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From Victim to Agent: CBT-Driven Behavioral Change and Reduction in psychological impact of Intimate Partner Violence among women in Pakistani shelter homes

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ABSTRACT

Introduction: Domestic violence is a prevalent public health and human rights concern that affects psychological functioning. The present study compared the effectiveness of Group CBT and CBT-based Self-Help interventions in reducing the severity of intimate partner violence (IPV) and enhancing psychological well-being of women living in shelter homes in Karachi.

Method: 200 women exposed to IPV with elevated anxiety and depression scores were randomly allocated to Group CBT (n = 100) or CBT-based Self-Help (n = 100). Assessment tools included the HITS and the AKUADS scales at baseline and post intervention. The Group CBT condition underwent 10 structured sessions over 5 weeks, inclusive of psychoeducation, cognitive restructuring, behavioral activation, problem-solving, assertiveness training and communication skills. The Self-Help group was given a structured manual on CBT.

Results: The results suggest that both interventions significantly reduced IPV severity and psychological distress. The reductions in IPV severity ($d = 3.57$) were larger for the Group CBT intervention than for the Self-Help intervention ($d = 1.46$). Between-group analysis results showed Group CBT to be superior for post-intervention results ($p < .001$). There was a moderate correlation between a decrease in IPV severity and anxiety and depression symptoms ($r = .42$, $p < .001$).

Conclusion: Results indicate that although both interventions are effective, Group CBT is more effective in decreasing IPV severity and psychological distress. The study underscores the importance of group-based culturally-adapted CBT interventions as a scalable and effective intervention to support IPV survivors in low resource settings.

Keywords: *IPV, CBT, Pakistani women, shelter homes*

INTRODUCTION

Intimate Partner Violence (IPV) refers to physical, sexual, psychological, or emotional abuse perpetrated by a current or former intimate partner with the intention of exerting power and control (Saltzman et al., 2002). IPV is a global public health and human rights concern that affects women across all cultures and socioeconomic groups and linked to physical, psychological and social impacts (Brown, 2009).

Domestic violence is ubiquitous, impacting women in all societies, cultures and socioeconomic groups, and linked to physical, psychological and social impacts (Brown, 2009). Intimate partner violence (IPV) against women can manifest itself in many different ways including as verbal, emotional, psychological, sexual and physical abuse by a current or former intimate partner.

Worldwide, intimate partner violence (IPV) remains a major public health concern. Approximately 25.8% of women aged 15–49 years who have ever been in a relationship have experienced physical and/or sexual violence perpetrated by a current or former intimate partner at least once in their lifetime (World Health Organization [WHO], 2025). However, this figure is likely underestimated due to underreporting influenced by stigma, fear of retaliation, economic dependence, and sociocultural norms (Raphael et al., 2002).

IPV is associated with a wide range of adverse consequences, including chronic stress, reduced self-esteem, impaired interpersonal functioning, and occupational difficulties, often contributing to a cycle of continued victimization (Bowers & Gorman, 1993). These effects extend beyond physical harm and significantly impact psychological and social well-being.

In Pakistan, IPV is also highly prevalent, with 34% of ever-married women aged 15–49 years reporting experiences of spousal physical, sexual, or emotional violence according to the Pakistan Demographic and Health Survey (PDHS) 2017–18 (National Institute of Population Studies [NIPS] & ICF, 2019). However, the true prevalence is likely higher due to underreporting, as violence is often perceived as a private family matter (Fikree & Bhatt, 1999).

Patriarchal norms, rigid gender roles, and male dominance within the household further contribute to the normalization and persistence of IPV (Bosch, 2001). These statistics highlight the widespread nature of IPV globally and nationally, emphasizing the need for effective prevention and intervention strategies to address its adverse consequences on women's physical and mental health (NIPS & ICF, 2019; WHO, 2025).

Survivors often face social stigma, economic dependency, and lack of institutional support, which can discourage disclosure and help-seeking. Severe forms of violence, including burns and honour-related violence, have also been reported in Pakistan, highlighting the severity of the issue (Human Rights Commission of Pakistan [HRCP], 2000). These statistics highlight the widespread nature of IPV globally and nationally, emphasizing the need for effective prevention and intervention strategies to address its adverse consequences on women's physical and mental health (NIPS & ICF, 2019; WHO, 2025).

