive but non-significant correlation with sexual abuse.

Table 37

Regression Coefficients of physical abuse, psychological abuse and sexual abuse predicting PTSD among women victims of husband's violence (n= 40)

Variables	*B*	*SE*	*β*	*t*	*p*	*95% CI*
Constant	46.31	6.98		6.64	.000	[32.39, 60.22]
Physical Abuse	.342	.267	.15	1.28	.000	[.19, .87]
Psychological Abuse	.358	.165	.23	2.2	.034	[.029, .68]
Sexual Abuse	.49	.22	.26	2.2	.028	[.058, .942]

Note. CI = Confidence Interval

Table 37 shows the impact of physical abuse, psychological abuse and sexual abuse on PTSD among women victims of husband's violence. The R^2 value of .18 revealed that the predictor explained 18% variance in the outcome variable with F (3, 71) = 5.33, p<.001. The findings revealed that all the three types of abuse i.e. physical abuse, psychological abuse and sexual abuse positively predicted PTSD (β = .15, .23 & .26, p<.001 respectively).

Table 38

Regression Coefficients of physical abuse, psychological abuse and sexual abuse predicting posttraumatic cognitions among women victims of husband's violence (n = 40)

Variables	*B*	*SE*	*β*	*t*	*p*	*95% CI*
Constant	236.82	18.09		13.08	.000	[200.74, 272.92]
Physical Abuse	.77	.69	.14	1.12	.000	[2.160, .606]
Psychological Abuse	.77	.43	.19	1.67	.000	[1.57, .138]
Sexual Abuse	.80	.58	.18	1.39	.000	[.348, 1.95]

Note. CI = Confidence Interval

Table 38 shows the impact of physical abuse, psychological abuse and sexual abuse on posttraumatic cognitions among women victims of husband's violence. The R^2 value of .07 revealed that the predictor explained 7% variance in the outcome variable with F (3, 71) = 1.81, p<.001. The findings revealed that all the three types of abuse i.e. physical abuse, psychological abuse and sexual abuse positively predicted posttraumatic cognitions (β = .14, .19 & .18, p<.001 respectively).

Table 39

Regression Analysis for Mediation of Posttraumatic Cognitions between Husband's Violence and PTSD (n = 40)

Variables	*B*	*95% CI*	*SEB*	B	R^2	ΔR^2
Step 1					.15	.15***
Constant	46.4***	[33.48,59.24]	6.43			
Husband's violence	.26***	[.121, .411]	.073	.39***		
Step 2					.18	.03***
Constant	32.31***	[9.757,54.86]	11.31			
Husband's violence	.26***	[.125, .413]	.072	.27***		
Posttraumatic Cognitions	.066***	[.021, .154]	.044	.16***		

Note. CI = Confidence Interval; *** $p<.001$

Table 39 shows the impact of violence committed against women by their husbands and posttraumatic cognitions on PTSD. In Step 1, the R^2 value of .15 revealed that husband's violence explained 15% variance in the PTSD with $F(1, 73) = 13.361, p<.001$. The findings revealed that the violence perpetrated against women by their husbands positively predicted PTSD ($\beta = .39, p<.001$). In Step 2, the R^2 value of .18 revealed that husband's violence and posttraumatic cognitions explained 18% variance in the PTSD with $F(2, 72) = 7.93, p<.001$. The results indicated that the husband's violence ($\beta = .27, p<.001$) and posttraumatic cognitions positively predicted PTSD ($\beta = .16, p<.001$). The ΔR^2 value of .03 revealed 3% change in the variance of Model 1 and Model 2 with $\Delta F(1, 72) = 2.27$, $p<.001$. The regression weights for husband's violence subsequently reduced from Model 1 to Model 2 (.39 to .27) but remained significant which confirmed the partial mediation.

More specifically, violence committed against women by their husbands has direct as well as indirect effect on PTSD.

Table 40

One- way ANOVA for Differences Among Three Assessments on PCL-5 and PTCI of Treatment Group (n=40)

	Ist Assessment		2nd Assessment		3rd Assessment				
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(2,117)*	*D2*	*Post Hoc*
PCL-5	70.75	2.66	70.25	3.01	61.23	3.81	112.3***	.66	1>2>3
PTCI	205.83	6.42	204.55	5.97	190.5	6.43	233.3***	.79	1>2>3

***$p<.001$

Table 40 shows mean, standard deviation and F-values for Posttraumatic Stress Disorder and Posttraumatic Cognitions across three levels of assessment. Results indicated significant mean differences across three levels of assessment on Posttraumatic Stress Disorder in treatment group with $F\ (2,117) = 112.3,\ p<.001$. Findings revealed that Narrative Exposure Therapy produced a significant reduction in Posttraumatic Stress scores on PCL-5 from pre-assessment to post-assessment. The value of *D2* was 0.66 (>.50) which indicated large effect size. The Post-Hoc Comparisons indicated significant between group mean differences of each level of assessment with other two levels of assessment. Results indicated significant mean differences across three levels of assessment on Posttraumatic Cognitions with $F\ (2,117) = 233.3,\ p<.001$. Findings revealed that Narrative Exposure Therapy produced a significant reduction in Posttraumatic Cognitions scores on PTCI from pre-assessment to post-assessment. The value of *D2* was 0.79 (>.50) which indicated large effect size. The Post-Hoc Comparisons indicated significant between group mean differences of each level of assessment with other two levels of assessment.

Table 41

One- way ANOVA for Differences Among Three Assessments on PCL-5 and PTCI of Control Group (n=35)

	Ist Assessment		2nd Assessment		3rd Assessment			
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(2,102)*	*Ω2*
PCL-5	70.67	2.60	71.88	2.43	70.26	1.93	2.46	.05
PTCI	212.32	4.22	210.08	5.38	210.41	4.78	1.93	.02

Table 41 shows mean, standard deviation and F-values for Posttraumatic Stress Disorder and Posttraumatic Cognitions across three levels of assessment. Results indicated non-significant mean differences across three levels of assessment on Posttraumatic Stress Disorder in control group with $F(2,102)=2.465$, $p=.09$. Findings revealed that general counseling and psychoeducation did not bring a significant reduction in Posttraumatic Stress scores on PCL-5 from pre-assessment to post-assessment. The value of $\Omega 2$ was 0.05 $(<.20)$ which indicated zero effect size. The Post-Hoc Comparisons were not conducted due to non- significant mean differences. Results indicated non-significant mean differences across three levels of assessment on Posttraumatic Cognitions with $F(2,102) = 1.93$, $p=.15$. Findings revealed that general counseling and psychoeducation produced a marginal reduction in Posttraumatic Cognitions scores on PTCI from pre-assessment to post-assessment. The value of $\Omega 2$ was 0.02 $(<.20)$ which indicated no effect size. The Post-Hoc Comparisons were not conducted due to non-significant mean differences of each level of assessment with other two levels of assessment.

Figure 5

Comparison of Treatment and Control Group across Three Assessments on PTSD

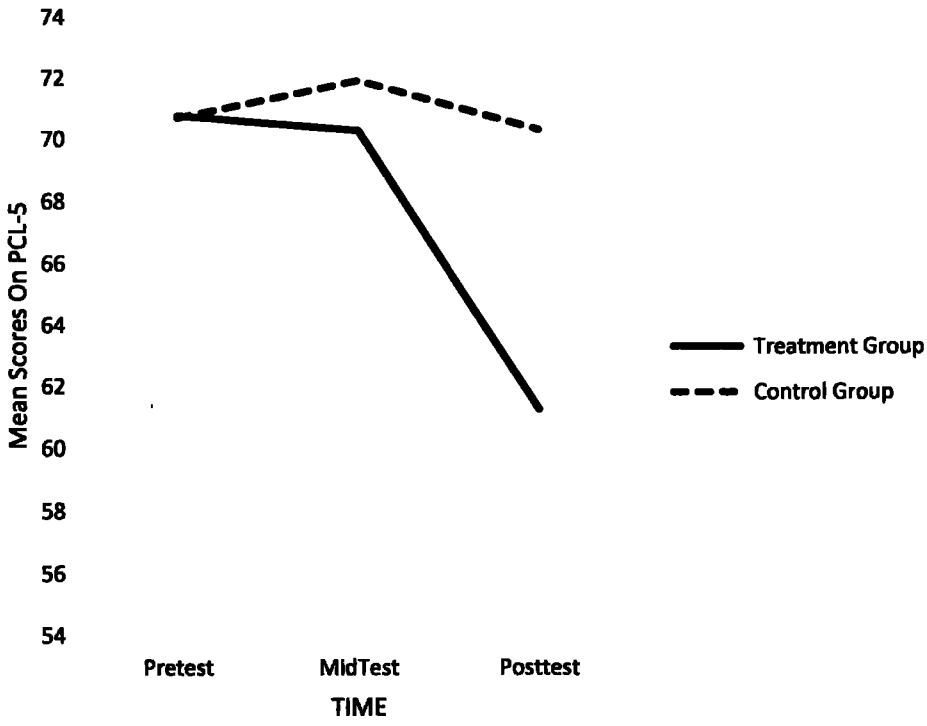


Figure 6

Comparison of Treatment and Control Group across Three Assessments on Posttraumatic Cognitions

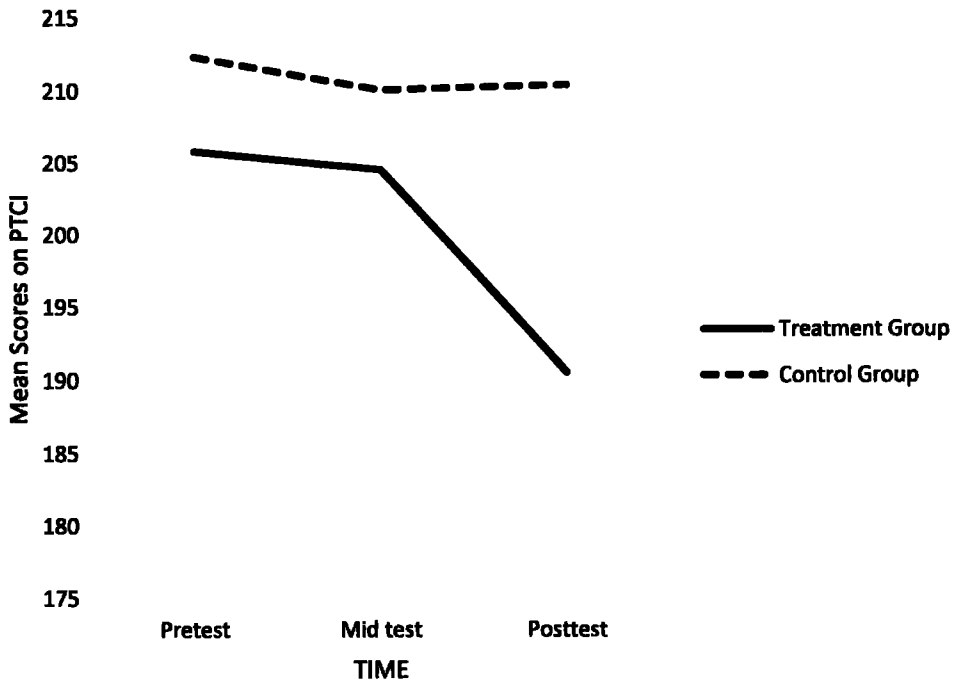


Table 42

Mixed Repeated Measures Analysis of Variance to Compare Three Assessments of Treatment and Control Group for PCL-5 (N=75)

Group Type	Time Point Assessment	*M*	*SD*
Control	1	70.67	2.60
	2	71.88	2.43
	3	70.26	1.93
Treatment	1	70.25	2.66
	2	70.75	3.01
	3	61.27	3.81

Source	SS	MS	*df*	*F*	*p*
Time	1103.398	551.699	2	148.4	.000
G.Type	443.907	443.907	1	26.774	.000
Time *G.Type	1095.772	557.248	2	141.352	.000
Error	542.860	3.718	146		

*G.Type=group type (treatment and control group)

Table 42 illustrates a significant main effect of the treatment i.e. Narrative Exposure Therapy (NET) to reduce PTSD symptoms across the assessments over three time points *(F [2, 146] = 148.4, p<.001)*. The between group result shows that there was a significant interaction between time and group type *(F [2,146] = 141.352, p<.001)*. Thus, women victims of husband's violence with PTSD who received Narrative Exposure Therapy showed significantly lower scores on PCL-5 when compared with those who received general counseling and psychoeducation.

Table 43

Mixed Repeated Measures Analysis of Variance to Compare Three Assessments of Treatment and Control Group for PTCI (N=75)

Group Type	Time Point Assessment	*M*	*SD*
Control	1	212.32	4.22
	2	210.08	5.38
	3	210.41	4.78
Treatment	1	205.83	6.42
	2	204.55	5.97
	3	190.09	6.43

Source	SS	MS	*df*	*F*	*p*
Time	9159.98	4579.994	2	267.876	.000
G.Type	11305.097	11305.097	1	176.801	.000
Time*G.Type	8141.658	4070.829	2	238.096	.000
Error	2496.226	17.097	146		

*G.Type= group type (treatment and control group)

Table 43 illustrated a significant main effect of the treatment i.e. Narrative Exposure Therapy (NET) to reduce Negative Cognitions across the assessments over three time points *(F [2, 146] = 267.876, p<.001)*. Result showed that negative cognitions decreased significantly across the three point assessments. The comparison of treatment and control group showed that there was a significant interaction between time and group type *(F [2,146] = 176.801, p<.001)*. Thus, women victim of husband's violence who received Narrative Exposure Therapy showed significant reduction in scores on PTCI when compared with those who received general counseling and psychoeducation.

DISCUSSION

Chapter-IV

Discussion

Worldwide, women face multiple forms of violence. Women activists and organizations all over the world have drawn attention to various forms of violence committed against females It includes physical, psychological and sexual violence committed by close relatives or intimate partners, forced marriages, abuses related to dowry, female genital mutilation and other customary rituals detrimental to females. Other forms of violence against women encompass female infanticide, prenatal sex selection, trafficking of women to other countries, forcing them into prostitution business, forced sterilization and forced abortion. Women also commonly face sexual harassment and bullying at their workplaces. The Convention for Eradication of all kinds of Discrimination Against Women (CEDAW) recognized all forms of violence as detrimental and stated, "gender based violence impairs and nullifies the victims' rights to life, equality and protection in the family, liberty, right to attain highest attainable standards of physical and mental health, and women should not be subjected to torture, inhumane or degrading treatment or punishment" (CEDAW, 1979).

The most prevalent form of violence committed against women worldwide is marital violence which has been defined as the physical, emotional/psychological and sexual abuse of women by their intimate partners (Heis, Pitanguy & Germain, 1992; Tjaden & Thoennes, 2000). Partner violence is faced by women in almost all societies of the world and it surpasses cultural, religious and economic distinctions. Researchers working on intimate relationships for the past 40 years have used a variety of terms to refer to abuse, assault or violence. Other terms used for intimate partner violence are wife-battering,

spousal violence, domestic violence, family violence, domestic abuse and intimate partner abuse. However, review of the literature revealed that when using these terms interchangeably, the feminist theorists and researchers (e.g., Beecham, 2009; McKie, 2005; Mullender, 1996; Saltzman, 2004) have noticed various methodological and political repercussions of using these terms. These researchers have suggested that terminology influences not only estimates of incidence and rates of prevalence but also influences how violence against women is perceived as a private or a public matter. However, mixed point of views prevail regarding the use of the term. Some feminist researchers advocate the term 'intimate partner abuse' as it integrates non-physical forms of abuse while other researchers oppose the use of 'abuse' instead of 'violence' as it minimizes the horrifying effects of physical violence experienced by the women (McKie, 2005). Hence, the researcher had to decide which terminology would be used in the current study while considering in mind the controversial nature of the argument about the use of terminology and being aware of its serious implications for the findings about the nature and extent of the problem. The term 'domestic violence' though most commonly used, seems to include all kinds of violence that take place inside the four walls of the home. Domestic violence in Pakistani cultural context incorporates all forms of violence between family members because of the joint or extended family structure. As the emphasis of the current research was on the violence committed within a marital relationship against women and keeping in view the cultural context of Pakistan, it was decided to use the term 'husband's violence' rather than 'intimate partner violence' or 'domestic violence'. Likewise, in the current study, the term 'violence' was preferred to be utilized instead of 'abuse' because abuse seems to have less severe consequences and might also help to neutralize violent acts by reducing the pain

and distress experienced by women. Therefore, the researcher used the term 'husband's violence' throughout the study to make it more clear and concise.

