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The Effectiveness of a Marital Violence Model on Women's Psychological Well-Being

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ABSTRACT

Purpose: The present study aimed to examine the effectiveness of a marital violence intervention model on improving psychological well-being among women experiencing marital violence who referred to welfare service centers in Kermanshah.
Methods and Materials: This applied study employed a quasi-experimental design with pretest–posttest and follow-up measurements including a control group. The statistical population consisted of women exposed to marital violence who had referred to Social Emergency Service centers, counseling centers, and welfare support institutions during 2023–2024. Using purposive sampling, 34 participants were selected and randomly assigned to experimental (n = 17) and control (n = 17) groups. Data were collected using the Haj Yahya Marital Violence Questionnaire (VTWI) and the Ryff Scales of Psychological Well-Being (RSPWB). The intervention consisted of a structured ten-session (90-minute) marital violence training program focusing on awareness of the violence cycle, emotional regulation, communication skills, empathy development, and conflict resolution strategies. The control group received no intervention during the study period. Data were analyzed using repeated-measures analysis of variance (ANOVA) in SPSS Version 26.
Findings: Repeated-measures ANOVA indicated significant effects of time ($F = 634.665$, $p \leq .001$, $\eta^2 = .952$), group ($F = 454.364$, $p \leq .001$, $\eta^2 = .934$), and time × group interaction ($F = 584.132$, $p \leq .001$, $\eta^2 = .948$) on psychological well-being scores. Multivariate tests (Pillai's Trace = .961, Wilks' Lambda = .039, $p \leq .001$) confirmed significant differences between experimental and control groups across measurement stages. Bonferroni post hoc comparisons demonstrated significant improvements from pretest to posttest and pretest to follow-up ($p \leq .001$). A significant difference between posttest and follow-up scores indicated partial decline in stability of intervention effects over time.
Conclusion: The marital violence intervention model significantly improved psychological well-being among women exposed to marital violence, suggesting that structured psychoeducational and skill-based programs can effectively enhance emotional functioning, relational competence, and psychological adjustment in vulnerable populations, although continued support may be necessary to sustain long-term outcomes.
Keywords: *Psychological well-being, marital violence, women.*

1. Introduction

Marital violence (also termed intimate partner violence in much of the international literature) is a pervasive and multidimensional phenomenon that undermines women's safety, dignity, and mental health, and it remains a major concern for psychological science, public health, and social policy. Contemporary evidence frames marital violence as encompassing physical assault, sexual coercion, psychological abuse (including humiliation, threats, intimidation, and chronic control), and economic/financial restriction—forms that often co-occur and intensify one another within the relational system. Cross-cultural analyses show that violence against women is not confined to a single society or cultural zone; rather, it is shaped by interacting structural, socio-cultural, and relational determinants, including gendered norms, economic constraints, and institutional responses (Alesina et al., 2016). Large-scale surveillance data have further documented the breadth of intimate partner and sexual violence, indicating substantial lifetime and recent prevalence in multiple jurisdictions and highlighting the enduring psychological sequelae associated with exposure (Smith et al., 2017). At the level of lived experience, qualitative evidence from diverse contexts shows that women frequently describe violence as "layered," beginning with controlling behaviors and verbal degradation and, over time, expanding to threats, physical harm, and coercive sexual practices, with profound impacts on emotional security, identity, and interpersonal functioning (Apatinga et al., 2021; Saeidi et al., 2020). Because marital violence is often embedded in social silence, stigma, and barriers to formal help-seeking, its mental-health burden can remain hidden, while its effects accumulate through repeated exposure and chronic stress activation.

From a psychological standpoint, marital violence is strongly linked to impaired psychological well-being—conceptualized not merely as the absence of disorder, but as a multidimensional construct involving autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Exposure to violence disrupts these domains by eroding a person's perceived agency, constraining freedom of action through coercive control, undermining relational trust, and producing persistent hypervigilance and self-blame. Biological and psychological explanations underscore how repeated threat and relational trauma can alter stress reactivity, emotion regulation, and cognitive appraisal patterns, thereby increasing vulnerability to depression, anxiety, dissociation, and diminished well-being (Azam Ali & Naylor, 2013). In marriage specifically, relational well-being is intertwined with individual mental health; empirical work suggests that marital functioning indices and emotional states influence one another over time, and depressive symptoms can co-occur with deteriorations in marital well-being in ways that exceed simple satisfaction metrics (Cao et al., 2017). This is particularly salient when the marital context is characterized by intimidation, fear, and an unstable sense of safety, as violence transforms the dyad from a potential source of support into a chronic stressor that compromises self-regulatory capacities and meaning-making processes.