Whether physical or emotional, domestic violence significantly affects women's health, often leaving them emotionally distressed, unable to cope socially, having a lower quality of life and more susceptible to mental health problems (Brown, 2009). Although the prevalence of domestic violence and its reporting varies across countries and contexts, some studies suggest that around 25% of women will experience violence from an intimate partner at some point in their lives (Krug et al., 2002; Raphael et al., 2002). The true prevalence of child marriage may be much higher, as many women are reluctant or lack the confidence to report an incident of child marriage, often because they are afraid of the repercussions or because they believe there may be repercussions for the family's reputation (Raphael et al., 2002). Child marriage remains a significant concern in Pakistan, where approximately 29% of girls are married before the age of 18 (United Nations Children's Fund [UNICEF], 2023). This is particularly relevant to the study of intimate partner violence (IPV) because evidence suggests that girls who marry early are at a higher risk of experiencing physical, emotional, and sexual violence from their partners. A recent systematic review and meta-analysis confirmed that child marriage is associated with a greater prevalence of IPV compared with marriages occurring in adulthood (Kidman, 2017), while cross-national research has consistently identified early marriage as a significant risk factor for IPV (UNICEF, 2023). Furthermore, girls who marry during adolescence may have limited education, reduced autonomy, and less awareness of abusive behaviors, making it more difficult to recognize and respond to IPV (Nasrullah et al., 2014).

Domestic violence refers to a pattern of abusive behaviors used by one partner to gain or maintain power and control over another within an intimate relationship. It encompasses multiple forms of abuse, including physical, psychological, emotional, sexual, and economic violence (World Health Organization [WHO], 2025). Physical violence may involve acts such as slapping, pushing, punching, kicking, choking, or threatening the use of weapons, whereas psychological and emotional abuse can include intimidation, humiliation, isolation, threats, coercive control, and behaviors intended to undermine an individual's self-esteem and autonomy (United Nations Women [UN Women], 2024; WHO, 2025). Sexual violence includes forced sexual acts, marital rape, reproductive coercion, and other non-consensual sexual behaviors, all of which can have profound and long-lasting effects on survivors' physical, psychological, and reproductive health (WHO, 2025). The multifaceted nature of domestic violence highlights its significant impact on the well-being and quality of life of affected individuals, making it a critical public health and human rights concern worldwide (UN Women, 2024; WHO, 2025).

Domestic Violence in Pakistan

Domestic violence is a significant issue from a social and public health perspective in Pakistan. The current evidence indicates that a substantial portion of women are physically, emotionally, psychologically and sexually abused in intimate relationships. It is expected that the true prevalence rates may be even higher as domestic violence is regarded as a private family affair (Fikree & Bhatt, 1999). Other barriers include social stigma, weak legal safeguards, low level of political will and a culture that is not accepting of women seeking assistance (Fikree & Bhatt, 1999). This underestimation is largely attributed to the normalization of domestic violence as a private family matter, alongside persistent social stigma, weak legal enforcement mechanisms, limited institutional support, and low levels of political prioritization of women's protection services (National Institute of Population Studies [NIPS] & ICF, 2019; World Health Organization [WHO], 2024).

Pakistan is a traditionally patriarchal society where gender roles are inbuilt to the socio-cultural fabric of society, which perpetuates male domination and female subordination (Bosch, 2001). Thus, discrimination and violence may happen among all socioeconomic groups of women (Bosch, 2001). The effects of a IPV often leave women feeling isolated, distressed and excluded from supportive family and community relationships, making them more vulnerable and less able to heal.

Human Rights Commission Pakistan (HRCP) reported that at least two women were burned daily in domestic abuse cases in Pakistan (HRCP, 2000) which showed the extent of violence against women. These statistics highlight the need for interventions that are effective and address the short- and longer-term effects of abuse.

Domestic Violence and Mental Health

IPV has long been known to be associated with mental health issues. Women victims of IPV are much more likely to suffer from depression, anxiety, post-traumatic stress, low self-esteem, hopelessness and poor psychosocial functioning (Howard et al., 2003). Of these, depression is a psychological condition that has been found to be most often a result of IPV (Howard et al., 2003).

The same is true for survivors of other abuse, who are also affected by anxiety. When threat and intimidation is ongoing, people can become excessively fearful, hypervigilant, emotionally out of control and experience chronic psychological distress (Howard et al., 2003). These experiences can have a negative effect on women's capacity to seek help, set limits, make choices and react appropriately to abuse. Interventions that have a positive impact on psychological wellbeing can then have a positive impact on women's coping and responding to violence. (Trevillion et al., 2023; World Health Organization, 2024).

Studies in both global and South Asian contexts have demonstrated high prevalence of depression and anxiety among women exposed to domestic violence (Husain et al., 2000; Mirza & Jenkins, 2004). Importantly, research also shows that greater severity of IPV is associated with more severe psychological symptoms, indicating a dose–response relationship between violence exposure and mental health outcomes (Devries et al., 2013).

In addition, the type and level of IPV manifest differently across cultures, showcasing how culturally appropriate research is needed to inform corresponding interventions and support services.