Women in Pakistan also face discrimination and violence throughout their lives on regular basis. Here domestic abuse against females is often taken as a normal part of Pakistani women's lives and is still not viewed a human rights violation (Babur, 2007; Masood, 2005; Niaz, 2003; Shaikh, 2003). Sultan, Khwaja and Kousar (2016) conducted a qualitative exploration of spousal abuse faced by Pakistani women residing in Lahore, Pakistan. Using thematic analysis, the researchers investigated different dimensions of spousal abuse, seeking to understand the forms of abuse faced by women and how they feel, think, and react in response to it. The findings revealed that the women were experiencing a myriad of abuse and mistreatment including physical violence, emotional abuse ranging from humiliation to cold indifference, disempowerment and deprivation. This led to effects on their sense of self, physical and mental health, cognitions, relationships and well-being.

World Health Organization in 2013 stated that "due to the consequences of domestic violence for the victims and their family members, as well as the high levels of prevalence, this form of violence constitutes a complex problem and requires public policies for its prevention and psychosocial treatment," (WHO, 2013). A study conducted by Masood (2014) sought to bring attention to the experiences and perceptions of Pakistani young adults who grew up in an abusive home environment. The study's findings revealed high and startling prevalence rates of exposure to intimate partner violence (IPV) and other types of victimization and favorable attitudes toward violence in the marital relationship. A review of qualitative research done by Ali, Farhan and Ayub (2020) consolidate research

data and provide an insight into areas that need further research regarding IPV. This review revealed the commonly found themes like experiences and perspectives of married women facing IPV, perspectives of married men, societal and cultural norms and impact on women and family as a whole. Considering the data, there is an urgent need to prevent intimate partner violence.

Different forums now increasingly recognize and discuss domestic violence against females. Serious questions related to the magnitude, consequences, prevention, intervention and risk factors of violence within intimate relationships are being asked. Although, there are many researches in Pakistan that have explored the nature, extent, prevalence and impact of violence with its various dimensions, the current study contributes by providing an evidence-based intervention that can be used to qualify the actions of public mental health services in Pakistan, where there is already a shortage of evidence-based approaches for the treatment of women victims of violence committed against them by their husbands. This study was planned to evaluate the effectiveness of Narrative Exposure Therapy (NET) in traumatized women victims of physical, psychological and sexual violence committed by their husbands in Pakistani context. The current study was comprised of three separate phases. The translation of PTSD Checklist for DSM-5 and Posttraumatic Cognitions Inventory was done in step I of phase I. Cross language validation and estimation of psychometric properties of translated scales were done in step-III and IV of phase -I. Screening out women victims of husband's violence with PTSD for therapeutic intervention and exploring the relationship and differences between sociodemographic variables and husband's violence. Before conducting the main study on a larger sample, it is recommended to carry out the research on a smaller sample

for finding out the results. Keeping in view this recommendation, the researcher designed pilot study to examine the efficacy of NET on a smaller sample (n = 12). The study was carried out in step II of phase II. Phase III was aimed at implementation and investigation of efficacy of Narrative Exposure Therapy for women victims of husband's violence with PTSD on a larger sample (n = 75).

Initially, 800 questionnaires were distributed among women for the purpose of data collection out of which 656 forms were returned. Results indicated that 60% (N=395) were identified as "abused" and 39.8% (N= 261) as "non-abused" (Table 9). This reveals the fact that at present the problem of violence committed against women by their husbands is prevalent in our society as a menace and providing psychological support will help some victims of husband's violence with platform where they can talk about their problems and think about utilizing the available options to prevent this sort of violence against themselves. While doing data collection for this study, the researcher herself found some women interested in knowing any available options to overcome the problems linked with husband's violence. These women were provided with information about agencies providing psychological services and legal assistance to women in Pakistan. Currently in Pakistan, insufficient resources are available to appropriately handle cases of violence against women. At the same time the family pressures, cultural and misinterpreted religious injunctions strongly discourage these women to seek any help from other resources like shelter homes or legal system. In these conditions, it is imperative to raise general awareness about the issue of husband's violence and sensitivity to clinical signs and symptoms associated with violence can provide some psychological support to these women. The general awareness and sensitivity will not only encourage women to discuss

their problems but also motivate policy makers to think about devising some strong supporting and healing networks for these women.

Similar findings were reported by other studies around the globe. For instance, in India analysis of criminal reports was used to estimate existence of intimate partner violence against women which revealed that only for year 2003, almost 36% were the cases of spousal violence (Government of India, 2004). A population based survey conducted in Arab countries like Egypt, Palestine, Israel and Tunisia also showed that at least 1 out of 3 women is physically victimized by her husband thus in line with the rates of spousal abuse indicated by this study findings (Douki, 2003).

Keeping in view the cultural, religious and traditional tenets of women in Pakistan and other South Asian countries, it was presumed that women would more likely to report psychological violence as compared to physical and sexual violence. Findings of the present study revealed that all types of violence were equally prevalent and reported by women. Forty-nine percent of women reported physical abuse, 83% of women reported psychological abuse and 47% of women reported sexual abuse in this study sample (Table 21). The current prevalence rates of physical, psychological and sexual abuse (49-83%) in this study sample are also in line with the previous statistics. During 1991-99 surveys conducted in seven cities of India showed that 15% of women experienced sexual violence by their husbands while 40-44% were physically and psychologically abused by their husbands (ICRW, 2000). Rabbani and colleagues (2008) revealed that husbands frequently carry out and often start with verbal abuse which then escalates into anger and then results in physical and sexual abuse. The most striking features of verbal/psychological abuse in spousal relation are abusive language in front of the children and insulting or ridiculing

partner. This high incidence of psychologically abusive behaviors carried out against wives in our society is understandable. There is general acceptance of this form of violence in marital relation in this region. A study by Sagot (2005) on family violence in Latin Americans has reported that both physical and psychological abuses were the most common manifestations of violence and women also expressed that physical and sexual violence are the worst kinds of abuses against anyone but psychological violence in marital relation is even more painful, harmful and devastating. These comments also support the observations from the study findings about impacts of psychological abuse on psychological health of women.

The data proposed by the current research was analyzed for hypotheses testing. Results revealed a positive association between all types of abuse (i.e. physical abuse, psychological abuse and sexual abuse) committed against women by their husbands and PTSD (Table 29). The findings of the current research were also supported by previous research demonstrating a common relationship between husband's violence and mental health impairments. The prevalence of PTSD among women victims of intimate partner violence is frequently reported more than any other mental health outcomes ranging from 45-84% (Houskamp & Foy, 1991; Kemp, Rawlings, & Green, 1991).

Literature shows that the most frequently found mental health disorder as a consequence of husband's violence is PTSD in females. Goldberg and colleagues (1990) observed that PTSD is considered as a normal reaction to abnormally high levels of stress and trauma due to the fact that women who are victimized by their husbands live in a constant state of fear and danger may consequently develop symptoms of PTSD. According to Woods (2000), as a result of continuing violence perpetrated by husbands and acute

experiences of trauma may increase the risk of chronic threats and injuries among such women.

Similar findings have been reported in previous researches that immediate outcomes of family violence include repercussions of acute trauma, unwanted pregnancy and sometimes even death. The long-term consequences include chronic body aches and pains, psychological problems such as posttraumatic stress disorder, depression, substance abuse, and suicide. A recent research carried out by Amell, Aloma, Soler and Cobo in 2022 assessed the prevalence of depression, anxiety and PTSD in female victims of IPV that participated in a public mental health care program, and to analyze the relationship between the type of IPV exposure, its psychological consequences and daily life adjustments. The results of the study showed that 73% scored above the cut-off point in physical IPV dimension. Seventy three percent had depression symptoms, 77% trait anxiety, and 87% state anxiety. Prevalence of PTSD was also high i.e. 87%. IPV significantly interfered in all the aspects of daily lives of 92% of the sample. It was observed that women who face domestic abuse were at increasing risk of committing or attempting suicide and five times more likely to require treatment for psychological disorders.

Mir and Naz (2017) examined the predictive relationship between spousal violence, coping strategies and psychological well-being in married women. The findings indicated that spousal violence negatively predicted psychological well-being in married women. Active-focus coping strategies and active-distracting strategies emerged as a significant predictor of psychological well-being. However, no mean differences were found regarding spousal violence between working women and housewives. Similar findings were reported by Inayat and colleagues (2017). They conducted a study to estimate

physical violence and its associated factors among married women living in Multan, Pakistan. Out of 375 women surveyed, 62.93% reported physical violence, across all socioeconomic settings.

A recent study conducted by Sattar (2020) explored the impact of marital violence on psychophysiological and reproductive health issues on female victims living in shelter home of Multan district, Pakistan. Results revealed that women victims of intimate partner violence reported various mental health problems such as depression, emotional distress and bipolar personality disorder caused by marital violence. These women reported head injuries as major physiological disorders and formation of ovarian cysts and other pregnancy related complications as major reproductive health problems on account of their husbands' ferocious acts. Similar findings were reported by Islam, Broidy, Baird and Mazerolle (2017). They investigated the influence of IPV during pregnancy and its serious consequences for mothers and newborns in Bangladesh. The results suggested that the high rates of IPV in Bangladesh have effects that can compromise women's health seeking behavior during pregnancy, putting them and their developing fetus at risk.

Siddique and colleagues (2019) in a study observed that women who were living in a violent relationship were more likely to use contraceptive in Pakistan. They further suggested that still there is a need for women reproductive health services and government should take initiatives to promote family planning services, awareness and access to contraceptive method options for women.

Domestic assault has a positive association with depression, anxiety and stress according to a recent study carried out by Malik, Munir, Ghani and Ahmad (2021).

Domestic abuse also found to have a negative impact on the quality of life of those women who have become victims of domestic violence.

Zakar and colleagues (2013) conducted a hospital-based cross-sectional survey in eight randomly selected hospitals of Lahore and Sialkot (Pakistan) to examine a relationship of spousal violence with women's poor mental health in a sample of 373 ever-married women between ages 18 to 45. It was found by the researchers that women's poor mental health was significantly correlated with their past and current experiences of physical, psychological and sexual violence inflicted against them by their husbands.

Khan, Ahmed, Saadia and Ahmed (2020) investigated types of violence and its impact on the lives of married women residing in Islamabad, Pakistan. Most of the respondents faced physical abuse by their husbands. Significant relationship prevailed between husbands' violence and its effects on the lives of married women.

The current study is the first study conducted in Pakistan which explored the incidence of husband's violence, PTSD and negative cognitions among traumatized women victims of husband's violence. Findings of this study add to the existing body of evidence that husband's violence has a positive link with negative cognitions. Results have clearly indicated that negative cognitions have significant positive correlation with physical and psychological abuse and positive but non-significant correlation with sexual abuse (Table 36). Positive correlations between cluster B, C, D and E of PTSD and posttraumatic cognitions were also reported by this study (Table 35). Numerous studies have found the link between PTSD and negative cognitions: individuals diagnosed with PTSD have more severe negative cognitions than individuals who do not have PTSD (Agar, Kennedy, & King, 2006; Beck et al., 2004; Daie-Gabai et al., 2011; Foa, Ehlers et

al., 1999; Matthews, Harris, & Cumming, 2009; Müller et al., 2010; Pérez Benítez, Zlotnick, Gomez, Rendón, & Swanson, 2013; Startup et al., 2007; Su & Chen, 2008; van Emmerik et al., 2006).

As hypothesized, husband's violence was supported as a predictor of PTSD and negative cognitions among traumatized women victims of husband's violence. Regression analysis were conducted to determine the direct relations between different forms of husband's violence and dependent variables i.e. PTSD and posttraumatic cognitions. Results revealed that violence committed against women by their husbands (i.e. physical, psychological and sexual violence) accounted for 18% variance in PTSD and 7% variance in negative cognitions (Table 37 & 38). That is, women who had been subjected to physical, psychological and/or sexual abuse were more likely to have more negative thoughts about their experiences after exposure to the trauma. This is also in line with previous research suggesting that a person's perception or assessment of the traumatic incident and its consequences may have a vital role in developing and maintaining PTSD as well as other mental health issues (Foa, et al., 1999; Ehlers & Clark, 2000). Posttraumatic cognitions can either protect or discourage healthy coping from the negative effects of abuse (Foa & Rothbaum, 1998).

The current study is the first to find the mediating impact of posttraumatic cognitions on violence committed by husbands against their wives and PTSD, in an attempt to fill gaps in the existing literature. One mechanism by which violence in intimate relationship can contribute to cause PTSD, according to Foa and colleagues' emotional processing theory, is through the cognitions that develop after exposure to violence or torture. "Normal process of recovery" is disrupted with the development of PTSD as

proposed by Foa, Ehlers, Clark, Tolin, and Orsillo (1999). According to this theory, the connection between violence and PTSD is mediated by cognitions that consider the world as completely dangerous (belief about the world), and that the self is totally incompetent (belief about self). People may develop these dysfunctional thoughts either by triggering schemas that already exist or finding it not easy to understand an unpleasant incident that are present in less flexible collection of schemas (Foa & Rothbaum, 1998; Foa & Riggs, 1993; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999)

The hypothesis that the association between husband's violence and PTSD is mediated by negative cognitions was supported by the findings of this study. The mediation model accurately explained all relationships between observed variables according to the results of the current study. The regression weights were reduced but remained significant which confirmed partial mediation that is, husband's violence has direct as well as indirect effect on PTSD among women victims of husband's violence (Table 39).

Results of the current study were consistent with the emotional processing theory by suggesting a possibility that negative appraisal and interpretation of the violence committed against them in intimate relationship may be considered a key factor in causing trauma among women victims of husband's violence. Briere and Elliott (2003) proposed certain thoughts such as the person is "helpless, inadequate, or weak" that might be viewed as negative cognitions.

Several studies have reported similar results. Reichert (2013) found a connection between childhood maltreatment, posttraumatic cognitions and mental and physical health outcomes in young adults (ages 18-29 years) in a cross-sectional analysis. Childhood maltreatment has been linked to higher risk of having mental and physical illnesses.

Posttraumatic cognitions in this research were found to be mediator in this relationship. The mediating role of dysfunctional cognitions in 206 women having a history of child abuse and depression was studied by Kaysen and colleagues (2005) who noted that the relationship between childhood maltreatment and adult depression was mediated by negative beliefs about one's self and others. Similarly, negative beliefs about the world found to mediate the relationship between childhood sexual abuse, physical abuse and depression. Over a two and a half year span, Gibb and colleagues (2001) examined the relationship between a self-reported history of childhood emotional, physical, and sexual abuse, attributional style, cognitions about one's self and the world, and depression in a sample of 297 male and female college students. In the relationship between emotional abuse and depression, dysfunctional cognitive style was found to be a mediator.

Taken together, the research studies indicate that beliefs or thoughts that develop after exposure to violence also known as posttraumatic cognitions, dysfunctional cognitions, or trauma- related cognitions can have a significant impact in subsequent mental health issues in victims of violence or abuse.

According to Sin (2010), selecting suitable research methodology in any research is critical for achieving accurate results. Keeping this in mind, the researcher decided to select quasi-experimental research design in combination with a quantitative method to adequately meet the research objectives. A quantitative survey helped the researcher to assess the prevalence of husband's violence and identified women victims of husband's violence who were experiencing trauma as an aftermath of this sort of violence. Exposure to violence in intimate relationships constitute a major stressor which causes significantly adverse effect on their physical and mental health, as well as on their social relationships

(Fonseca, Ribeiro, Leal, 2012; Gomes et al., 2012). The review of the previous studies observed that women victims of violence in intimate relationship are vulnerable to develop anxiety, depression, obsessive-compulsive disorder and PTSD as consequences of violence (Adeodato, Carvalho, Siqueira, & Souza, 2005; Devries, et al., 2011; Dillon, Hussain, Loxton, & Rohman, 2013; Jonas et al., 2014).

The above-mentioned consequences require interventions directed towards minimizing the effects of violence. Therefore, reliable and evidence-based treatment approaches are essential for improving the quality of life women who are victims of repeated violence and abuse (Courtois & Ford, 2009). In this light, the current research was designed to assess the efficacy of Narrative Exposure Therapy for women who have been victims of marital abuse perpetrated against them by their husbands. Narrative Exposure therapy is a form of exposure that motivates the survivors of the trauma to chronologically narrate their life history in detail to a skilled mental health professional usually a counselor or a psychotherapist. The task of the therapist is to keep a record of the narrative, reread it to the patient and help the survivor assimilate fragmented traumatic memories into a meaningful and comprehensible narrative (see Annexure-J).