The Iranian evidence base consistently indicates that domestic violence against women is shaped by a constellation of social, cultural, and interpersonal factors that operate at multiple ecological levels. Social-structural analyses have highlighted associations between violence and factors such as socioeconomic strain, community norms, and family power dynamics, suggesting that violence is maintained not only by individual pathology but also by enabling contexts that normalize aggression or limit women's access to resources (Mohammadi & Mirzaei, 2014; Yaghoubi & Raoufi, 2013). Studies in Tehran have similarly reported correlates of domestic violence linked to relational conflict and social pressures, reinforcing the need to approach violence as a systemic phenomenon rather than a purely private issue (Sadeghi et al., 2017). Qualitative research in Iranian social emergency services has documented the complexity of women's pathways into and out of violent relationships, including cycles of reconciliation, fear of social consequences, financial dependency, and limited supportive networks—factors that can constrain coping and intensify psychological distress (Bagherzaei et al., 2017; Saeidi et al., 2020). Complementing women's narratives, conceptual modeling from men's perspectives has attempted to map underlying drivers—such as learned gender scripts, anger dysregulation, cognitive justifications, and relational insecurity—illustrating how violence may be maintained through maladaptive beliefs and interactional patterns (Ghazizadeh et al., 2017). In addition, qualitative examination of psychological spouse abuse has underscored the centrality of nonphysical abuse (e.g., humiliation, isolation, threats) as a psychologically corrosive form of violence that may be minimized by families yet remains strongly damaging to well-being (Nouri et al., 2017).

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A central implication of this literature is that effective response requires more than crisis intervention; it requires evidence-based psychosocial models that address both the relational cycle of violence and the psychological mechanisms through which violence harms well-being. Research on the prevalence and patterns of family violence indicates that perpetration and victimization can be distributed across genders and contexts, but women experience disproportionate harms from severe and chronic forms, reinforcing the need for gender-responsive interventions (Mohammadkhani et al., 2010). Moreover, risk and maintenance factors may intersect with psychiatric vulnerabilities; evidence indicates that family violence may be associated with psychiatric disorders and related functional impairments, suggesting that comprehensive assessment must consider comorbid mental health issues and relational stressors together (Labrum & Solomon, 2016). At the same time, contemporary syntheses stress that what is "missing" in some domestic violence systems is an integrated, trauma-informed, and context-responsive approach that bridges prevention, therapeutic intervention, and service coordination (Edmunds et al., 2025). This emphasis aligns with trauma- and violence-informed frameworks that call for holistic programming, acknowledging that survivors' needs extend beyond symptom reduction to include empowerment, safety planning, social support, and restoration of agency (Williams et al., 2024). Within this broader movement, there has also been increased interest in restorative and justice-oriented pathways for domestic and sexual violence contexts, although evaluation of such approaches underscores the complexity of implementation and the necessity of survivor-centered safeguards (Lawler et al., 2025).

Intervention studies conducted in Iran provide important evidence that structured psychological and couple-based programs can reduce violence and improve women's functioning, though their mechanisms and sustainability require continued investigation. Cognitive-behavioral approaches have demonstrated effectiveness in reducing distress and improving quality of life in women exposed to domestic violence, indicating that modifying maladaptive cognitions, building coping skills, and strengthening emotion regulation can yield meaningful benefits (Zabihi Valiabad et al., 2017). Family-based cognitive-behavioral components have also been reported to decrease relational conflicts, suggesting that skills training (e.g., communication, problem solving, cognitive restructuring) can modify interactional patterns that fuel escalation and hostility (Goodarzi et al., 2018). Targeted couple therapy approaches focused explicitly on domestic violence have shown promise in reducing violence against women in maladjusted couples, supporting the clinical logic that changing dyadic patterns and accountability processes can decrease aggressive behavior when implemented under safe and appropriate conditions (Aslani et al., 2019). Newer interventions have compared empowerment-based educational programming with emotion-focused therapy for women experiencing domestic violence and reported differential effects on resilience and emotion regulation, reinforcing the utility of integrative models that combine skills building, emotional processing, and empowerment principles (Vejdani et al., 2025). At a broader evidence-mapping level, scoping review work has synthesized factors associated with domestic violence against women in Iran, strengthening the argument that multilevel interventions should be prioritized—spanning individual emotion regulation, couple dynamics, and socio-cultural barriers to support (Manzouri et al., 2025).