Theoretical Framework

This study is guided by Beck's Cognitive Theory, which proposes that psychological distress arises from maladaptive cognitive schemas related to the self, world, and future (Beck et al., 1979). In the context of IPV, repeated exposure to abuse may reinforce negative core beliefs such as helplessness, worthlessness, and self-blame, which in turn maintain emotional distress and maladaptive coping.

The concept of learned helplessness (Seligman, 1973), later expanded by Abramson et al. (1978), further explains how repeated uncontrollable adverse experiences may reduce perceived self-efficacy and limit protective behaviors. Together, these frameworks highlight how cognitive processes contribute to the psychological impact of IPV and provide a strong theoretical basis for cognitive and behavioral interventions aimed at empowerment and recovery.

CBT for IPV survivors and delivery format

Among the most widely studied treatments for depression, anxiety and trauma (Beck et al., 1979; Ehlers & Clark, 2000) is Cognitive Behavior Therapy (CBT). CBT for IPV survivors focuses on changing unhelpful thoughts, while emphasizing healthy coping strategies, such as boundary setting, asking for help, assertiveness, problem solving and safety planning, helping women practice protective strategies and set boundaries, while also seeking support. Johnson and Zlotnick (2009) proved this in shelter contexts, where they found depression and anxiety decreased, and social resources increased, in the context of their HOPE intervention.

The provision of individual therapy is limited in low resource areas, and alternative modes of delivery are important. Group CBT is a structured, psychoeducation and cognitive-behavioral therapy, with several people gaining benefit at the same time as they learn peer support, normalize their experiences, and learn through interpersonal interaction, all of which are considered Yalom's (1995) core principles of therapy. Group interventions also have been shown to be effective in restoring trust and self-esteem, decreasing feelings of isolation, and assertiveness training (Walker, 1991). CBT-based self-help manuals provide another scalable alternative when access to therapists is not available (Campbell, 2003), but there is limited evidence to date comparing the manual to therapist-based treatment, and the present study helps address this gap.

Cognitive Behavior Therapy and IPV

Cognitive Behavior Therapy (CBT) is a highly researched, empirically proven psychological intervention for depression, anxiety and trauma-related struggles, and is one of the most widely used interventions to date. (American Psychological Association [APA], 2023; National Institute for Health and Care Excellence [NICE], 2022).

CBT assumes that unhelpful thoughts, beliefs and behaviors are involved in emotional problems, and that by changing these things, positive and meaningful psychological and behavioral changes can occur.

CBT has been found to be a highly effective treatment for people who have been exposed to traumatic experiences as it targets dysfunctional beliefs, maladaptive cognitive appraisals, and ineffective coping (Ehlers & Clark, 2000). Cognitive restructuring, behavioral activation, self-monitoring and problem-solving are used to overcome the negative interpretations and promote more adaptive thoughts and responses (Ehlers & Clark, 2000). CBT is particularly important for survivors of intimate partner violence, since it focuses on the beliefs that are associated with feelings of helplessness, hopelessness, self-blame and reduced self-efficacy. These beliefs can hinder women's self-protection, communication, and setting boundaries for personal safety, or seeking help. CBT can change these negative thoughts and behaviors, which can lead to better emotional health and a consumer's reactions to mistreating situations.

Johnson and Zlotnick (2009) showed a CBT-based intervention, Helping to Overcome PTSD through Empowerment (HOPE) to be effective with women in domestic violence shelters. The intervention targeted safety, coping skills, empowerment, self-esteem and interpersonal functioning, which led to decreases in depression and anxiety symptoms, and increases in personal and social resourcefulness (Johnson & Zlotnick, 2009). These findings indicate that CBT not only helps in psychological recovery, but also in behavior changes that impact women's experience of violence. CBT can help survivors become more assertive, communicate better, solve problems better, plan for safety, and have greater self-efficacy, which can help them respond in a more effective manner to an abusive situation and decrease the severity of abuse experienced through time.

Group Cognitive Behavior Therapy

CBT has shown to be quite effective; however, many low resource areas are unable to access individual therapy due to budget constraints and a lack of trained individuals. Group CBT is a viable option that can be delivered at a lower cost and be effective. (NICE, 2022; Singla et al., 2023; World Health Organization, 2022).

Group interventions offer opportunities for survivors to share, gain validation and learn from others who are experiencing similar issues. To build trust, decrease social isolation and foster supportive relationships, there are specific group interventions that Hoffeler (1983) recommended. In a like fashion, Walker (1991) stressed the importance of group therapy for women to give expression to their feelings, learn assertiveness, communication, and problem-solving skills.