While NET is treating survivors through the narrative process, it is also simultaneously documenting violations of child rights and human rights. Based on scientific evidence from various disciplines (clinical psychology, neuropsychiatry, neuroscience, public health, and refugee studies), NET has been compiled and successfully field tested (Hensel-Dittmann, in press; Bichescu, Neuner, Schauer, & Elbert, 2007; Neuner, Schauer, & Elbert, & Roth, 2002; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Neuner et al., 2008; Ruf et al., 2010; Schaal, Elbert, & Neuner, 2009; Schauer

et al., 2006). Among other things, its applicability and efficacy for survivors of violence have been demonstrated under a variety of conditions such as refugee camps/settlements, national or local emergencies or crises, and in European and American outpatient clinic settings (Robjant & Fazel, 2010). Furthermore, NET has been extended for use specifically with children/adolescents and is referred to as KidNET. KidNET includes using illustrative material to represent the lifeline of the child/adolescent (Neuner et al. 2008). Additionally, NET has also been extended for use with individuals who are both victims of trauma and perpetrators of aggressive acts, known as Narrative Exposure Therapy for Forensic Offender Rehabilitation (FORNET; Elbert et al. 2012).

The primary goal of developing NET has been to create such a method of psychological treatment that will be used for healing purpose as well as for directly contributing to the fight against violence and abuse. The core elements are thus threefold: healing of the individual, healing from violence committed against children and women or against one's ethnic or cultural group, and reconciliation from violence.

The impact of Narrative Exposure Therapy was measured by comparing the presence of variations in PTSD diagnosis before and after therapy. Psychological evaluation has shown to play an important role in the healing process as it provides details about the severity of the effects of abuse (Hatzenberger et al., 2010; Ribeiro, Andreoli, Ferri, Prince, & Mari, 2009). Moreover, symptoms of trauma and posttraumatic cognitions were also identified by utilizing the psychological instruments. The major aim of the therapeutic intervention was to offer an evidence-based intervention to treat women who are suffering from violence and abuse inflicted upon them by their husbands.

Hansen and colleagues (2014), developed semi-structured multidisciplinary intervention to evaluate the impact of traumatic situations associated with domestic abuse in 70 women. The findings suggested a visible decrease in PTSD symptoms, depression and anxiety. It also found an increase in the perceived social support by the participants.

Dutton and colleagues (2013) examined the effects of Mindfulness Based Stress Reduction (MBSR) intervention in 53 low-income American women who experienced domestic abuse with PTSD. The participants reported an increase in self-efficacy, anger control, better focus on the present and decreased symptoms of PTSD.

Iverson and colleagues (2009) conducted a study to evaluate treatment effect of dialectical behavioral therapy in 31 women victims of violence with 12 group DBT sessions for the treatment of emotional dysregulation that resulted after the exposure to repeated violent acts. Positive and significant improvements were reported by women victims in depression, hopelessness, psychological distress and social adjustment in post-treatment assessments.

Habigzang and colleagues (2018) conducted a study to evaluate the impact of Cognitive Behavioral Therapy for 116 abused women living in a situation of a domestic violence. The results of the study indicated that Cognitive Behavioral Therapy significantly reduced the symptoms of anxiety, depression and stress over a course of 13 therapeutic sessions with a weekly frequency. Therapeutic interventions allowed abused women to perceive themselves with control over their current life situations, knowing their existing rights and services that can aid in their protection.

The results of the current study revealed that NET significantly lowered the symptoms of PTSD and improved posttraumatic cognitions from pre-assessment to post-assessment in the treatment group (Table 40) as compared to control group who did not receive intervention (Table 41). The techniques used in therapy proved to be effective in lessening the distress. Participants were briefed about the cycle of violence and abuse and as well as its expression in various forms through psychoeducation which helped the women victims to review their experiences and change their perceptions that they were responsible for the violence or abuse. Another component of the therapy was restructuring of the memories related to trauma and promotion of self-protection techniques. These techniques were specifically designed to allow the participants to perceive themselves with control over their current life situations, informing them about their basic rights and availability of various services for their safety.

Based on the hypothesis, the data of this study was analyzed to evaluate the main effect of therapeutic intervention to minimize symptoms of PTSD in treatment group across the assessments over three time points. The findings indicated that participants who received Narrative Exposure Therapy presented significant reduction in PTSD symptomatology on PCL-5 when compared to those who received general counseling (Table 42). Similarly, a significant main effect of NET was indicated by a decrease in the scores on Posttraumatic Cognitions Inventory across the three point assessments in the treatment group as compared to those in the control group who only received general counseling and psychoeducation (Table 43). The reason for these differences in treatment and control group may be attributed to the contribution of the healing aspect of narratives or story telling commonly practiced in every culture across the globe. Likewise, NET has

been developed on the similar intention of healing individuals while integrating fragmented traumatic memories into a meaningful narrative.

Treatment fidelity measures were also employed in the present study. In clinical research treatment fidelity is typically attained by intensive training and supervision techniques and demonstrated by measuring therapist adherence and competence to the protocol using external raters. In the present research, the treatment manual developed by Schauer, Neuner and Elbert (2011) was used to organize and conduct sessions of NET. Moreover, the sessions were planned and supervised by the research supervisor and a senior clinical psychologist.

Based on observations of NET in practice, it is found that NET has empowering consequences on both individual and societal levels. Striving for appropriate mental health services for trauma victims turns out to be anything but a "luxury," especially in resource-poor, conflict-ridden countries (Schauer & Schauer, 2010). Many survivors suffering from disorders of acute stress are not capable of performing daily tasks crucial to survival, such as creating viable financial and social standard of living. Victims may be suffering from multiple adverse conditions such as intrusions of traumatic memories, nightmares, their physical health may be deteriorating, and an increase in the feelings of worthlessness, suicidal ideation and hopelessness. After treatment, it has been shown that survivors have been able to perform their daily activities as they used to do them previously and engage themselves again in close relationships. With this, the process of individual and community recovery is able to begin. Therefore, treatment related to trauma is considered a core connection between person's psychological health and an overall social and economic development of the community.

Limitations and Suggestions for Future Research

The study presented certain limitations. First limitation of the current study was its reliance on information self-reported by participants of the study. Women have themselves provided information on assessment measures therefore, the validity of information obtained through self-reporting of the participants is sometimes questioned as it does not guarantee accurate responses and also subject to biases because there is chance of socially desirable responses.

Another limitation of this research was the dropped out cases. Drop out from therapies remain a major cause for inefficiency in improving the mental health status of the society and thus leads to low clinical improvements for the clients. It was not possible to approach many women because they frequently changed the address and telephone contact for confidentiality. Despite having consent from all participants, only 75 out of 100 completed the therapeutic protocol. The difficulty in changing working hours and looking after the children and household duties or being relocated from the city during the process of treatment, may be the cause. Therefore, generalizability of the research findings is limited because of the low number of the participants. Future interventions should be provided in flexible hours for women participants who need to adjust different activities.

Another potential limitation of the study was related to the recording of therapeutic sessions. The participants did not give their consent to record the sessions mainly due to the sensitivity of the issue and for the possibility of marital conflict. Similarly, ethical issues and cultural barriers were also considered by the researcher while conducting the sessions. Confidentiality of the participants was the main priority of the researcher as the women victims of husband's violence were more concerned about the disclosure of their identity. That's why co-

researcher or any other personnel were not included in the study. However, the researcher planned and shared the sessions with the research supervisor on regular basis for feedback on pre and post assessments.

The present research was limited to small representative sample of only two cities of Pakistan, so it is suggested that it should be replicated on a large representative sample of whole Pakistan.

This study highlights the abused married women's perspective only while gender differences are not explored.

Data has been collected from multi-ethnic cities of Pakistan but the demographic information lacked data upon race and ethnicity of participants, which would have been very useful in providing estimates about generalization of findings.

Majority of the data was collected by the sample having Islam as the religious background. However, for comparability, participants from various other religions would have been included in the study.

Lack of availability of instruments in Urdu language was one of the major hazards. The scales were used after translation.

The current study has compared the effects of Narrative Exposure Therapy (NET) with general counseling and psychoeducation in the treatment and control group. It is recommended for future researches that Narrative Exposure Therapy should be compared with some other therapeutic intervention.

There is need for more research in order to gain further insight and to devise appropriate prevention and intervention strategies in addressing problems of violence in

intimate relationship in our society. Some areas are highlighted below on the basis of observations obtained from this study:

- How the routine screening of victims can be done effectively in various set ups of Pakistani society?
- How to devise appropriate prevention and intervention strategies for violence against women according to the ethnic backgrounds of people in multi-ethnic cities?
- Can poor psychological functioning increase the chances of re-victimization?
- Can men also be involved in our society to address the issue of violence against women and if yes how and at what level?
- What is the role of counseling and psychotherapeutic services in addressing the issue of violence against women in our society?
- Is dissolution of marriage the only solution to the problem of marital violence?
- How to target the risk factors and what short-term strategies can be devised to address the issue violence committed against women by their husbands in our society?

Implications of the Study

Domestic violence is rising globally. In Pakistan because of the sensitivity of the issue, it is most of the time under reported. However, still many women having daily experiences of violence are living with its consequences. The most obvious finding from all of this research is that identification of violence against women is an important issue which needs to be enhanced through educational and health awareness programs, prevention and control. Moreover, comprehensive laws and legislations need to be developed, strengthened and implemented.

The current research reveals the experience of husband abuse among women in Pakistan and serves as an initiative towards spreading awareness in general public about this important issue. The study can inform policy makers about domestic violence in Pakistan and the measures that can be taken for prevention and control of abuse. Also, the information that has been obtained can be useful for NGOs, social workers and counselors in understanding and preventing abuse.

People in our society need to be educated about the socio-cultural factors that perpetuate patterns of abuse. There is a need to return to the Islamic notion of the husband as the caretaker and supporter of the family and a compassionate head of the household. An active role of health care centres, judiciary and high authorities can be very effective in reducing spousal abuse. Moreover, group counseling programs and applied research on spousal abuse should be conducted in which different strategies are applied to see which techniques work best for reducing spousal abuse.

The findings of this study have implications for both clinical practice and future research. Clinical implications include attending to the multiple needs of abused women in terms of stress reduction via enhanced access to personal and social resources. Future research would benefit from more detailed analysis of the pathways by which different forms of intimate partner violence or domestic violence result in PTSD and from perspective studies assessing changes in the trajectories of symptoms as a function of exposure to various forms of abuse overtime.

The present study attempted to address some of the aspects related to the identification, consequences and treatment of victims of intimate partner violence in Pakistani urban society. According to Coker (2005) controlling violence in marital relationship has significance for stopping other forms of interpersonal abuse. In families where mother is abused, for example, the risk of child abuse is higher. Early and effective assessment and treatment can help reduce future child abuse, violence by husband, and a variety of mental and physical health problems associated with it.

Keeping in view the high prevalence and devastating outcomes of violence upon victims' psychological health as demonstrated by this study and in order to provide culturally competent leadership concerning family violence prevention, intervention and health policy in Pakistan, health policy makers must improve basic knowledge and expertise. Besides providing appropriate healthcare services, some women can also be provided vocational training, emergency shelter, legal aid and other essential services.

Findings of several studies demonstrated that intimate partner violence is a preventable problem and its prevention primarily requires coordinated policies and action within different societal sectors. Both state institutions and civil society has vital role to

play in the prevention, intervention and eradication of family violence in our society. For instance, girls' education can significantly reduce occurrence of violence as well as its consequences (such as high rates of depression and stress in women) as identified by results of this research and supported by previous literature (Stewart et al., 2006).

There are number of other steps which are required at societal level to control prevalence, consequences and risk factors of violence in intimate relationship. These include:

- Altering social norms that promote abuse of females.
- Stop tolerating use of controlling behaviors as well as physical and sexual violence carried out by husbands against wives.
- Changing stereotypic roles that encourage hostile behaviors of husbands and suppression of women's emotions.
- Making policies that improve overall position of women in society by providing education and employment.
- Utilizing mass media programs to raise public awareness about violence carried out by husbands against their wives.
- Train mental health providers to encourage the patients in health care settings to discuss issues like conducive relationships, healthy parenting styles, stable marriages and also the warning signs of an abusive relationship. Assessments, interventions and discussion with patients in the healthcare settings can help not only current victims of husband's violence but also save our children from experiencing the adverse and long lasting mental health issues of violence inflicted upon women by their husbands.

Conclusion

In Pakistan, women are at a greater risk of developing serious psychological problems and having poor mental health as a consequence of being exposed to repeated episodes of physical, psychological, and sexual violence carried out against them by their husbands. Consistent with prior research, this study also found violence carried out by husbands against their wives associated with psychological ill-being including PTSD. Although numerous studies have been done to examine the psychological outcomes of violence against women in intimate relationship around the world, this study has its own importance for two reasons: firstly, this study extends what we know about patterns of intimate partner violence and its association with PTSD. Secondly, this study has investigated the efficacy of therapeutic intervention i.e. Narrative Exposure Therapy (NET) among traumatized female victims of husband's violence which is directly related with person's overall well-being and desire to survive. Early and effective interventions at larger community level are required to stop violence against women.

REFERENCES

References

Adeodato, V. G., Carvalho, R. D. R., Siqueira, V. R. D., & Souza, F. G. D. M. (2005). Quality of life and depression in women abused by their partners. *Revista de saude publica*, *39*(1), 108-113.

Agar, E., Kennedy, P., & King, N. S. (2006). The role of negative cognitive appraisals in PTSD symptoms following spinal cord injuries. *Behavioural and Cognitive Psychotherapy*, *34*(4), 437.

Ali, T. S., Asad, N., Mogren, I., & Krantz, G. (2011). Intimate partner violence in urban Pakistan: prevalence, frequency, and risk factors. *International Journal of Women's Health*, *3*, 105.

Ali, T. S., Farhan, R., & Ayub, M. (2020). Intimate partner violence against women in Pakistan: A review of qualitative research. *The Journal of Pakistan Medical Association, 70*(5), 892-903. Doi: https: //doi.org/10.5455/JMPA.20759.

Ali, T. S., Mogren, I., & Krantz, G. (2013). Intimate partner violence and mental health effects: A population-based study among married women in Karachi, Pakistan. *International Journal of Behavioral Medicine*, *20*(1), 131-139.

Almeida, R. V., & Durkin, T. (1999). The cultural context model: Therapy for couples with domestic violence. *Journal of Marital and Family Therapy*, *25*(3), 313-324.

Alpert, E. J., Shannon, D., Velonis, A., Georges, M., & Rich, R. A. (2002). Family violence and public health education: A call for action. *Violence Against Women, 8*(6), 746-778.

Amell, R.C., Aloma, R., & Cobo, S.J. (2022). Psychological consequences and daily life adjustment for victims of intimate partner violence. *The International Journal of Psychiatry in Medicine.* https://doi.org/10.1177/00912174211050504.

American Medical Association. (1992). Diagnostic and treatment guidelines on domestic violence. *Archives of Family Medicine, 1*, 39-47.

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC: Author.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, DC: Author.

Amnesty International (2004). Making Violence Against Women Count, Facts and Figures (ACT 77/306/2004). Retrieved on 5 March, 2015 from http://www2.amnesty.se/externt/aiglobal.nsf/(sidor)69ED35F8AA34FOE3C1257516004F8D6B/S file/factsfigures.pdf

Amnesty International (2004). Making Violence Against Women Count, Facts and Figures- Retrieved on 9 January, 2018 from http://www.amnesty.ca/amnestynews/upload/ATT_Facts_Figures.pdf

Anand, E., Unisa, S., & Singh, J. (2016). Intimate Partner Violence and unintended pregnancy among adolescents and young adult married women in South Asia. *Journal of Biosocial Science*, 1-16.

Anastasi, A., & Urbina, S. (1997). *Psychological testing*. Prentice Hall/Pearson Education.

Anderson, K. L. (1997). Gender, status, and domestic violence: An integration of feminist and family violence approaches. *Journal of Marriage and the Family*, 655- 669.

Anolue, F. C., & Uzoma, O.L., (2017). Intimate partner violence prevalence, contributing factors and spectrum among married couples in Southeast Nigeria. *International Journal of Reproduction, Contraceptives, Obstetrics and Gynecology, 6*(9), 3748-3753. doi: http://dx.doi.org/10.18203/2320-1770.ijrcog20174019.

Arias, I., & Pape, K. T. (1999). Psychological abuse: Implications for adjustment and commitment to leave violent partners. *Violence and victims, 14*(1), 55- 67.

Arriaga, X. B., & Oskamp, S. (1999). *Violence in intimate relationships*. Sage.

Australian Medical Association. (1998). Position statement on domestic violence. *Canberra: AMA*.

Ayyub, R. (2000). Domestic violence in the South Asian Muslim immigrant population in the United States. *Journal of Social Distress and the Homeless*, *9*(3), 237-248.

Babcock, J. C., Jacobson, N. S., Gottman, J. M., & Yerington, T. P. (2000). Attachment, emotional regulation, and the function of marital violence: Differences between secure, preoccupied, and dismissing violent and nonviolent husbands. *Journal of Family Violence*, *15*(4), 391- 409.

Babcock, J. C., Roseman, A., Green, C. E., & Ross, J. M. (2008). Intimate partner abuse and PTSD symptomatology: Examining mediators and moderators of the abuse-trauma link. *Journal of Family Psychology*, *22*(6), 809-818.

Babcock, J. C., Waltz, J., Jacobson, N. S., & Gottman, J. M. (1993). Power and violence: the relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology*, *61*(1), 40.

Babur, Z. U. (2007). Violence Against Women in Pakistan: Current realities and strategies for change [Unpublished MA Thesis]. European University Center for Peace Studies.

Baldry, A. C. (2003). "Stick and stones hurt my bones but his glance and words hurt more": The impact of psychological abuse and physical violence by current and former partners on battered women in Italy. *International Journal of Forensic Mental Health*, *2* (1), 47-57.

Bandura, A. (1973). *Aggression: A social learning analysis*. Prentice-Hall.

Bano, S., Zafar, A., & Rahat, R. (2021). Sociodemographic factors associated with intimate partner violence during pregnancy among women in Pakistan. *Pal Arch's Journal of Archaeology of Egypt/ Egyptology, 18* (8), 5058-5068.

Beck, J. G., Coffey, S. F., Palyo, S. A., Gudmundsdottir, B., Miller, L. M., & Colder, C. R. (2004). Psychometric Properties of the Posttraumatic Cognitions Inventory (PTCI): a replication with motor vehicle accident survivors. *Psychological Assessment, 16* (3), 289-298.

Beecham, D. M. (2009). *The Impact of Intimate Partner Abuse on Women's Experiences of the Workplace: A Qualitative Study* [Doctoral dissertation]. University of Warwick.

Bennice, J. A., Resick, P. A., Mechanic, M., & Astin, M. (2003). The relative effects of intimate partner physical and sexual violence on post-traumatic stress disorder symptomatology. *Violence and victims, 18*(1), 87-94.

Bichescu, D., Neuner, F., Schauer, M., & Elbert, T. (2007). Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. *Behaviour Research and Therapy, 45*(9), 2212 – 2220.

Blain, L. M., Galovski, T. E., Elwood, L. S., & Meriac, J. P. (2013). How does the posttraumatic cognitions inventory fit in a four-factor posttraumatic stress disorder world? An initial analysis. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(6), 513 – 520.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2007). Health outcomes in women with physical and sexual intimate partner violence exposure. *Journal of Women's Health, 16*(7), 987-997.

Bowker, L. H. (1983). *Beating wife-beating* (p. 113). Lexington, MA: Lexington Books.

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect, 27*(10), 1205-1222.

Bryant, R. A., & Guthrie, R. M. (2005). Maladaptive appraisals as a risk factor for posttraumatic stress: A study of trainee firefighters. *Psychological Science, 16*(10), 749-752.

Bryant, R. A., & Guthrie, R. M. (2007). Maladaptive self-appraisals before trauma exposure predict posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 75*(5), 812-815.

Buodo, G., Novara, C., Ghisi, M., & Palomba, D. (2012). Posttraumatic and depressive symptoms in victims of occupational accidents. *Depression Research and Treatment*, 1-8.

Burazeri, G., Roshi, E., Jewkes, R., Jordan, S., Bjegovic, V., & Laaser, U. (2005). Factors associated with spousal physical violence in Albania: cross sectional study. *BMJ, 331*(7510), 197-201.

Buvinic, M., Morrison, A., & Shifter, M. (1999). *Violence in Latin America and the Caribbean: a framework for action.* Bid (Banco Interamericano de Desarrollo).

Cabrejos, M.L., Rivera, A.C., Garcia, A.G., Medrano, L.A., & Bianchi, E.B. (1998). Paths of women who broke the silence: A qualitative study of help-seeking by women affected by family violence. Lima, Peru, cited in Heis, L., Ellsberg, M. & Gottemoeller, M. (1999). Ending Violence against Women. Population Reports, Series L, No.11. University School of Public Health, Population Information Program. Johns Hopkins, Baltimore.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*(9314), 1331-1336.

Campbell, J. C. (2004). Helping women understand their risk in situations of intimate partner violence. *Journal of Interpersonal Violence*, *19*(12), 1464-1477.

Carden, A. D. (1994). Wife abuse and the wife abuser: Review and recommendations. *The Counseling Psychologist*, *22*(4), 539-582.

Carek, V., Norman, P., & Barton, J. (2010). Cognitive appraisals and posttraumatic stress disorder symptoms in informal caregivers of stroke survivors. *Rehabilitation Psychology*, *55*(1), 91-96.

Convention on the elimination of all forms of discrimination (1979). against women. *Retrieved April*, *20*, 2006.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*(4), 260-268.

Coker, A. L., Smith, P. H., McKeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering. *American Journal of Public Health, 90*(4), 553 - 559.

Coker, A. L., Weston, R., Creson, D. L., Justice, B., & Blakency, P. (2005). PTSD symptoms among men and women survivors of intimate partner violence: The role of risk and protective factors. *Violence and victims, 20*(6), 625-643.

Constans, J. I., Vasterling, J. J., Deitch, E., Han, X., Tharp, A. L. T., Davis, T. D., & Sullivan, G. (2012). Pre-Katrina mental illness, post disaster negative cognitions, and PTSD symptoms in male veterans following Hurricane Katrina. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(6), 568-577.

Counts, D. A., Brown, J. K., & Campbell, J. C. (1992). Sanctions and sanctuary: Cultural perspectives on the beatings of wives. Boulder, CO: Westview.

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press.

Cromer, L. D., & Smyth, J. M. (2010). Making meaning of trauma: Trauma exposure doesn't tell the whole story. *Journal of Contemporary Psychotherapy, 40*(2), 65-72.

Daie-Gabai, A., Aderka, I. M., Allon-Schindel, I., Foa, E. B., & Gilboa-Schechtman, E. (2011). Posttraumatic Cognitions Inventory (PTCI): Psychometric properties and gender differences in an Israeli sample. *Journal of Anxiety Disorders, 25*(2), 266-271.

Dantas-Berger, S. M., & Giffin, K. (2005). Violence in conjugal relations: concealing and taking sexual violence for granted. *Cadernos de saude publica, 21*(2), 417-425.

Denmark, F.I., Krauss, H., Halpern, E., & Sechzer, J.A. (2006). Conceptualizing violence and exploitation against females. *Annuals of the New York Academy of Sciences, 1087*, 1-3, doi: 10.1196/annuals. 1385.026.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., ... & WHO Multi-Country Study Team. (2011). Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine, 73*(1), 79-86.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine*, 1-15.

Dobash, R. E., & Dobash, R. (1979). *Violence against wives: A case against the patriarchy* (pp. 179-206). New York: Free Press.

Douki, S., Nacef, F., Belhadj, A., Bouasker, A., & Ghachem, R. (2003). Violence against women in Arab and Islamic countries. *Archives of Women's Mental Health, 6*(3), 165-171.

Dutton, D. G. (1988). Profiling of wife assaulters: Preliminary evidence for a trimodal analysis. *Violence and victims, 3*(1), 5-29.

Dutton, D. G. (2000). Witnessing parental violence as a traumatic experience shaping the abusive personality. *Journal of Aggression, Maltreatment & Trauma, 3*(1), 59-67.

Dutton, M. A., Bermudez, D., Matas, A., Majid, H., & Myers, N. L. (2013). Mindfulness-based stress reduction for low-income, predominantly African American women with PTSD and a history of intimate partner violence. *Cognitive and Behavioral Practice, 20*(1), 23-32.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*(4), 319-345.

El-Bayoumi, G., Borum, M. L., & Haywood, Y. (1998). Domestic violence in women. *Medical Clinics of North America, 82*(2), 391-401.

Ellsberg, M.C., Rena, R., Herrera, A., Liljestrand, J., & Winkvist, A. (1999). Wife abuse among women of childbearing age in Nicaragua. *American Journal of Public Health, 89*, 241-4.

Faizunnisa, A. (2002). *Pakistan's population: Statistical profile 2002*. Population Association of Pakistan.

Farmer, A., & Tiefenthaler, J. (2003). Explaining the recent decline in domestic violence. *Contemporary Economic Policy*, *21*(2), 158-172.

Fedovskiy, K., Higgins, S., & Paranjape, A. (2008). Intimate partner violence: how does it impact major depressive disorder and posttraumatic stress disorder among immigrant Latinas? *Journal of Immigrant and Minority Health*, *10*(1), 45-51.

Field, E. L., Norman, P., & Barton, J. (2008). Cross-sectional and prospective associations between cognitive appraisals and posttraumatic stress disorder symptoms following stroke. *Behaviour Research and Therapy*, *46*(1), 62-70.

Fikree, F. F., & Bhatti, L. I. (1999). Domestic violence and health of Pakistani women. *International Journal of Gynecology & Obstetrics*, *65*(2), 195-201.

Fikree, F. F., Ali, T. S., Durocher, J. M., & Rahbar, M. H. (2005). Newborn care practices in low socioeconomic settlements of Karachi, Pakistan. *Social Science & Medicine*, *60*(5), 911-921.

Foa, E. B., & Riggs, D. S. (1993). Post-traumatic stress disorder in rape victims. In J. Oldham, M. B. Riba, & A. Tasman (Eds.), *American Psychiatric Press Review of Psychiatry* (Vol. 12, pp. 273-303). Washington, DC: American Psychiatric Press.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive behavioral therapy for PTSD*. New York, NY: Guilford Press.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The posttraumatic cognitions inventory (PTCI): Development and validation. *Psychological Assessment, 11*(3), 303.

Follingstad, D. R., & Dehart, D. D. (2000). Defining psychological abuse of husbands toward wives: Contexts, behaviors, and typologies. *Journal of Interpersonal Violence, 15*(9), 891-920.

Follingstad, D. R., Rutledge, L. L., Berg, B. J., Hause, E. S., & Polek, D. S. (1990). The role of emotional abuse in physically abusive relationships. *Journal of Family Violence, 5*(2), 107-120.

Fonagy, P., & Bateman, A. (2008). The development of borderline personality disorder—A mentalizing model. *Journal of Personality Disorders, 22*(1), 4-21.

Fonseca, D. H. D., Ribeiro, C. G., & Leal, N. S. B. (2012). Domestic violence against women: realities and social representations. *Psychology & Society, 24*(2), 307-314.

Frazier, P. A. (2003). Perceived control and distress following sexual assault: a longitudinal test of a new model. *Journal of Personality and Social Psychology. 84*(6), 1257-1269.

Frieze, I. H., & Browne, A. (1989). Violence in marriage. *Crime and Justice, 11*, 163-218.

Garcia-Linares, M. I., Pico-Alfonso, M. A., Sanchez-Lorente, S., Savall-Rodriguez, F., Celda-Navarro, N., Blasco-Ros, C., & Martinez, M. (2005). Assessing physical, sexual, and psychological violence perpetrated by intimate male partners toward women: A Spanish cross-sectional study. *Violence and victims, 20*(1), 99-123.

Garcia-Moreno C. (1999). *Violence Against Women, Gender and Health Equity.* Harvard Center for Population and Development Studies, Working Paper Series.Cambridge, Massachusett.

Garcia-Moreno, C., Heise, L., Jansen, H. A., Ellsberg, M., & Watts, C. (2005). *Violence against women. Science, 310* (5752), 1282-1283.

García-Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C., & Abrahams, N. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization.

Garg, Suneela, Singh, M.M., Rustagi, Ruchir, Engtipi, Kajok, Bala,. & Indu. (2019). Magnitude of domestic violence and its sociodemographic correlates among pregnant women in Delhi. *Journal of Family Medicine and Primary Care,*

8 (11), 3634-3639. Doi: 10.4103/jfmpc. jfmpc._597._19.

Gelles, R. J. (1999). Through a sociological lens: Social structure and family violence. *Sociology of Families*, 299-308.

Gelles, R. J., & Straus, M. A. (1988). *Intimate violence*. Simon & Schuster.

Gelles, R.J. (1974). *The Violent Home. Newbury Park.* CA: Sage.

Gelles, R.J., & Cornell, C.P. (1985). *Intimate violence in families*. Beverly Hills: Sage Publications.

Gibb, B. E., Alloy, L. B., Abramson, L. Y., Rose, D. T., Whitehouse, W. G., Donovan, P., ... & Tierney, S. (2001). History of childhood maltreatment, negative cognitive styles, and episodes of depression in adulthood. *Cognitive Therapy and Research, 25*(4), 425-446.

Giles-Sims, J., & Straus, M. A. (1983). *Wife battering: A systems theory approach.* New York: The Guilford Press.

Goldberg, J., True, W. R., Eisen, S. A., & Henderson, W. G. (1990). A twin study of the effects of the Vietnam War on posttraumatic stress disorder. *Jama, the Journal of American Medical Association, 263*(9), 1227-1232.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132.

Gomes, N. P., Garcia, T. C. S., Conceição, C. D. R., Sampaio, P. D. O., Almeida, V. D. C., & Paixão, G. P. D. N. (2012). Marital violence: factors that favor the recognition of appeal. *Saúde em Debate, 36*(95), 514-522.

Government of India, (2004). Crime in India: Crimes against Women 2003, National Crime Record Bureau. Available at http://ncrb.nic.in/crime2003/cii-2003/CHAP5.pdf

Habigzang, L.F., Schneider, J.A., Frizzo, R.P., & de Freitas, C.P.P. (2018). Evaluation of the Impact of Cognitive Behavioral Intervention for Women in Domestic Violence Situation in Brazil. Univ. *Psychology, 17*(3). Retrieved from http://dx.doi.org/10.11144/javeriana.upsy 17-3.eicb.

Hansen, N. B., Eriksen, S. B., & Elklit, A. (2014). Effects of an intervention program for female victims of intimate partner violence on psychological symptoms and perceived social support. *European Journal of Psychotraumatology, 5*(1), 1-10.

Hassan, S., & Malik, A. A. (2009). Standardization of Karachi domestic violence screening Scale-Urdu version. *Journal of Social Sciences, 20*(2), 83-90.

Hassan, Y. (1995). *The heaven becomes hell: A study of domestic violence in Pakistan.* Lahore: Shirkatgah.

Hatzenberger, R., Lima, A. V. R., Lobo, B., Leite, L., & Kristensen, C. H. (2010). Posttraumatic stress disorder and cognitive impairments in women victims of intimate partner violence. *Science and Cognitions, 15*(2), 94-110.

Hayyat, A. (2002). *Women: Victims of Social Evils*. Pakistan Institute of Security Management, Karachi, Pakistan.

Heise, L.L., Pitanguy, J., & Germain, A., (1992*). Violence against Women, The Hidden Health Burden.* World Bank Discussion Paper, 225, 4-10.

Hensel-Dittman, D., Schauer, M., Ruf, M., Catani, C., Odenwald, M., Elbert, T., Neuner, F. (in press). The treatment of traumatized victims of war and torture. A randomized controlled comparison of Narrative Exposure Therapy and Stress Inoculation Training. *Psychotherapy and Psychosomatics.*

Ho, C. K. (1990). An analysis of domestic violence in Asian American communities: A multicultural approach to counseling. *Women & Therapy, 9* (1-2), 129-150.

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: three subtypes and the differences among them. *Psychological Bulletin, 116*(3), 476.

Hornung, C., McCullough, B., & Summoto, T. (1981). Status relationship in marriage: risk factors in spouse abuse. *Journal of Marriage and the Family, 43,* 675-92.

Houskamp, B. M., & Foy, D. W. (1991). The assessment of posttraumatic stress disorder in battered women. *Journal of Interpersonal violence, 6*(3), 367-375.

Human Rights Commission of Pakistan (HRCP) (2003). Violence against Women. Retrieved on January, 2017 from http://www.hrcp-web.org/women.cfm

Human Rights Watch, (1999). *Crime or Custom? Violence against Women in Pakistan.* Printed in United States of America. 29-32.

Humphreys, J., Lee, K., Neylan, T., & Marmar, C. (2001). Psychological and physical distress of sheltered battered women. *Health Care for Women International, 22*(4), 401-414.