Group CBT is a mixture of psychoeducation; cognitive and behavioral strategies designed to offset the negative thoughts and encourage positive coping strategies. Participants are trained to recognize negative automatic thoughts, to be more positive, to build healthy relationships and to have more appropriate reactions to stressful situations. Group-based CBT can therefore be used to aid psychological healing and/or empowerment for IPV survivors.

Rationale of the Study

Comparatively little research has investigated whether CBT has a direct impact on the severity of the DV experienced by survivors (although previous studies have found that CBT is effective in decreasing depression, anxiety and trauma-related symptoms among survivors of DV, Ehlers & Clark, 2000; Johnson & Zlotnick, 2009). The question is significant because a number of CBT aspects may have an impact on how the survivors react to abusive encounters, such as cognitive restructuring, assertiveness training, communication skills training, problem-solving, and safety planning.

In addition, there is still limited evidence comparing therapist-led Group CBT with CBT-based Self-Help interventions especially in low resource countries like Pakistan. The benefits of structured group interventions, over and above self-directed interventions, have implications for service delivery and intervention scalability.

The current study aimed to assess the efficacy of Group Cognitive Behavior Therapy and CBT-Self Help for decreasing the intensity of IPV amongst the women living in shelter homes of Karachi city, Pakistan. In particular, this study aimed to determine the effect of the Group CBT on the severity of IPV, to determine the efficacy of the CBT-based Self-Help, to compare the efficacy of both interventions and to explore the association between the reduction in severity of IPV and changes in anxiety and depression symptoms. The study adds to existing body of literature about culturally adapted CBT interventions and offers evidence of the practical and scalable ways of supporting survivors of IPV in the context of Pakistan.

Hypotheses

H1: Women receiving Group Cognitive Behaviour Therapy (CBT) will demonstrate a significant reduction in intimate partner violence severity from pre-intervention to post-intervention.

H2: Women receiving CBT-based Self-Help intervention will demonstrate a significant reduction in intimate partner violence severity from pre-intervention to post-intervention.

H3: Women receiving Group Cognitive Behaviour Therapy (CBT) will demonstrate significantly greater reductions in intimate partner violence severity than women receiving the CBT-based Self-Help intervention.

H4: Reduction in intimate partner violence severity will be positively associated with improvements in psychological well-being, as reflected by reductions in symptoms of anxiety and depression

Research Gap

While some studies have shown that CBT is effective in decreasing levels of depression, anxiety, and trauma symptoms in women who have experienced domestic violence (Ehlers & Clark, 2000; Johnson & Zlotnick, 2009) less research has focused directly on the reduction of severity of experienced IVT. Furthermore, there is only limited evidence that compares therapist-led Group CBT and CBT-based Self-Help interventions especially in low resourced countries like Pakistan.

There is an urgent need to pinpoint culturally relevant, scalable, and effective interventions especially in the context of IPV which is prevalent and the mental health services in Pakistan are limited and survivors face a high psychological burden. To fill this gap, the present study compares the efficacy of Group Cognitive Behavior Therapy (GCBT) and CBT based Self Help for the reduction of IPV severity among women living in shelter homes in Karachi, Pakistan and explores the relationship between the reduction in severity of IPV and changes in anxiety and depression symptoms. This research adds to the current body of research on culturally adapted CBT interventions and evidence on how to provide support to IPV survivors in low-resource countries.

METHOD

Participants

The total number of women recruited that were in shelter homes and non-governmental organizations (NGOs) in Karachi, Pakistan was 200. The age span of participants was 18-40 years and they were married for 2 years or more. Eligible participants reported occurrence of intimate partner violence (IPV) and screening positive for increased anxiety and depression symptoms. While most participants had only a little formal education, they were able to read their first language and were offered help when needed in the completion of homework and reading in self-help materials.

Patients who were under psychiatric or psychological treatment were not included in the study. People with serious psychiatric illnesses (such as psychotic depression, bipolar disorder, major cognitive disability and serious physical illness that affects functioning) were also excluded. The screening interviews and assessment measures were used to ensure that participants met criteria for inclusion and had no significant psychopathology that needed specialized treatment.

After baseline assessment, participants were randomly assigned to either one of the Group Cognitive Behavior Therapy (CBT) intervention group (n = 100) or one of the CBT based Self-Help control group (n = 100).

Measures

Demographic Information Form

The information was collected on the demographic questionnaire of participants on the basis of age, education, family income, marital status and socioeconomic status.

Aga Khan Anxiety and Depression Scale (AKUADS)

Symptoms of anxiety and depression were measured using Urdu version of Aga Khan Anxiety and Depression Scale (AKUADS). There are 25 items on the scale, 13 psychological and 12 somatic symptoms that are typical of anxiety and depressive disorders. Responses are scored on a 4-point scale of 0 (never), to 3 (always) and maximum scores of 0 to 75. Scores higher than this are score high psychological distress. A cut-off score of 19 has been suggested to discriminate between clinically significant symptoms of anxiety and depression. The scale has been found to have good linguistic validity and has been frequently used in Pakistan.