Hussain, H., Hussain, S., Zahra, S., & Hussain, T. (2020). Prevalence and risk factors of domestic violence and its impacts on women's mental health in Gilgit-Baltistan, Pakistan. *Pakistan Journal of Medical Sciences, 36* (4), 627-631. Doi: https://doi.org/10.12669/pjms.36.4.1530.

ICRW (International Center for Research on Women) and INCLEN (International Clinical Epidemiologists Network) (2000). *Domestic Violence in India: A Summary Report of a Multi-site Household Survey.* Washington D.C: ICRW

Inayat, S., Pirani, S., Ali, T.S., Khan, U.R., & Sarnholm, J. (2017). Physical violence and its associated factors among married women in Multan, Pakistan. *Pakistan Journal of Public Health, 7* (1), 38-47.

Islam, M.J., Broidy, L., Baird, K., & Mazerolle, P. (2017). Exploring the association between intimate partner violence victimization during pregnancy and delayed entry into prenatal care: Evidence from a population-based study in Bangladesh. *Midwifery, 47*, 43-52.

Iverson, K. M., Shenk, C., & Fruzzetti, A. E. (2009). Dialectical behavior therapy for women victims of domestic abuse: A pilot study. *Professional Psychology:*

Research and Practice, 40(3), 242.

Jacobson, N. S., & Gottman, J. M. (1998). *When men batter women: New insights into ending abusive relationships*. New York: Praeger.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social cognition, 7*(2), 113-136.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York, NY: The Free Press.

Jewkes, R., Penn-Kekana, L., Levin, J., Ratsaka, M., & Schrieber, M. (2001). Prevalence of emotional, physical and sexual abuse of women in three South African provinces. *South African Medical Journal, 91*(5), 421- 428.

Jewkes, R., Penn-Kekana, L., Levin, J., Ratsaka, M., & Schrieber, M. (1999). He must give me money, he mustn't beat me": Violence against women in three South African provinces. *CERSA (Women's Health) technical report. Pretoria: Medical Research Council.*

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family,* 283-294.

Johnson, M. P. (2008). *A typology of domestic violence. Intimate terrorism, violent resistance, and situational couple violence*. Boston: Northeastern University Press.

Johnson, M. P. (2011). Gender and types of intimate partner violence: A response to an anti-feminist literature review. *Aggression and Violent Behavior*, *16*(4), 289-296.

Jonas, S., Khalifeh, H., Bebbington, P. E., McManus, S., Brugha, T., Meltzer, H., & Howard, L. M. (2014). Gender differences in intimate partner violence and psychiatric disorders in England: results from the 2007 adult psychiatric morbidity survey. *Epidemiology and Psychiatric Sciences*, *23*(2), 189-199.

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-traumatic stress disorder (PTSD) in victims of domestic violence: A review of the research. *Trauma, Violence, & Abuse*, *2*(2), 99-119.

Kabir, R., Khan, H.T.A. (2019). A cross-sectional study to explore intimate partner violenceand barriers to empowerment of women in Armenia. *BioMed Research International.* https://doi.org/10.1155/2019/6939684.

Kaufman Jr, G. (1992). The mysterious disappearance of battered women in family therapists' offices: male privilege colluding with male violence. *Journal of Marital and Family Therapy*, *18*(3), 233-243.

Kaysen, D., Resick, P. A., & Wise, D. (2003). Living in danger: The impact of chronic traumatization and the traumatic context on posttraumatic stress disorder. *Trauma, Violence, & Abuse*, *4*(3), 247-264.

Kaysen, D., Scher, C. D., Mastnak, J., & Resick, P. (2005). Cognitive mediation of childhood maltreatment and adult depression in recent crime victims. *Behavior*

Therapy, 36(3), 235-244.

Kebede, S.A., Weldesentbet, A.B., & Tusa, S. (2022). Magnitude and determinants of intimate partner violence against women in East Africa: Multilevel analysis of recent demographic and health survey. *BMC Women's Health, 22* (74), 1-8. doi: 10.1186/s12905-022-01656-7.

Kemp, A., Green, B. L., Hovanitz, C., & Rawlings, E. I. (1995). Incidence and correlates of posttraumatic stress disorder in battered women: Shelter and community samples. *Journal of interpersonal violence, 10*(1), 43-55.

Kemp, A., Rawlings, E. I., & Green, B. L. (1991). Post-traumatic stress disorder (PTSD) in battered women: A shelter sample. *Journal of Traumatic Stress, 4*(1), 137-148.

Khan, S., Ahmed, A., Saadia,. & Ahmed, M.F. (2020). Cause and consequences of domestic violence in Islamabad, Pakistan. *Perspectives on Humanities and Social Sciences, 1,* 1-11.

Kimberling, R., Alvarez, J., Pavao, J., Mack, K. P., Smith, M. W., & Baumrind, N. (2009). Unemployment among women: Examining the relationship of physical and psychological intimate partner violence and posttraumatic stress disorder. *Journal of Interpersonal Violence, 24*(3), 450-463.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet, 360*(9339), 1083-1088.

Krupnick, J. L., Green, B. L., Stockton, P., Goodman, L., Corcoran, C., & Petty, R. (2004). Mental health effects of adolescent trauma exposure in a female college sample: Exploring differential outcomes based on experiences of unique trauma types and dimensions. *Psychiatry: Interpersonal and Biological Processes*, *67*(3), 264-279.

Laing, L., & Humphreys, C. (2013). *Social work and domestic violence: Developing critical and reflective practice*. Sage.

Lambert, L. C., & Firestone, J. M. (2000). Economic context and multiple abuse techniques. *Violence Against Women*, *6*(1), 49-67.

Laurence, L., & Spalter-Roth, R. M. (1996). *Measuring the Costs of Domestic Violence Against Women and the Cost-effectiveness of Intervention: An Initial Assessment and Proposals for Further Research*. Institute for Women's Policy Research.

Levinson, D. (1989). *Family violence in cross-cultural perspective*. Sage Publications.

Lloyd, S. A. (1990). Conflict types and strategies in violent marriages. *Journal of Family Violence*, *5*(4), 269-284.

Loring, M. T. (1994). *Emotional abuse*. Lexington Books/Macmillan.

Macey, M. (1999). Religion, male violence, and the control of women: Pakistani Muslim men in Bradford, UK. *Gender & Development*, *7*(1), 48-55.

Mahbub ul Haq Human Development Centre. (2000). *Human development in South Asia 2000: The gender question*. Oxford University Press, USA.

Maiuro, R.D., Cohn, T.S., Vitaliano, P.P., Wanger, B.C., & Zegree, J.B. (1988). Anger, hostility and depression in domestically violent versus generally assaultive men and nonviolent control subject. *Journal of Consulting and Clinical Psychology, 56*, 24-33.

Malik, M., Munir, N., Ghani, M. U., & Ahmad, N. (2021). Domestic violence and its relationship with depression, anxiety and quality of life: A hidden dilemma of Pakistani women. *Pakistan journal of Medical Sciences*, *37*(1), 191.

Martin, S. L., Moracco, K. E., Garro, J., Tsui, A. O., Kupper, L. L., Chase, J. L., & Campbell, J. C. (2002). Domestic violence across generations: findings from northern India. *International Journal of Epidemiology*, *31*(3), 560-572.

Martin, S. L., Tsui, A. O., Maitra, K., & Marinshaw, R. (1999). Domestic violence in northern India. *American Journal of Eepidemiology*, *150*(4), 417-426.

Masood, S. (2005). *Gender role attitudes and attribution of blame for spousal violence in married people* [Unpublished MPhil Thesis]. Quaid-Azam University Islamabad.

Masood, S. (2014). *Intimate Partner Violence: Childhood Exposure and Respective Attitudes among Pakistani Young Adults* [An Unpublished Doctoral Dissertation]. The University of Warwick. Retrieved from http://go.warwick.ac.uk/wrap/65226.

Matthews, L. R., Harris, L. M., & Cumming, S. (2009). Trauma-related appraisals and coping styles of injured adults with and without symptoms of PTSD and their relationship to work potential. *Disability and Rehabilitation, 31*(19), 1577-1583.

Mayda, A. S., & Akkuş, D. (2005). Domestic violence against 116 Turkish housewives: A field study. *Women & Health, 40*(3), 95-108.

McCue, M. L. (2008). *Domestic violence: A reference handbook.* ABC-CLIO.

McKie, L. (2005). *Families, violence and social change.* Berkshire: OU Press.

Miller, N. (2004). *Domestic violence: A review of state legislation defining police and prosecution duties and powers.* Institute for Law and Justice. Alexandria, VA.

Mir, S., & Naz, F. (2017). Spousal psychological violence, coping strategies and psychological well-being in married women. *FWJ Journal of Social Sciences, 11*(1), 242-253.

Mitra, N. (1999). Best practices among responses to domestic violence in Maharashtra and Madhya Pradesh. *Domestic Violence in India, 1.*

Mitra, P. (2002). *Domestic Violence and the Personality Profile of the Male Perpetrator* [Unpublished Doctoral Dissertation]. Andhra University, Visakhapatnam. India.

Morash, M., Bui, H. N., & Santiago, A. M. (2000). Cultural-specific gender ideology and wife abuse in Mexican-descent families. *International Review of Victimology, 7*(1-3), 67-91.

Morrison, A. R., & Orlando, M. B. (1999). Social and economic costs of domestic violence: Chile and Nicaragua. *Too close to home: Domestic Violence in the Americas*, 51-80.

Moser, J. S., Hajcak, G., Simons, R. F., & Foa, E. B. (2007). Posttraumatic stress disorder symptoms in trauma-exposed college students: The role of trauma-related cognitions, gender, and negative affect. *Journal of Anxiety Disorders, 21*(8), 1039-1049.

Mullender, A. (2002). *Rethinking domestic violence: The social work and probation response*. Routledge.

Müller, J., Wessa, M., Rabe, S., Dörfel, D., Knaevelsrud, C., Flor, H., ... & Karl, A. (2010). Psychometric properties of the Posttraumatic Cognitions Inventory (PTCI) in a German sample of individuals with a history of trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 2*(2), 116-125.

Mumtaz, K., Mitha, Y., & Tahira, B. (2003). *Pakistan: Tradition and change*. Oxfam.

Naz, S., & Malik, N.I. (2018). Domestic violence and psychological well-being of survivor women in Punjab, Pakistan. *Journal of Psychology and Clinical Psychiatry, 9* (2), 184-189. Doi: 10.15406/jpcpy.2018.09.00519.

Neuner, F., Onyut, P. L., Ertl, V., Odenwald, M., Schauer, E., & Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *76*(4), 686-694.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an african refugee settlement. *Journal of Consulting and Clinical Psychology*, *72*(4), 579-587.

Niaz, U. (2003). Violence against women in South Asian countries. *Archives of Women's Mental Health*, *6*(3), 173-184.

Niaz, U. (2004). Women's mental health in Pakistan. *World Psychiatry*, *3*(1), 60-62.

O'Campo, P., Kub, J., Woods, A., Garza, M., Jones, A. S., Gielen, A. C., ... & Campbell, J. (2006). Depression, PTSD, and comorbidity related to intimate partner violence in civilian and military women. *Brief Treatment and Crisis Intervention*, *6*(2), 99-110.

O'Donnell, M. L., Elliott, P., Wolfgang, B. J., & Creamer, M. (2007). Posttraumatic appraisals in the development and persistence of posttraumatic stress symptoms. *Journal of Traumatic Stress*, *20*(2), 173-182.

Pagelow, M. D. (1992). Adult victims of domestic violence: Battered women. *Journal of Interpersonal Violence*, *7*(1), 87-120.

Pagelow, M. D., & Pagelow, L. W. (1984). *Family violence*. New York. Praeger.

Papadakaki, M., Tzamalouka, G. S., Chatzifotiou, S., & Chliaoutakis, J. (2009). Seeking for risk factors of intimate partner violence (IPV) in a Greek national sample: The role of self-esteem. *Journal of Interpersonal Violence*, *24*(5), 732-750.

Pardhan, A. (2009). *Women kindergarten teachers in Pakistan: Their lives, their classroom practice* [Doctoral dissertation]. Ontario Institute for Studies in Education of the University of Toronto.

Pattison, E. M. (1985). Violent marriages. *Medical Aspects of Human Sexuality*, 19,57-74.

Pérez Benítez, C. I., Zlotnick, C., Gomez, J., Rendón, M. J., & Swanson, A. (2013). Cognitive behavioral therapy for PTSD and somatization: An open trial. *Behaviour Research and Therapy, 51*, 284-289.

Pico-Alfonso, M. A. (2005). Psychological intimate partner violence: The major predictor of posttraumatic stress disorder in abused women. *Neuroscience & Biobehavioral Reviews*, *29*(1), 181-193.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health, 15*(5), 599-611.

Poppe P. (1999) Partnerships with the Media to Prevent Domestic Violence, in 'Too Close to Home: Domestic Violence in the Americans' op. cit.

Rabbani, F. (1999). Views about women's mental health: study in a squatter settlement of Karachi. *JPMA: Journal of the Pakistan Medical Association, 49*(6), 139-142.

Rabbani, F., Qureshi, F., & Rizvi, N. (2008). Perspectives on domestic violence: case study from Karachi, Pakistan. *EMHJ-Eastern Mediterranean Health Journal, 14(2),* 415-426.

Rao, V. (1997). Wife-beating in rural South India: A qualitative and economic analysis. *Social Science and Medicine, 44(8)*,1169-1180.

Reichert, E. (2013). *Childhood Maltreatment, Posttraumatic Cognitions, and Health Outcomes Among Young Adults* [Unpublished Doctoral Thesis]. University of Rhode Island. Retrieved from http://digitalcommons.uri.edu/oa_diss/14.

Resick, P. A., Schnicke, M. K., & Markway, B. G. (1991). *The relationship between cognitive content and post-traumatic stress disorder*. Paper presented at the annual meeting of the Association for Advancement of Behavior Therapy, New York, NY.

Ribeiro, W. S., Andreoli, S. B., Ferri, C. P., Prince, M., & Mari, J. J. (2009). Exposure to violence and mental health problems in low and middle-income countries: a literature review. *Brazilian Journal of Psychiatry*, *31*, 49-57.

Robjant, K., & Fazel, M. (2010). The emerging evidence for narrative exposure therapy: A review. *Clinical Psychology Review*, *30*(8), 1030-1039.

Romans, S., Forte, T., Cohen, M. M., Du Mont, J., & Hyman, I. (2007). Who is most at risk for intimate partner violence? A Canadian population-based study. *Journal of Interpersonal Violence*, *22*(12), 1495-1514.

Roomani, F., Tayyab, F., Kamal, N., Siddique, K. (2016). Role of women in perpetuating violence against women: Case studies of domestic violence victims. *Pakistan Journal of Social Sciences, 36*(2), 1185-1195.

Rosales, O. J., Loaiza, E., Primante, D., Barberena, A., Blandon, S. L., & Ellsberg, M. (1999). *Nicaraguan demographic and health survey 1999.* Managua, Nicaragua.

Rosenbaum, A., & O'Leary, K. D. (1981). Marital violence: Characteristics of abusive couples. *Journal of Consulting and Clinical Psychology*, *49*(1), 63-71.

Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7-to 16-year-olds: A randomized controlled trial with traumatized refugee children. *Journal of Traumatic Stress*, *23*(4), 437-445.

Russell, D.E. (1982). *Rape in marriage.* New York: McMillan Publishing Company.

Sagot, M. (2005). The critical path of women affected by family violence in Latin America: case studies from 10 countries. *Violence Against Women, 11*(10), 1292-318.

Saltzman, L. E. (2004). Definitional and methodological issues related to transnational research on intimate partner violence. *Violence against Women, 10*(7), 812-830.

Sardinha, L., Maheu-Giroux, M., Stockl, H., Meyer, S.R., & Garcia-Moreno, C. (2022). Global, regional, and national prevalence estimatesof physical or sexual, or both, intimate partner violence against women in 2018. *The Lancet, 399*(10327), 803-813. doi: https://doi.org/10.1016/S0140-6736(21) 02664-7.

Sattar, T. (2020). The impact of intimate partner violence on victimized women residing in shelter home in Multan, Pakistan. *Rawal Medical Journal, 45(3),* 711-715.

Schaal, S., Elbert, T., & Neuner, F. (2009). Narrative exposure therapy versus interpersonal psychotherapy. *Psychotherapy and Psychosomatics, 78*(5), 298-306.