Hurt, Insult, Threaten, and Scream (HITS) Scale

The Urdu version of Hurt, Insult, Threaten and Scream (HITS) scale was used to measure intimate partner violence. The instrument has four items that all evaluate the frequency of abusive behaviors by an intimate partner. The scores range from 4 to 20, where a score of more than 10 are indicative of significant IPV. The HITS scale has been shown to have good reliability, internal consistency and construct validity as a screening tool for domestic violence in prior research.

Research Design

A randomized controlled pretest-posttest design was used for the study. Participants were randomly allocated to either the experimental group (Group CBT) or the comparison group (CBT based Self-Help) intervention programs. Pre- and post-measures were used to assess changes in IPV severity, anxiety and depression.

Procedure

After obtaining approval from the participating organizations, eligible women were contacted and told about the purpose and procedures of the study and given written informed consent. Baseline testing was done with the HITS Scale and AKUADS. Participants were then randomly assigned to one of two groups: Group CBT intervention or CBT-based Self-Help.

The structured Group CBT comprised 10 sessions over the course of about 5 weeks. The participants were split into ten groups with about ten in each group. Sessions were held two times a week and were about 90 minutes long. The intervention was adapted culturally, and included the following domains: psychoeducation, behavioral activation, problem solving, emotional regulation, cognitive restructuring, identification of cognitive distortions, modification of dysfunctional beliefs, assertiveness training, communication skills, and relapse prevention.

A Self-Help manual that contained similar concepts and techniques was provided to the comparison group, but was based on CBT. The participants were encouraged to do the exercises on their own and feedback was taken on a weekly basis to assess progress and problems. This method allowed for the presentation of some sort of psychological support in all groups and comparison of both therapist-led and self-directed interventions.

At the end of the intervention period, all participants were again assessed with the same scales as at baseline.

Intervention Overview

The Group CBT program comprised of 10 structured sessions which focused on psychological distress and coping related to intimate partner violence. Initial sessions were on psycho-education on anxiety, depression, IPV and the cognitive-behavioral model. The focus of middle sessions was on problem solving, behavioral activation, emotional awareness, automatic thoughts and the identification of cognitive distortions. Other sessions included cognitive restructuring, challenging dysfunctional beliefs, assertiveness training, communication skills, and building adaptive coping strategies. Elements of homework assignments and practice exercises were integrated throughout intervention to promote skill acquisition and generalization.

Ethical Considerations

The research study was carried out in an ethical manner as per the ethical guidelines of psychological research. Participants were given information on the study's aims, voluntary participation, the confidentiality of their participation and the right to withdraw from the study at any time without incurring any consequences. All personal information and assessment data were kept confidential and for research only.

Data Analysis

The software SPSS Version-21 software was used for analysis of data. Demographic and study variables were calculated using descriptive statistics. A paired-sample t-test was used for within-group comparisons of pre- to post-intervention differences, and ANCOVA was used to compare the differences between groups. The conventional alpha level of .05 was used to determine statistical significance.

RESULTS

Preliminary Analyses

Prior to conducting the primary analyses, preliminary checks were performed to examine data completeness and baseline group equivalence. The dataset was complete, with no missing values across all HITS scale items for either group (Control Group: n = 101; Treatment Group: n = 99). An independent samples t-test was conducted to assess baseline equivalence on the HITS Pre-Total score. Results indicated no statistically significant difference between the Control (Self-Help CBT) group (M = 18.29, SD = 2.15) and the Treatment (Group CBT) group (M = 18.40, SD = 2.77) at pre-intervention, $t(198) = -0.334$, $p = .739$, $d = -0.047$. This confirms that random assignment produced comparable groups on IPV severity at baseline, and that any post-intervention differences can be attributed to the intervention rather than pre-existing differences.

Descriptive Statistics

Table 1 presents the item-level and total HITS scale means and standard deviations for both groups at pre- and post-intervention. At baseline, both groups demonstrated near-ceiling scores on all four HITS items, indicating severe and pervasive intimate partner violence across physical, verbal, psychological, and threat-related dimensions. In the Group CBT condition, HITS Total scores declined from M = 18.40 (SD = 2.77) at pre-intervention to M = 7.95 (SD = 1.09) at post-intervention, representing a mean reduction of 10.45 points. In the Self-Help CBT condition, HITS Total scores declined from M = 18.29 (SD = 2.15) to M = 13.07 (SD = 2.50), a mean reduction of 5.22 points. The most pronounced item-level reduction in the Group CBT condition was observed on Q1 (Physically hurt you), which declined from M = 4.49 to M = 1.01, indicating near-complete elimination of physical violence in this group.