Schauer, M., & Schauer, E. (2010). Trauma-focused public mental-health interventions: a paradigm shift in humanitarian assistance and aid work. In *Trauma rehabilitation after war and conflict* (pp. 389-428). Springer, New York, NY.

Schauer, M., Elbert, T., Gotthardt, S., Rockstroh, B., Odenwald, M., & Neuner, F. (2006). Re-experience through psychotherapy modifies the mind and brain. *Behavioral Therapy, 16* (2), 96-103.

Schauer, M., Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative Exposure Therapy: A Short-Term Treatment for Traumatic Stress Disorders*. Hogrefe Publishing.

Schechter, S., & Edleson, J. L. (1999). *Effective intervention in domestic violence & child maltreatment cases: Guidelines for policy and practice: Recommendations*. The Council.

Schuler, S. R., Hashemi, S. M., Riley, A. P., & Akhter, S. (1996). Credit programs, patriarchy and men's violence against women in rural Bangladesh. *Social Science & Medicine, 43*(12), 1729-1742.

Shah, D. (2003). *Decentralization in the Education system of Pakistan: Policies and Strategies*. Ministry of Education, Government of Pakistan.

Shahar, G., Noyman, G., Schnidel-Allon, I., & Gilboa-Schechtman, E. (2013). Do PTSD symptoms and trauma-related cognitions about the self constitute a vicious cycle? Evidence for both cognitive vulnerability and scarring models. *Psychiatry Research, 205*(1-2), 79-84.

Shaikh, M. A. (2000). Domestic violence against women-perspective from Pakistan. *Journal of Pakistan Medical Association, 50*(9), 312-4.

Shaikh, M. A. (2003). Is domestic violence endemic in Pakistan: perspective from Pakistani wives. *Pakistan Journal of Medical Sciences, 19*(1), 23-28.

Siddique, K. (2019). Intimate partner violence and its association with contraceptive use among women in Pakistan. *Pakistan Journal of Psychological Research, 34*(1), 157-173. doi: 10.33824/PJPR.2019.34.1.9

Sin, S. (2010). Considerations of quality in phenomenographic research. *International Journal of Qualitative Methods, 9*(4), 305-319.

Sonkin, D. J., & Durphy, M. (1997). *Learning to live without violence: A handbook for men*. Volcano Press.

Startup, M., Makgekgenene, L., & Webster, R. (2007). The role of self-blame for trauma as assessed by the Posttraumatic Cognitions Inventory (PTCI): A self-protective cognition? *Behaviour Research and Therapy, 45*(2), 395-403.

Stewart, D.E., Ashraf, I.J., & Muneer, S.E. (2006). Women's mental health: A silent cause of mortality and morbidity. *International Journal of Gyneacology and Obstetrics, 94*, 343-349. Retrieved from www.elsevier.com/locate/ijgo.

Straus, M. A. (2008). Dominance and symmetry in partner violence by male and female university students in 32 nations. *Children and Youth Services Review, 30*(3), 252-275.

Straus, M. A. (2014). Why the overwhelming evidence on partner physical violence by women has not been perceived and is often denied. In *Female Offenders of*

Intimate Partner Violence (pp. 12-31). Routledge.

Straus, M. A., Gelles, R. J., & Asplund, L. M. (1990). Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families. *Violence and Victims, 5* (4).

Stubbs, J. (2007). Beyond apology? Domestic violence and critical questions for restorative justice. *Criminology & Criminal Justice*, *7*(2), 169-187.

Su, Y. J., & Chen, S. H. (2008). The posttraumatic cognitions inventory-Chinese revised: Validation and refinement with a traumatized college sample in Taiwan. *Journal of Anxiety Disorders*, *22*(7), 1110-1119.

Sultan, H., Khwaja, A.O. & Kousar, T. (2016). Spousal abuse among Pakistani women: A thematic analysis. *Pakistan Journal of Social and Clinical Psychology, 14* (2), 33-41.

Swanberg, J. E., & Logan, T. K. (2005). Domestic violence and employment: a qualitative study. *Journal of Occupational Health Psychology*, *10*(1),

Temple, J. R., Weston, R., Rodriguez, B. F., & Marshall, L. L. (2007). Differing effects of partner and nonpartner sexual assault on women's mental health. *Violence against Women*, *13*(3), 285-297.

Tjaden, P. G., & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey.* Washington D.C.

Tolman, R. M., & Rosen, D. (2001). Domestic violence in the lives of women receiving welfare: Mental health, substance dependence, and economic well-being. *Violence against Women, 7*(2), 141-158.

United Nations (2000). *The World's Women: 2000 Trends and Statistics* (3rd ed.). New York.

United Nations, (1993). *Declaration on Elimination of Violence against Women.* General Assembly (Resolution No. 48/104). Retrieved on Feb 10, 2015 from http/www.unhchr,ch/huridocdahuridoda.nsf/(symbol)/A.

Van Emmerik, A. A. P., Schoorl, M., Emmelkamp, P. M. G., & Kamphuis, J. H. (2006). Psychometric evaluation of the Dutch version of the posttraumatic cognitions inventory (PTCI). *Behaviour Research and Therapy, 44*(7), 1053-1065.

Vest, J. R., Catlin, T. K., Chen, J. J., & Brownson, R. C. (2002). Multistate analysis of factors associated with intimate partner violence. *American Journal of Preventive Medicine, 22*(3), 156-164.

Vigdor, E. R., & Mercy, J. A. (2006). Do laws restricting access to firearms by domestic violence offenders prevent intimate partner homicide?. *Evaluation Review, 30*(3), 313-346.

Vindhya, U., Kiranmayi, A., & Vijayalakshmi, V. (2001). Women in psychological distress: Evidence from a hospital-based study. *Economic and Political Weekly*, 4081-4087.

Walker, L. E. (1992). Battered women syndrome and self-defense. *Notre Dame Journal of Law, Ethics, and Public Policy, 6*, 321-334.

Walker, L. E. (2009). *The battered woman syndrome*. Springer Publishing Company.

Ward, J. (2002). *If Not Now, When? Addressing Gender-Based Violence in Refugees, Internally Displaced, and Post-Conflict Settings. A Global Overview.* The Reproductive Health for Refugees Consortium, New York. Pg 47-78. Retrieved on 14 Nov, 2017 from http://www.womencommission.com

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. In *annual convention of the international society for traumatic stress studies, San Antonio, TX* (Vol. 462).

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD checklist for DSM-5 (PCL-5). *Scale available from the National Center for PTSD at www. ptsd. va. gov/*

Wet-Billings, N.D., & Godongwana, M. (2021). Exposure to intimate partner violence and hypertension among young women in South Africa. *International Journal of Hypertension.* https://doi.org/10.1155/2021/5519356.

Whitchurch, G. G., & Constantine, L. L. (1993). Systems theory. In Boss, P.G., Doherty, W.J., LaRossa, R., Schumm, W.R., & Steinmetz, S.K (Eds.), *Sourcebook on theories and methods: A contextual approach.* Springer: US.

Wild, D., Grove., A., Martin, M., Eremenco, S., McElroy,S., Verjee-Lorenz, A., & Erikson, P. (2005). Principles of good practice for the translation and adaptation process for patient-reported outcomes (PRO) measures: Report of the task force for translation and cultural adaptation. *Value in Health, 8* (2), 94-104.

Woods, S. J. (2000). Prevalence and patterns of posttraumatic stress disorder in abused and post abused women. *Issues in Mental Health Nursing, 21*(3), 309-324.

Woods, S. J., Hall, R. J., Campbell, J. C., & Angott, D. M. (2008). Physical health and posttraumatic stress disorder symptoms in women experiencing intimate partner violence. *Journal of Midwifery & Women's Health, 53*(6), 538-546.

World Health Organization. (1999). *'WHO Multi-country study of women's health and domestic violence. Core protocol'*. WHO/EIP/GPE/99.3 Geneva: WHO.

World Health Organization. (2002). *World report on violence and health: Summary.* Geneva. Retrieved from http://www.who.int/inf-new/aids2.htm

World Health Organization. (2005). *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevention, health outcomes and women's responses.* Geneva: World Health Organization.

World Health Organization. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non partner sexual violence.* Geneva: World Health Organization.

Yodanis, C. L., & Godenzi, A. (1999). *Report on the economic costs of violence against women.* Department of Social Work and Social Policy- University of Fribourg.

Zakar, R. (2012). *Intimate partner violence against women and its implications for women's health in Pakistan.* Disserta Verlag.

Zakar, R., Zakar, M. Z., & Kraemer, A. (2013). Men's beliefs and attitudes toward intimate partner violence against women in Pakistan. *Violence against Women, 19*(2), 246-268.

Zavala, E. (2007). *Nonphysical intimate partner violence: Emotional abuse and controlling behaviour against women* [Unpublished MA Thesis]. Kansas State University, Manhattan, Kansas.

Zink, T., & Sill, M. (2004). Intimate partner violence and job instability. *Journal of the American Medical Women's Association (1972), 59*(1), 32-35.

APPENDICES

Appendix-A
Informed Consent

رضامندی کا فارم

"Efficacy of Narrative Exposure Therapy among traumatized women victims of husband's violence"

تحقیق کنندہ کا نام۔ ثمینہ ہمایوں خان

سپروائزر: ڈاکٹر میمونہ اسماعیل

برائے مہربانی نیچے دیئے گئے بیانات کے سامنے دیئے گئے خانوں پر نشان لگائیں۔

1۔ میں اس بات کی تصدیق کرتا/ کرتی ہوں کہ میں نے شرکت کنندہ کی معلوماتی شیٹ پڑھ لی ہے اور اچھی طرح سمجھ لی ہے۔ ☐

2۔ تحقیق کنندہ نے مجھے تحقیق کی نوعیت، مقاصد، اس کا ممکنہ وقت اور یہ کہ مجھے کیا کرنا ہوگا، سے متعلق تفصیل بتا دی ہے۔ ☐

3۔ مجھے موقع فراہم کیا گیا ہے کہ میں معلومات کو سمجھ لوں اور کوئی سوال ہے تو پوچھ لوں۔ ☐

4۔ مجھے اس بات سے آگاہ کر دیا گیا ہے کہ میرا نام اور شناخت ایک کوڈ کی صورت میں محفوظ کیا جائے گا۔ ☐

5۔ میں اپنی مرضی سے اس تحقیق میں شرکت کر رہا/رہی ہوں اور میں سمجھتا/ سمجھتی ہوں کہ میں کسی وجہ کو بیان کئے بغیر اس کو چھوڑنے کے لئے آزاد ہوں اور اس سے مجھے کوئی نقصان نہیں پہنچے گا۔ ☐

6۔ مجھے معلوم ہے کہ مجھ سے لی گئی تمام معلومات کو صیغہ راز میں رکھا جائیگا اور صرف تحقیقی مقاصد کے لئے استعمال کیا جائے گا۔ ☐

7۔ میں اس تحقیق میں شمولیت کے لئے رضامند ہوں۔

تحقیق شرکت کنندہ کا نام: _____ تاریخ: _____ دستخط یا انگوٹھے کا نشان: _____

رضامندی لینے والے کا نام: _____ تاریخ: _____ دستخط: _____

Appendix-B

Demographic Data Sheet

میرا تعلق شعبہ نفسیات اسلامک انٹرنیشنل یونیورسٹی اسلام آباد سے ہے۔ مجھے پی ایچ ڈی کی تحقیق میں آپ کے تعاون کی ضرورت ہے۔

ہم گھریلو تشدد سے متعلق تحقیق کررہے ہیں۔ جس کے ذریعے ہم خواتین کے مختلف مسائل کے بارے میں معلومات حاصل کرنا چاہتے ہیں۔ اس تحقیق کے لیے ہم آپ کو یقین دلاتے ہیں کہ آپ جو معلومات ہمیں دے رہے ہیں اسے صرف تحقیق کے لیے استعمال کیا جائے گا حتی کہ آپ کے خاوند کو بھی اس کے متعلق نہیں بتایا جائے گا اس لیے آپ بغیر خوف کے جواب دیں۔ آپ کے تعاون کے لیے ہم آپ کے مشکور ہیں۔

ذاتی کوائف

آپ کا نام ---------------- آج کی تاریخ ----------------

عمر ---------------- تعلیم ----------------

شادی کو عرصہ ---------------- مذہب ----------------

بچوں کی تعداد ------------ بیٹا ------------ بیٹی ------------

ملازمت پیشہ / گھریلو خاتون

اگر ملازمت پیشہ ہیں تو آپ کا پیشہ ------------------------

ماہانہ آمدنی ----------------

شوہر کی عمر ----------------

شوہر کی تعلیم ---------------- ملازمت پیشہ / بے روزگاری

ماہانہ آمدنی ---------------- شوہر کا پیشہ ----------------

خاندانی نظام: مشترکہ / علیحدہ رہائش: شہری / دیہی

گھر میں رہنے والے کل افراد کی تعداد ------------------------

گھر میں رہنے والے دوسرے افراد کا آپ سے کیا رشتہ ہے؟ ------------------------

Appendix-C
Permission by Authors

Fw: Request for Scale

Sameena Humayun <sameenahumayun@yahoo.com> Sun, Sep 18, 2022 at 1:45 PM
To: Saim Stationers <saimstationers@gmail.com>

—— Forwarded Message ——
From: Sameena Humayun <sameenahumayun@yahoo.com>
To: sehar.unnisa@s3h.nust.edu.pk <sehar.unnisa@s3h.nust.edu.pk>
Sent: Thursday, March 16, 2017 at 12:56:28 AM PDT
Subject: Request for Scale

Assalam o Alaikum.

Respected Madam,
I am PhD Scholar in Psychology Department, International Islamic University, Islamabad. I am doing PhD research on women victims of domestic violence. I have seen your article " Standardization of Karachi Domestic Violence Screening Scale-Urdu version" on internet. Madam, I intend to use KDVSS-Urdu version in my study. I need your permission and a copy of KDVSS-Urdu version. Your cooperation in this regard will be highly appreciated.

Regards,
Sameena Humayun Khan
PhD Scholar, Psychology Department,
International Islamic University, Islamabad.

Sameena Humayun <sameenahumayun@yahoo.com> Sun, Sep 18, 2022 at 1:45 PM
To: Saim Stationers <saimstationers@gmail.com>

—— Forwarded Message ——
From: Sameena Humayun <sameenahumayun@yahoo.com>
To: DR SEHAR UN NISA <sehar.unnisa@s3h.nust.edu.pk>
Sent: Sunday, March 26, 2017 at 08:52:21 PM PDT
Subject: Re: Request for Scale

Respected Madam,

Thank you for granting permission to use your scale Karachi Domestic Violence Screening Scale-Urdu Version. Madam, can you please tell me from where do I get the copy of this scale? I need it on urgent basis.
I will be thankful to you.

Regards.
Sameena Humayun Khan
PhD Scholar. Psychology Department.
International Islamic University. Islamabad.

On Saturday, March 25, 2017 10:23 AM, DR SEHAR UN NISA <sehar.unnisa@s3h.nust.edu.pk> wrote:

Sure Sana Go ahead.

Sameena Humayun <sameenahumayun@yahoo.com> Sun, Sep 18, 2022 at 1:45 PM
To: Saim Stationers <saimstationers@gmail.com>

—— Forwarded Message ——
From: DR SEHAR UN NISA <sehar.unnisa@s3h.nust.edu.pk>
To: Sameena Humayun <sameenahumayun@yahoo.com>
Sent: Sunday, March 26, 2017 at 08:59:02 PM PDT
Subject: Re: Request for Scale

Sure Samina

I can send you the scanned copy of questionnaire hopefully by tomorrow.

Thanks
Sehar

Fw: PTCI Urdu Translation Instructions

Sameena Humayun <sameenahumayun@yahoo.com> Mon, Sep 19, 2022 at 12:15 PM
To: Saim Stationers <saimstationers@gmail.com>

---- Forwarded Message ----
From: Sameena Humayun <sameenahumayun@yahoo.com>
To: Hamlett, Gabriella <gabriella.hamlett@pennmedicine.upenn.edu>
Sent: Friday, September 11, 2020 at 05:26:14 AM PDT
Subject: Re: PTCI Urdu Translation Instructions

Dear Gabriella,

Thank you for your prompt response. I am glad that you have granted me permission to translate PTCI into Urdu. Let me inform you that I, myself will use and administer the measure to collect data

for my Doctoral research work. The measure will be administered to women victims of spousal violence with Posttraumatic Stress Disorder. I will surely send English back translation of PTCI to you as

soon as I get it translated.

Please let me know if you have any questions.