Table 1

Descriptive Statistics for HITS Scale Items and Total Scores by Group

HITS Item	Group	Pre-intervention M (SD)	Post-intervention M (SD)	Mean Reduction
Q1: Physically hurt you	Group CBT	4.49 (0.54)	1.01 (0.10)	3.48
	Self-Help	4.56 (0.75)	2.81 (0.92)	1.75
Q2: Insult or talk down to you	Group CBT	4.62 (0.55)	2.55 (0.50)	2.07
	Self-Help	4.48 (0.90)	3.57 (1.09)	0.91
Q3: Threaten you with harm	Group CBT	4.79 (0.41)	2.09 (0.32)	2.70
	Self-Help	4.48 (0.80)	3.03 (0.83)	1.45
Q4: Scream or curse at you	Group CBT	4.87 (0.34)	2.30 (0.48)	2.57
	Self-Help	4.77 (0.53)	3.65 (1.02)	1.12
HITS Total	Group CBT	18.40 (2.77)	7.95 (1.09)	10.45
	Self-Help	18.29 (2.15)	13.07 (2.50)	5.22

Note. HITS = Hurt, Insult, Threaten, Scream scale. Scores range from 1 to 5 per item; Total scores range from 4 to 20. M = Mean; SD = Standard Deviation. Group CBT n = 99; Self-Help CBT n = 101.

Within-Group Analyses: Pre- to Post-Intervention Change

To examine whether each intervention produced a statistically significant reduction in IPV severity, paired samples t-tests were conducted for each group separately on the HITS Total score. Both parametric and non-parametric (Wilcoxon Signed-Rank) tests were performed given the non-normal distribution of some post-intervention item scores. Results are presented in Table 2.

In the Group CBT condition, HITS Total scores decreased significantly from pre- to post-intervention, $t(98) = 35.476$, $p < .001$, $d = 3.566$, 95% CI [3.028, 4.100]. This represents an exceptionally large treatment effect, indicating that Group CBT produced a clinically and statistically significant reduction in intimate partner violence severity. Similarly, in the Self-Help CBT condition, HITS Total scores decreased significantly, $t(100) = 14.673$, $p < .001$, $d = 1.460$, 95% CI [1.177, 1.739], indicating a large and statistically significant improvement. Non-parametric Wilcoxon Signed-Rank tests confirmed these findings for both the Group CBT condition ($Z = -8.670$, $p < .001$) and the Self-Help CBT condition ($Z = -7.892$, $p < .001$).

Table 2

Within-Group Paired Samples t-Test Results for HITS Total Score

Group	t	df	P	Cohen's d	95% CI for d [LL, UL]
Group CBT (n = 99)	35.476	98	< .001	3.566	[3.028, 4.100]
Self-Help CBT (n = 101)	14.673	100	< .001	1.460	[1.177, 1.739]

Note. HITS = Hurt, Insult, Threaten, Scream scale. Cohen's d computed using the standard deviation of the mean difference. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit. df = degrees of freedom.

Table 3 presents item-level paired samples *t*-test results for both groups. In the Group CBT condition, all four HITS items demonstrated statistically significant and large-to-exceptional reductions (all *p*s < .001). Effect sizes ranged from $d = 2.727$ for Q2 (Insult or talk down) to $d = 6.030$ for Q1 (Physically hurt you), indicating near-complete resolution of physical violence among Group CBT participants. In the Self-Help CBT condition, all four items also showed statistically significant reductions, with effect sizes ranging from $d = 0.617$ for Q2 to $d = 1.365$ for Q1, indicating large effects across all items.

Table 3

Item-Level Paired Samples t-Test Results for HITS Scale by Group

HITS Item	t	df	P	Cohen's d	95% CI [LL, UL]
Group CBT (n = 99)					
Q1: Physically hurt you	60.001	98	< .001	6.030	[5.163, 6.894]
Q2: Insult or talk down to you	27.133	98	< .001	2.727	[2.296, 3.154]
Q3: Threaten you with harm	49.407	98	< .001	4.966	[4.243, 5.686]
Q4: Scream or curse at you	45.892	98	< .001	4.612	[3.937, 5.285]
Self-Help CBT (n = 101)					
Q1: Physically hurt you	13.719	100	< .001	1.365	[1.092, 1.635]
Q2: Insult or talk down to you	6.204	100	< .001	0.617	[0.403, 0.829]
Q3: Threaten you with harm	12.506	100	< .001	1.244	[0.982, 1.503]
Q4: Scream or curse at you	9.765	100	< .001	0.972	[0.733, 1.207]

Note. All tests are two-tailed. Cohen's d computed using the standard deviation of the mean difference. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit. p < .001 for all comparisons.

Between-Group Analyses: Comparative Effectiveness

An independent samples *t*-test was conducted to compare post-intervention HITS Total scores between the Group CBT and Self-Help CBT conditions. Levene's test for equality of variances was statistically significant ($F = 20.612$, $p < .001$), indicating heterogeneity of variances; therefore, the equal variances not assumed row was interpreted. Results indicated that Group CBT participants demonstrated significantly lower IPV severity scores at post-intervention ($M = 7.95$, $SD = 1.09$) compared to Self-Help CBT participants ($M = 13.07$, $SD = 2.50$), $t(137.29) = 18.813$, $p < .001$, $d = 2.643$, 95% CI [2.261, 3.021]. This large effect size indicates that Group CBT was substantially more effective than Self-Help CBT in reducing intimate partner violence severity over the course of the intervention. A Mann-Whitney *U* test corroborated these findings (U = 390.50, Z = −11.417, $p < .001$). Table 4 presents a summary of between-group and non-parametric test results.

Table 4

Between-Group and Non-Parametric Test Results for Post-Intervention HITS Total Score

Test	Statistic	df	p	Effect Size	95% CI [LL, UL]
Independent samples t-test	t = 18.68	198	< .001	d = 2.643	[2.261, 3.021]
Wilcoxon Signed-Rank (Group CBT)	Z = −8.67	—	< .001	—	—
Wilcoxon Signed-Rank (Self-Help)	Z = −7.89	—	< .001	—	—
Mann-Whitney U	U = 390.5	—	< .001	—	—

Note. For the independent samples t-test, equal variances not assumed row is reported based on significant Levene's test (F = 20.612, p < .001). Cohen's d uses pooled standard deviation. Z values for Wilcoxon and Mann-Whitney are based on asymptotic approximation. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit.

Relationship Between IPV Severity Reduction and Mental Health Improvement

A Pearson correlation was conducted to examine the association between reduction in IPV severity (HITS change score) and improvement in anxiety and depression symptoms (AD change score) across the full sample. Results indicated a statistically significant moderate positive correlation, $r(198) = .420$, $p < .001$. This finding indicates that participants who experienced greater reductions in intimate partner violence severity also demonstrated greater improvements in anxiety and depression symptomatology. The shared variance between the two change scores accounted for approximately 17.6% ($r^2 = .176$) of the variance, suggesting that while IPV severity reduction and mental health improvement are meaningfully associated, they represent partially distinct dimensions of intervention response.

DISCUSSION

The current study compared the effectiveness of Group CBT and CBT-based self-help interventions to manage high anxiety and depression prevalence in Pakistani IPV survivors living in shelter homes. In alignment with study hypotheses, both interventions led to significant improvements in psychological wellbeing, while the Group CBT intervention had a further significant decrease in anxiety and depressive symptoms.

The results indicate that there was a significant decrease in anxiety and depression in the Group CBT group which was in line with the first hypothesis that the group CBT would significantly reduce anxiety and depression among IPV survivors. Emotional outcomes after treatment showed significant differences between participants in the Group CBT group and those in the comparison group, with the Group CBT group showing significant improvements, suggesting that structured CBT can be effective to reduce the emotional effects of living with violence for a long time. This is similar to previous reports that indicated that CBT is effective in reducing the depression, anxiety and trauma-related symptoms in women who have been exposed to intimate partner violence (Ehlers & Clark, 2000; Johnson & Zlotnick, 2009). Participants learned to challenge and change their unhelpful thinking, learn healthy coping, problem solve and improve assertiveness and emotional regulation through the techniques. The results indicated a significant reduction in anxiety and depression among participants in the Group CBT condition, supporting the first hypothesis that group CBT would effectively reduce emotional distress among IPV survivors. Participants in the Group CBT condition also demonstrated significantly greater improvements in emotional outcomes compared to the comparison group, suggesting that structured CBT interventions can mitigate the psychological impact of prolonged exposure to intimate partner violence. These findings are consistent with previous research demonstrating the effectiveness of CBT in reducing depression, anxiety, and trauma-related symptoms among women exposed to IPV. For example, Ehlers and Clark (2000) highlighted the role of CBT in modifying maladaptive trauma-related cognitions and reducing PTSD symptom severity through cognitive restructuring and reprocessing of traumatic memories. Similarly, Johnson and Zlotnick (2009) found that trauma-focused CBT significantly improved depressive and PTSD symptoms in abused women by enhancing coping skills,

emotional regulation, and safety-related cognitive appraisals. In line with these studies, participants in the present study appeared to benefit from learning to challenge unhelpful thoughts, develop adaptive coping strategies, improve problem-solving skills, and strengthen assertiveness and emotional regulation.