Sincerely,
Sameena Humayun Khan
PhD Scholar
Department of Psychology
International Islamic University, Islamabad, Pakistan.
Contact # 0300-9878310

On Thursday, September 10, 2020, 06:52:27 AM PDT, Hamlett, Gabriella <gabriella.hamlett@pennmedicine.upenn.edu> wrote:

Dear Sameena,

We would be glad to have you translate the measure. I have attached the original version of the PTCI and scoring key here.

Below is the process for translation:

1. Translate the PTCI into Urdu
2. Do a back-translation of the Urdu measure into English.
3. Send the back translation to me, and inform us of the reason for your request, the intended use of the measure, and if applicable, the qualifications of individuals who will be administering the measure. I will review and make any necessary comments or edits to the English back translation
4. Edits are incorporated into the measure in Urdu and then back-translated again into English.
5. The English back translation is sent to me for final approval.

Please let me know if you have any questions.

Sincerely,

Gabriella Hamlett
Research Coordinator
Center for the Treatment and Study of Anxiety

University of Pennsylvania
Phone: 215-746-3338
Fax: 215-746-3311

Sameena Humayun <sameenahumayun@yahoo.com> Mon, Sep 19, 2022 at 12:17 PM
To: Saim Stationers <saimstationers@gmail.com>

---- Forwarded Message ----
From: Sameena Humayun <sameenahumayun@yahoo.com>
To: Hamlett, Gabriella <gabriella.hamlett@pennmedicine.upenn.edu>
Sent: Friday, September 11, 2020 at 12:45:01 PM PDT
Subject: Re: [External] Re: PTCI Urdu Translation Instructions

Hi Gabriella,

Thanks. Stay Blessed.

Best Regards,
Sameena

On Friday, September 11, 2020, 06:16:24 AM PDT, Hamlett, Gabriella <gabriella.hamlett@pennmedicine.upenn.edu> wrote:

Hi Sameena,

Your work sounds very interesting and extremely important! Looking forward to seeing the back translation and don't hesitate to email me if any questions come up.

Warm Regards,

Gabi

From: Sameena Humayun <sameenahumayun@yahoo.com>
Sent: Friday, September 11, 2020 8:26 AM
To: Hamlett, Gabriella <Gabriella.Hamlett@Pennmedicine.upenn.edu>
Subject: [External] Re: PTCI Urdu Translation Instructions

Appendix-D

Permission by Authorities

INTERNATIONAL ISLAMIC UNIVERSITY

ISLAMABAD – PAKISTAN

FACULTY OF SOCIAL SCIENCES

Department of Psychology

P.O. Box No. 1243 Telegram ALJAMIA Telex.54068 IIU PK, Tel: 9258008, Fax No.9257929

Dated: September 24, 2018

TO WHOM IT MAY CONCERN

It is certified that Ms. Sameena Humayun Khan, Registration No. 41-FSS/PHDPSY/F14 is a student of PhD Psychology at Department of Psychology (Female Campus), International Islamic University, Islamabad. She has completed her course work and currently her research work is in progress. Kindly allow her to collect data for her research work from your prestigious institute.

Dr. Mamoona Ismail Loona
Assistant Professor/Clinical Psychologist
Department of Psychology
International Islamic University
Islamabad

Dr. Mamoona Ismail.
Acting Chairperson,
Deptt.of Psychology,
Female Campus, IIUI.

PIMS
Islamabad

INTERNATIONAL ISLAMIC UNIVERSITY

ISLAMABAD – PAKISTAN

FACULTY OF SOCIAL SCIENCES

Department of Psychology

P.O. Box No. 1243 Telegram ALJAMIA Telex.54068 IIU PK. Tel: 9258008, Fax No.9257929

Dated: September 24, 2018

TO WHOM IT MAY CONCERN

It is certified that Ms. Sameena Humayun Khan, Registration No. 41-FSS/PHDPSY/F14 is a student of PhD Psychology at Department of Psychology (Female Campus), International Islamic University, Islamabad. She has completed her course work and currently her research work is in progress. Kindly allow her to collect data for her research work from your prestigious institute.

Dr. Mamoona Ismail Loona
Assistant Professor/Clinical Psychologist
Department of Psychology
International Islamic University
Islamabad.

Dr. Mamoona Ismail Loona
Acting Chairperson.
Deptt.of Psychology.
Female Campus, IIUI.

INTERNATIONAL ISLAMIC UNIVERSITY

ISLAMABAD – PAKISTAN

FACULTY OF SOCIAL SCIENCES

Department of Psychology

P.O. Box No. 1243 Telegram ALJAMIA Telex.54068 IIU PK, Tel: 9258008, Fax No.9257929

Dated: September 24, 2018

TO WHOM IT MAY CONCERN

It is certified that Ms. Sameena Humayun Khan, Registration No. 41-FSS/PHDPSY/F14 is a student of PhD Psychology at Department of Psychology (Female Campus), International Islamic University, Islamabad. She has completed her course work and currently her research work is in progress. Kindly allow her to collect data for her research work from your prestigious institute.

Dr. Mamoona Ismail Loona
Assistant Professor/Clinical Psychologist
Department of Psychology
International Islamic University
Islamabad

Dr. Mamoona Ismail.
Acting Chairperson.
Deptt.of Psychology.
Female Campus, IIUI.

Appendix-E

Karachi Domestic Violence Screening Scale-Urdu

(Original)

[illegible]

[illegible]				
1	[illegible]			
2	[illegible]			
3	[illegible]			
4	کیا آپ کے شوہر غصے میں آپ پر ہاتھ اٹھاتے ہیں؟			
5	کیا آپ کے شوہر ... آپ کے لیے نازیبا الفاظ استعمال کرتے ہیں؟			
6	[illegible]			
7	[illegible]			
8	کیا آپ کے شوہر آپ سے لڑتے ہیں؟			
9	[illegible]			
10	کیا آپ کے شوہر غصے میں آپ کو چھوڑ دینے کی دھمکی دیتے ہیں؟			
11	کیا آپ کے شوہر غصے میں آپ پر چیزیں اٹھا کر پھینکتے ہیں؟			
12	[illegible]			
13	[illegible]			
14	کیا آپ کے شوہر خاندان والوں یا دوستوں سے ملنے پر پابندی لگاتے ہیں؟			
15	[illegible]			
16	[illegible]			
17	[illegible]			
18	[illegible]			
19	[illegible]			
20	[illegible]			
21	[illegible]			
22	[illegible]			
23	[illegible]			
24	[illegible]			
25	[illegible]			
26	[illegible]			
27	[illegible]			
28	[illegible]			
29	[illegible]			
30	[illegible]			
31	[illegible]			
32	[illegible]			
33	[illegible]			
34	[illegible]			
35	[illegible]			

Appendix-F
Posttraumatic Checklist for DSM-5
(Original Scale)

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Patient Name: _____ Date: _____

Instructions

The table below lists problems that people sometimes have in response to extremely stressful experiences. **Keeping your worst event in mind**, please read each problem carefully and then circle one of the numbers to indicate how much you have been bothered by that problem **in the past month.**

IN THE PAST MONTH, HOW MUCH WERE YOU BOTHERED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (e.g., heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (e.g., people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4

IN THE PAST MONTH, HOW MUCH YOU WERE BOTHERED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
9. Having strong negative beliefs about yourself, other people, or the world (e.g., having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (e.g., being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "super-alert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Appendix-G
Posttraumatic Cognitions Inventory
(Original Scale)

PTCI (ORIGINAL)

Your name: _____ Today's date: _____

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each by putting the appropriate number between 1 & 7 in the box to the right of the statement.

People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

		Totally Disagree	Disagree Very Much	Disagree slightly	Neutral	Agree Slightly	Agree Very much	Totally Agree
1	The event happened because of the way I acted.	1	2	3	4	5	6	7
2.	I can't trust that I will do the right thing.	1	2	3	4	5	6	7
3	I am a weak person.	1	2	3	4	5	6	7
4.	I will not be able to control my anger and will do something terrible.	1	2	3	4	5	6	7
5.	I can't deal with even a slightest upset.	1	2	3	4	5	6	7
6	I used to be a happy person but now I am always miserable.	1	2	3	4	5	6	7
7	People can't be trusted.	1	2	3	4	5	6	7
8.	I have to be on guard all the time.	1	2	3	4	5	6	7
9.	I feel dead inside.	1	2	3	4	5	6	7
10	You can never know who will harm you.	1	2	3	4	5	6	7
11	I have to be especially careful because you never know what can happen next.	1	2	3	4	5	6	7
12.	I am inadequate.	1	2	3	4	5	6	7
13	If I think about the event. I will not be able to handle it.	1	2	3	4	5	6	7
14	The event happened to me because of the sort of a person I am.	1	2	3	4	5	6	7
15	My reactions since the event mean that I am going crazy.	1	2	3	4	5	6	7
16	I will never be able to feel normal emotions again.	1	2	3	4	5	6	7
17	The world is a dangerous place.	1	2	3	4	5	6	7

		Totally Disagree	Disagree very much	Disagree Slightly	Neutral	Agree Slightly	Agree Very much	Totally Agree
18	Somebody would have stopped the event from happening.	1	2	3	4	5	6	7
19.	I have permanently changed for the worse.	1	2	3	4	5	6	7
20	I feel like an object, not like a person.	1	2	3	4	5	6	7
21.	Somebody else would not have gotten into this situation.	1	2	3	4	5	6	7
22.	I can't rely other people.	1	2	3	4	5	6	7
23.	I feel isolated and set apart from others.	1	2	3	4	5	6	7
24.	I have no future.	1	2	3	4	5	6	7
25	I can't stop bad things from happening to me.	1	2	3	4	5	6	7
26.	People are not what they seem.	1	2	3	4	5	6	7
27.	My life has been destroyed by the trauma.	1	2	3	4	5	6	7
28	There is something wrong with me as a person.	1	2	3	4	5	6	7
29.	My reactions since the event show that I am a lousy coper.	1	2	3	4	5	6	7
30.	There is something about me that made the event happen.	1	2	3	4	5	6	7
31	I feel like I don't know myself anymore.	1	2	3	4	5	6	7
32	I can't rely on myself.	1	2	3	4	5	6	7
33	Nothing good can happen to me anymore.	1	2	3	4	5	6	7

Appendix-H
Posttraumatic Checklist for DSM-5
(Translated Scale)

ہدایات: درج ذیل فہرست میں ایسے مسائل بیان کیے گئے ہیں جن کا اظہار لوگ اکثر انتہائی دباؤ/ تناؤ والے تجربات کے ردعمل کے طور پر کرتے ہیں۔ اپنے سب سے بد ترین واقعے کو ذہن میں رکھتے ہوئے برائے مہربانی ہر مسئلہ کو غور سے پڑھیں اور بیان کے سامنے دیے گئے کسی ایک نمبر پر دائرہ لگا کر اس مسئلے کی نشاندہی کریں جس نے پچھلے ایک ماہ سے آپ کو پریشان کر رکھا ہے۔

نمبر شمار	بیانات	کبھی نہیں	بہت کم	کبھی کبھار	اکثر اوقات	ہمیشہ
.1	ذہنی دباؤ کے تجربے سے متعلق مسلسل بے چین کرنے والی اور ناپسندیدہ یادوں کا آنا۔	0	1	2	3	4
.2	ذہنی دباؤ والے تجربے کے متعلق بار بار تکلیف دہ خواب آنا۔	0	1	2	3	4
.3	اچانک ایسے محسوس کرنا یا عمل کرنا جیسا کہ ذہنی دباؤ والا تجربہ حقیقت میں ہو رہا ہو (جیسا کہ حقیقت میں وہ تجربہ کرنے کے لیے میں واپس ہو گیا ہوں)۔	0	1	2	3	4
.4	بہت بے چینی محسوس کرنا جب کوئی چیز ذہنی دباؤ والے تجربے کی یاد دلائے۔	0	1	2	3	4
.5	جب کوئی چیز ذہنی دباؤ والے تجربے کی یاد دلائے تو سخت جسمانی ردعمل ظاہر کرنا۔	0	1	2	3	4
.6	ذہنی دباؤ والے واقع سے متعلق یادوں، سوچوں اور احساسات کو نظر انداز کرنا۔	0	1	2	3	4
.7	ذہنی دباؤ کے تجربے کو یاد دلانے والے عوامل کو نظر انداز کرنا (مثال کے طور پر لوگوں، جگہوں، گفتگو، سرگرمیاں، چیزیں یا صورت حال)۔	0	1	2	3	4
.8	ذہنی دباؤ والے واقعہ کے کسی اہم حصہ کو یاد کرنے میں دشواری ہونا۔	0	1	2	3	4
.9	لوگوں کے اور دنیا کے بارے میں پختہ منفی یقین رکھنا (جیسا کہ یہ سوچنا کہ میں برا ہوں، میرے ساتھ ضرور کچھ غلط ہے، کسی پر بھی بھروسہ نہیں کیا جا سکتا، دنیا مکمل طور پر خطرناک ہے)۔	0	1	2	3	4
.10	ذہنی دباؤ والے واقعہ یا اس کے بعد جو ہوا اس کے لیے خود کو یا کسی اور کو قصور وار ٹھہرانا۔	0	1	2	3	4
.11	شدید منفی احساسات رکھنا جیسا کہ خوف و ڈر، غصہ، احساس ندامت اور شرمندگی۔	0	1	2	3	4
.12	سرگرمیوں میں دلچسپی کھو دینا جن سے آپ لطف اندوز ہوتے تھے۔	0	1	2	3	4
.13	دوسرے لوگوں سے فاصلہ اور کٹا ہوا محسوس کرنا۔	0	1	2	3	4
.14	مثبت احساسات کا تجربہ کرنے میں اذیت ہونا (مثال کے طور پر خوشی محسوس کرنے اور اپنے قریبی لوگوں کے لیے محبت کے احساسات کا نہ ہونا)۔	0	1	2	3	4
.15	چڑچڑاپن، غصے کا ہیجان اور غصے سے پیش آنا۔	0	1	2	3	4
.16	بہت زیادہ خطرات مول لینا یا وہ کام کرنا جس سے آپ کو نقصان ہو سکتا تھا۔	0	1	2	3	4
.17	بہت زیادہ چوکس یا مستعد رہنا۔	0	1	2	3	4
.18	آسانی سے چونک جانا۔	0	1	2	3	4
.19	توجہ مرکوز کرنے میں مشکل ہونا۔	0	1	2	3	4
.20	سونے یا سوتے رہنے میں مشکل ہونا۔	0	1	2	3	4

Appendix-I
Posttraumatic Cognitions Inventory
(Translated Scale)

- Questionnaire on

"PTC1"

آج کی تاریخ:_____ آپ کا نام:_____

ہم کسی بھی صدمے کے بعد آنے والے خیالات کو جاننے میں دلچسپی رکھتے ہیں۔ نیچے دیئے گئے بیانات آپ کی سوچ سے ملتے جلتے یا مختلف ہو سکتے ہیں۔ برائے مہربانی ہر بیان کو غور سے پڑھنے کے بعد اپنی رائے دیں کہ آپ اس بیان سے کس حد تک متفق یا غیر متفق ہیں۔ اپنی رائے کا اظہار بیان کے بائیں جانب دیئے گئے خانے میں سے "۱" سے "۷" تک نمبر لکھ کر کیجئے۔

لوگ صدمے کی صورت میں مختلف طریقوں سے اپنا ردعمل ظاہر کرتے ہیں۔ ان بیانات کا صحیح یا غلط جواب نہیں ہے۔

بلکل غیر متفق ۱	کافی حد تک غیر متفق ۲	کچھ حد تک غیر متفق ۳	غیر جانبدار ۴	کچھ حد تک متفق ۵	کافی حد تک متفق ۶	بلکل متفق ۷

شمار	بیانات	۱	۲	۳	۴	۵	۶	۷
۱	یہ واقعہ میرے ردعمل کی وجہ سے پیش آیا۔							
۲	مجھے یقین نہیں کہ میں کوئی صحیح کام کر سکوں گا/گی۔							
۳	میں ایک کمزور انسان ہوں۔							
۴	میں اپنے غصے کو قابو نہیں کر سکوں گا/گی اور کچھ ہولناک کر بیٹھوں گا/گی۔							
۵	میں ایک معمولی سی پریشانی سے بھی نہیں نمٹ سکتا/سکتی۔							
۶	میں ایک خوش باش انسان ہو کرتا تھا/کرتی تھی مگر اب میں ہر وقت اذیت میں رہتا/رہتی ہوں۔							
۷	لوگوں پر بھروسہ نہیں کیا جا سکتا۔							