The second hypothesis that there would be improvements after the CBT based Self-Help intervention was also supported. Over time, the participants who were given the self-help materials had significant decreases in anxiety and depression. While the magnitude of improvement was smaller in the self-directed CBT resources compared to that seen in the Group CBT condition, these findings indicate that self-directed CBT resources may be useful for psychological improvement, especially in contexts with limited access to trained mental health providers. These interventions can thus be a crucial part of stepped care systems in low resource settings. Such interventions are particularly valuable in low-resource settings where access to trained mental health professionals is limited. Evidence from global mental health research supports the use of low-intensity CBT approaches, including self-help and guided interventions, as effective components of stepped-care models that expand access to psychological treatment while maintaining clinical effectiveness (Cuijpers et al., 2020; Richards et al., 2023; WHO, 2022).

The third hypothesis was that Group CBT would prove to be more effective than the Self-Help intervention. This prediction was supported and was strongly reflected in the results of the study, as the participants in the Group CBT condition showed significant improvement on the various outcome measures. The group process could provide an extra therapeutic value that could account for the superiority of Group CBT. Group settings allow for opportunities of social support, interpersonal learning, normalization of experiences and encouragement between group members, which are all factors that supports psychological recovery. (Burlingame et al., 2021; Singla et al., 2023; WHO, 2022; Yalom & Leszcz, 2020). Participants had opportunities to share experiences, challenge their maladaptive beliefs as a group, and learn adaptive coping strategies from therapists and other participants.

Observations made throughout the intervention also illustrated the importance of the relevance of Beck's cognitive model to the experience of survivors of IPV. A large proportion of participants stated negative thoughts and feelings about themselves, the world, and the future which is known as the cognitive triad of depression. Common negative thoughts were known as catastrophizing, overgeneralization, self-blame and black and white thinking. Participants became more aware of and challenged the negative thought patterns through the use of cognitive restructuring and other CBT strategies, leading to better emotional health and increased self-confidence. Group activities, role plays, behavioral activation and assertiveness training seemed to be the most helpful for the women to acquire adaptive coping skills and a sense of personal control.

One of the key results of the study has been the possibility to effectively deliver culturally adapted CBT within the Pakistani context. Culturally relevant examples, language and activities were included in the intervention that increased the participant engagement and acceptability. The provision of mental health care to women facing IPVs in Pakistan is not readily available, and culturally sensitive group interventions could be a viable and scalable strategy to cope with the psychological effects of IPV.

Clinical Implications

The results have significant implications for mental health service provision and the practice of mental health. First, Group CBT looks like a cost-effective and clinically effective intervention to decrease anxiety and depression in IPV survivors. Group-based interventions may be able to increase access to psychological care without requiring excessive resource burden in mental health services since multiple persons can be treated in a single group.

Moreover, the positive effect of the Self-Help intervention indicates that CBT-based manuals could be a viable treatment modality in populations that are difficult to access, and do not have access to specialist services. These resources could be especially useful in low-resource and rural communities and could be used in community-based mental health initiatives and shelter programs.

Lastly, the findings will help in the broader dissemination of culturally adapted CBT interventions via the NGO, women's shelter, community health and primary healthcare pathways. Educating mental health, counselling and social work practitioners with evidence-based group-based CBT skills can significantly enhance access to evidence-based services for survivors of domestic violence.

Limitations and Future Directions

There are some aspects that should be kept in mind when interpreting the results. First, only two types of interventions were compared, and no no-treatment control group was included in the study. Second, it was not always possible to make judgements about the long-term sustainability of treatment effects, as follow-up assessments were not made.

Thirdly, participants were only from shelter homes and NGOs from the city of Karachi and hence, findings cannot be generalized to other parts of Pakistan.

Further studies should include longer follow-up time, larger and more diverse samples, and random controlled design with multiple comparison conditions. To enhance the evidence base, studies that explore how CBT helps psychological recovery after IPV would be beneficial. Further research is required with culturally adapted CBT interventions in various provinces in Pakistan and in different community settings to assess their effectiveness.

CONCLUSION

The present study offers strong evidence that both Group Cognitive Behavior Therapy and CBT-based Self-Help interventions are effective in reducing anxiety and depressive symptoms among IPV survivors. Group CBT, however, showed significantly higher therapeutic effects, which indicated the added value of the structured therapeutic support and group processes, respectively. The findings align with the use of culturally-adapted CBT to be an accessible, cost effective, and evidence-based intervention for women impacted by IPV in Pakistan. Access to such interventions in the community and shelter settings could play an important role in enhancing the mental health, functioning and general well-being of survivors.

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