۸	مجھے ہر وقت چوکنا رہنا پڑتا ہے۔							
۹	میں اندر سے خود کو مردہ / بے جان محسوس کرتا / کرتی ہوں۔							
۱۰	آپ نہیں جان سکتے کہ کون آپ کو نقصان پہنچائے گا۔							
۱۱	مجھے خاص طور پر محتاط رہنا پڑتا ہے کیونکہ آپ نہیں جانتے آگے کیا ہو سکتا ہے۔							
۱۲	میں کسے قابل / اہل نہیں۔							
۱۳	اگر میں اس واقعے کے بارے میں سوچوں تو میں اُس سے نپٹنے سے قاصر ہوں گا / گی۔							
۱۴	میں اس قسم کا انسان ہوں۔ اسی لیئے میرے ساتھ یہ واقعہ پیش آیا۔							
۱۵	واقعے کے بعد میرے رد عمل ظاہر کرتے ہیں کہ میں پاگل ہو گیا / گئی ہوں۔							
۱۶	میں اب کبھی دوبارہ معمول کے جذبات محسوس کرنے کے قابل نہیں ہوں گا / گی۔							
۱۷	دنیا ایک خطرناک جگہ ہے۔							
۱۸	کوئی اور اس حادثے کو رونما ہونے سے روک سکتا تھا۔							
۱۹	میں ہمیشہ کے لیئے بدتر حالت میں بدل چکا ہوں۔							
۲۰	میں خود کو انسان نہیں بلکہ کوئی چیز محسوس کرتا / کرتی ہوں۔							
۲۱	کسی اور کا اس صورت حال سے سامنا نہیں ہونا چاہیئے۔							

۲۲	میں لوگوں پر انحصار / بھروسہ نہیں کر سکتا / سکتی۔							
۲۳	میں خود کو تنہا محسوس کرتا / کرتی ہوں اور الگ تھلگ رہتا / رہتی ہوں۔							
۲۴	میرا کوئی مستقبل نہیں۔							
۲۵	میں اپنے ساتھ ہونے والے بری چیزوں کو روک نہیں سکتا / سکتی ہوں۔							
۲۶	لوگ وہ نہیں جو نظر آتے ہیں۔							
۲۷	صدمے نے میری زندگی برباد کر دی ہے۔							
۲۸	بحیثیت انسان میرے ساتھ کوئی مسئلہ ہے۔							
۲۹	واقعے کے بعد میرے رد عمل ظاہر کرتے ہیں کہ میں ایک بہت ہی ناکارہ آدمی ہوں۔							
۳۰	مجھ میں کچھ ایسا ہے جس کی وجہ سے یہ واقعہ پیش آیا۔							
۳۱	مجھے لگتا ہے کہ اب میں اپنے آپ کو نہیں جانتا / جانتی۔							
۳۲	میں خود پر بھروسہ نہیں کر سکتا / سکتی۔							
۳۳	اب میرے ساتھ کچھ بھی اچھا نہیں ہو سکتا۔							

Appendix-J

Description of Narrative Exposure Therapy Sessions

Description of NET Sessions

NET is a short-term treatment approach that has been tested with varying lengths of treatment. The number of sessions required depends upon the setting and the severity of PTSD in your patient. Experiences implemented NET in African refugee settlements indicated that the minimum number of sessions required is four, each about 120 minutes in length. For the treatment of the survivors of torture, more sessions (typically 8 to 12, of 90 minutes each) may be necessary.

Narrative Exposure Therapy consisted of 12 sessions with a weekly frequency in the present study. The therapeutic process was divided into four steps with each step having its own number of sessions depending upon the techniques employed:

Step 1: Diagnosis and Psychoeducation (two session);

Step 2: Laying/Construction of Lifeline (four sessions);

Step3: Resolution of the problems, Rereading of the narrations (four sessions)

Step 4: Testimony/Signing of the documents (two sessions)

Step 1: Diagnosis and Psychoeducation

Session 1

Introduction. The therapist starts the first session in the following way:

a. Introduces himself or herself (name, profession).
b. Explains his or her interests (the purpose of the present project/mission).
c. Explains the ethical stance.
d. Evaluates the participant's expectations.
e. Builds trust and rapport
f. Establishes a clear psychiatric history and correct diagnosis of PTSD.

The patient has a right to know who the therapist is and what his or her motivations are. This initial phase and the way the therapist presents himself or herself and his/her work, is already a crucial trust-building step between therapist and the patient.

Pretreatment Diagnostics. When introducing the preliminary assessment to the patient, explain that the therapist has brought a set of questions with him/her that will cover symptoms that many survivors often suffer from.

a. Explain that it is necessary to gather this information to get a better idea of what the person is experiencing and that it will help the therapist to establish a diagnosis. Therapist should also be sure to mention that while some items may apply, others may not.
b. Before starting the interview ensure that the person has understood the importance of answering each question.
c. Finally, reassure the patient that all answers given will remain confidential.

Session 2

Psychoeducation. If the person suffers from PTSD, it is advisable to continue with psychoeducation immediately following the diagnosis. Initial patient education includes explaining the patient's condition such that he or she understands the diagnosis.

Psychoeducation includes the following elements:

- ***Normalization***: It is important to explain to the patient that it is normal/understandable to have such reactions after a trauma;
- ***Legitimization***: Explain that the symptoms experienced today are the result of responses from the traumatic situation;
- ***Description of trauma reactions***: It includes the related symptoms;
- ***Explanation of the therapeutic procedure***: It is very important to explain that this *healing journey* will only be possible when the patient is fully active in the process and fully aware of the procedure. Explain that imaginative exposure and habituation, narration are the step-by-step therapeutic process.

The above-mentioned elements result in the following:

- The patient should clearly understand what therapist is going to do and that he or she has voluntarily agreed to participate.
- The patient should understand what is expected of him or her in the process of NET.
- The patient should not be left with unanswered questions about the therapeutic activities and the techniques the therapist is employing.

Explaining the narration procedure. The therapist tells the patient clearly the narration procedure in the following manner:

Though telling your story, we want you to construct a detailed, comprehensive and meaningful narrative of the traumatic events in your life. The goal of having you retell the things that have happened to you is that you can reintegrate it into your and your people 's life history. We want to fill in all the gaps and holes until your testimony is complete. We want you to retell it to us until some of the bad feelings about the events subside, until some of the pain dissolves, and until the fear has a chance to defuse. In our experience, the more complete the narrative, the more the symptoms will get better. We will always go according to your life 's timeline. We will proceed in chronological order, step by step, as events unfolded. After this, we will go over it again, correcting and completing things, as necessary, until we reach a final version within 10-12 sessions. However, each single session will always be taken to a point of completion. It will last about 90-120 minutes. We will take enough time at the end of each session to make sure you are comfortable with whatever came up during our work.

Step 2: The Lifeline

Session 3: Laying/Construction of the Lifeline

After a diagnosis of PTSD has been established in the first session, and after psychoeducation has been provided, the lifeline is next, usually at the beginning of the third session. The lifeline has become a symbol for NET, because it represents the life "story" of a person in a ritualized and symbolic way. Hereby survivors lay out their path of life along a rope or string that symbolizes that contiguous flow of time. They place flowers for happy major events and good times in life. Flowers can serve as resources for life. Stones are placed as symbols for fearful and in particular for

traumatic events such as life-threatening experiences, violent acts, abuse, combat experiences, rape, assault, injury or harm, captivity, natural disasters, accidents, etc. It is good to offer a variety of stones (large and small) and flowers, so as to give the patient choices for the representation of events. The patient starts with a first symbol for his/her birth, which is put down at the very beginning of the rope. The symbols are then placed in chronological order. The therapist guides the patient to name and mark important events and turns in life. The therapist verbalizes and summarizes what he or she understands from the patient's "life-map." The lifeline is a useful roadmap for the therapist; it helps in structuring the coming sessions and allows the therapist to foresee the "big" stones-namely, major traumatic events or very difficult life periods. However, there is an important rule which must be kept in mind by the therapist that lifeline exercise must be concluded within one session. It is not advisable to distribute the lifeline work over several sessions. Executing the lifeline as a form of incomplete and superficial exposure to traumatic material would be a severe mistake. This would result in the patient's fortified avoidance and heightened anxiety. Therefore, make sure there is enough time to complete the lifeline in one go.

Session 4: Starting the Narration

The therapist helps the patient get started by asking the question "so, when/where were you born?" The patients are extremely tense, since they know that "it is going to happen today." The patients usually want to get the process over with as quickly as possible. For this reason, it is advisable to not waste too much time getting started. The narration will likely proceed through the following stages:

- Childhood ---- pretrauma (brief);
- First traumatic incident (detailed);

- Posttrauma (brief);
- Lifetime in between (very condensed);
- Second and following traumatic events (detailed);
- Outlook for the future (brief)

Recognizing the Traumatic Incident. One of the important steps about gathering the information from the narrative is developing the ability to recognize when the patient is discussing a traumatic event. The therapist identifies the traumatic event in a several possible ways:

a) The therapist can use the information gathered in the pretreatment diagnosis;
b) The patient's narrative may begin to be more fragmented and incoherent;
c) The patient gets nervous and emotional when discussing a traumatic event.

Assessing the Context of the Traumatic Event. The therapist clearly narrates the following contextual information before talking about the event in detail:

Time and setting: establish *when* the incident took place: Lifetime period, time of the year, time of the day, particular moment in the day.

Location and activity: Establish *where* the incident took place. Where was the person at that time? What was he/she doing?

Beginning: Establish the beginning of the incident. What points *marks the beginning* of this trauma or experience?

At this point in time the therapist makes sure to:

- Have survivor *imagine the beginning of the incident*. Begin to work through the incident from this point of the patient's imagination, viewing all of it in sequence.
- Go in *slow motion!*

- Help the patient to *focus on what was being perceived* during the traumatic event (physical sensations, thoughts, actions at the time- ask for shape and color of objects, types of smell, patterns of sounds, etc.).Support the processing of the material by following the emotional reactivity. Generate the physiology of that emotion. Pursue memorial association of the affect and generate memorial cues that elicit the physiological responsiveness.
- *Reinforce reality.* Prevent avoidance, dissociation, or flashbacks. Make sure that the person stays with the therapist in his/her consciousness in the present time and talks about the past.
- Do not allow the patient to be taken back completely in the past in the form of a flashback. *Keep the patient grounded in the present.*

Activating the "Hot" Memory. The core of NET is to link the hot memory- i.e., sensations, feelings, and thoughts to the corresponding sequences in the autobiography by putting all memory fragments into words and thus into declarative memory. The main procedure of emotional exposure within NET consists of two processes that must be present simultaneously:

1) The hot memory (the fear/trauma structure) must be activated.
2) The elements of the fear/trauma structure need to be put into words and inserted in the narration about the traumatic event.

Examples of questions used to target elements of the fear/trauma structure across different levels of processing.

Element of fear structure	Past	Present
Sensory	"What did the battered body look like?" "Could you hear the others screaming?" "Did you feel the pain in your body?"	"Do you have the pictures of the battered body in your mind right now like it was then?" "Can you feel the pain in your body right now like it hurt then? How does it feel?"
Cognitive	"Did you think that you would die at this moment?"	"What did you think then; what now?"
Emotional	"Did you feel intense horror at that moment?"	" Can you feel the horror right now, like it felt then?"
Physiological	"Did your heart beat fast at that moment?" "Did you sweat a lot at that time?"	"Can you feel your heart beating fast right now, like it was beating then?" "Are your hands sweating right now, like they were sweating then?"

Session 5: Habituation and Exposure session

Habituation is the decrease in symptoms that occurs after being exposed to the stressor for a significant amount of time. The continuous process of activating and narrating hot memory will lead to habituation, which means that the emotional impact and physiological arousal decreases over time. A session should never be stopped before some habituation has taken place. In fact, there has been evidence that ending a session when the emotion is still at its peak level of intensity, only serves to aggravate the symptoms (Rothbaum, Foa, Riggs, Murdoch, & Walsh, 1992). Habituation will continue to take place between sessions, as the patient will most likely to continue to think about the event differently from the way they did before treatment. By the final NET session, the therapist's goal is to achieve the maximum level of habituation possible.

Step 3: Resolution of the problems/ Rereading of the narrations

Session 6 & 7: Cognitive Restructuring and Diary Keeping

Cognitive restructuring means to modify the way one thinks. In NET sessions, cognitive restructuring starts after some habituation takes place when the patient makes sense of the trauma and to put meaning to the trauma. The therapist's task in these sessions is to replace the dark thoughts with more rational ones. After exposure to the memory of the incidents, the following *cognitive restructuring* process starts:

- With the help of the therapist the patient develops some *new insights about the meaning of the event* for her/his life. Often patients realize how the everyday emotions and unhealthy behavioral patterns such as general anxiety, mistrust, rage, anger have their origins in the traumatic event.

- The detailed narration often leads to *more thorough understanding of a person's behavior during the incident.* This will help to modify the resulting feelings of guilt and shame, as the patient comes to realize that he or she had no other choice at that time.

It is important for the therapist to inform the patient about the possibility that the patient may experience more unrest than usual or may suffer from an increased sensitivity to cues triggering the fear/trauma network. At this point of the therapy, the therapist asks the patient to start keeping a diary and write down anything that the patient observes. The life of the patient will start changing- not just internally, but also in interactions with others or in day-to-day behaviors.

Session 8 & 9: Monitoring of Levels of Parallel Processing and Rereading of the written narratives

The therapist's continuous monitoring is required for several processes going on in parallel during and between NET sessions:

1. The incident: what happened then, at the time of the incident? (past)
2. Here and now: what happens now during the session?
3. What is going on currently in the life of the client, and how does it influence the therapy? (present)
4. The narration and the narrative: during the session and when updating the testimony.
5. The therapeutic contact: how are "we" doing during and between sessions?
6. The therapist: how am "I" doing during and between sessions?
7. Cognitive and emotional reorganization: during and between sessions
8. Admin: timing, appointments, etc., during and between sessions.

Following all sessions, the therapist writes the first draft of the client's life narration up to the point at which the narration stops.

Session 10: Recognizing emotional and cognitive changes by the client

The therapist asks about changes in the client's perception with the help of following questions:

1. "Did you feel different this time when we talked about the traumatic incident?"
2. "How about your heartbeat? How was that?"
3. "What were you feeling this time?"

In this way the client starts to build up personal awareness about emotional and cognitive changes within herself/himself. By going through this step-by-step process of reading back the narrative to the client and having the details filled in, an entire narration or eyewitness testimony will be completed, including all traumatic events of that person's life in chronological order.

Another important component i.e. the promotion and the development of *strategies of self-protection* are also added to the original intervention. These strategies have allowed women to perceive themselves with control over their current life situation, knowing their existing rights and services that can aid their protection.

Step 4: Testimony and signing of the documents

Session 11: Preparation of the final draft

The written narratives from the previous sessions will be re-read to the client. Where appropriate, the client will be asked to fully imagine and relive the incidents with the purpose of correcting and detailing the report. The purpose of this is that the testimony and habituation process become more and more complete.

The therapist will help the client to look at the narrative with a sense of distance by saying that it's a sad but true story) or might look at this document as a tool for peace-building and educational purposes. Clients will learn to take their narratives lightly when they are reread to them, making some comments such as "It is kind of strange listening to my own words. I realize that my perception has changed a lot ....." It will promote *sense of personal growth* in the clients.

Session 12: Wrapping Up

Finally, the client, the translator and the therapist signs the written testimony. The signed document is handed to the client. If the client agrees, another copy is kept for scientific documentation purposes. The therapist asks the client to write one last paragraph about:

- How do you feel differently now, as opposed to when your trauma was occurring?
- What have you learned?
- Have you grown stronger in any ways?
- What would you say to someone who is going through the same experience?

Appendix-K
Plagiarism Report
(Turnitin Similarity Index)

INTERNATIONAL ISLAMIC UNIVERSITY

(Examination Branch)

***

No.IIU/Exam/2021-2613 Dated: 05 05 2021

Report of Plagiarism Check-I

Reference PHD Psychology thesis of Ms. Sameena Humayun Khan, Registration No.41-FSS/PHDPSY/F14, titled: **"EFFICACY OF NARRATIVE EXPOSURE THERAPY AMONG TRAUMATIZED WOMEN VICTIMS OF HUSBAND'S VIOLENCE".**

The Plagiarism check prescribed/authorized by HEC was processed on the thesis and report is as under:-

I The percentage of copied material/references is 16% which is less than the allowed limit i.e. 19%.

II The thesis has been accepted for evaluation.

(Ali Raafie)
Incharge (Research Section)

Copy to.

H.O.D (Psychology), IIU (F/C)