Emotion regulation appears particularly central as a mediator between violence-related stress and psychological outcomes. Empirical evidence suggests that emotion regulation strategies can account for variance in the relationship between personality vulnerabilities and marital violence, implying that deficits in regulating intense affect, impulsivity, and maladaptive coping may contribute to aggression, victimization dynamics, or both (Aftab et al., 2014). When violence is present, survivors may adopt emotion regulation strategies such as suppression, avoidance, or hypervigilance that can reduce short-term threat but worsen long-term psychological well-being by sustaining physiological arousal and impairing meaning-making. At the same time, psychological well-being in married women is intertwined with sexual schemas, sexual function, and broader relational processes, indicating that well-being is multi-determined and connected to intimate relational domains that violence can severely disrupt (Chalmeh & Abdollahi, 2019). Studies examining marital and sexual satisfaction also show bidirectional and dyadic influences over time, suggesting that intimate relationship functioning is dynamic and may influence emotional states and coping trajectories—an issue that becomes particularly salient when violence undermines sexual autonomy and safety (Cao et al., 2019). Relatedly, constructs such as intimacy, sexual satisfaction, and dysfunction have been used to predict attitudes and relational vulnerabilities

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(including attitudes toward infidelity), illustrating that intimate dissatisfaction may intersect with maladaptive relational behaviors and conflict escalation pathways (Soltanizadeh & Bajelani, 2020). In contexts where polygamy practices or informal marital arrangements exist, women's legal and social protections may be further complicated, potentially shaping vulnerability and access to support; legal perspectives have highlighted the need for protective frameworks addressing women's rights under such arrangements (Nurul Hikmah, 2020).

In addition to psychosocial and clinical determinants, legal and socio-institutional structures can indirectly influence mental health outcomes for women exposed to marital violence by shaping marriage stability, help-seeking routes, and the feasibility of separation or protective action. For example, reasons for divorce outside of formal court processes and their community consequences have been discussed in local legal scholarship, signaling that informal separations may carry distinct risks and barriers for women, including lack of enforceable protections or economic rights (Khairuddin, 2022). Related legal analyses have examined the implications of registered versus unregistered marriage clauses and family documentation, which can affect women's access to legal remedies and social services and, by extension, their psychosocial safety net (Febrianty et al., 2024). Although these legal discussions are not psychological interventions per se, they underscore a critical ecological point: psychological well-being cannot be fully protected when structural conditions restrict agency, safety, and service access, and thus effective intervention planning benefits from interdisciplinary awareness.

Within the socio-cultural landscape, emotional estrangement and "emotional divorce" have been investigated as relational outcomes shaped by socio-cultural context, suggesting that marital relationships may deteriorate into chronic disconnection long before formal separation occurs (Zahrakar et al., 2019). Such relational climates can operate as both risk factors and consequences of violence: chronic conflict, reduced empathy, and mutual invalidation may increase the likelihood of aggression, while violence accelerates emotional distance and erodes relational repair capacity. Internationally, narratives and empirical models continue to emphasize that violence is sustained through interacting mechanisms—individual vulnerabilities, learned norms, relational patterns, and institutional responses—implying that single-component solutions are rarely sufficient (Azam Ali & Naylor, 2013; Edmunds et al., 2025). Accordingly, a growing emphasis has been placed on comprehensive and structured intervention models—particularly those delivered in welfare and social emergency settings—because these contexts are often the first point of contact for women seeking help after repeated violence episodes (Bagherzaei et al., 2017; Saeidi et al., 2020).

Against this background, developing and evaluating an intervention model specifically designed to address marital violence and to improve women's psychological well-being is both clinically and socially consequential. A violence-focused model that increases awareness of the violence cycle, targets triggers and anger dysregulation, strengthens healthy communication and conflict resolution, and supports emotion regulation and self-protection capacities is theoretically aligned with the mechanisms highlighted across prior studies. Such a model can be expected to promote psychological well-being through multiple pathways: restoring perceived autonomy and environmental mastery via empowerment and skills, improving positive relations through safer communication patterns, enhancing purpose in life and personal growth by reducing chronic fear and enabling goal pursuit, and supporting self-acceptance by reducing self-blame and internalized stigma (Goodarzi et al., 2018; Williams et al., 2024; Zabihi Valiabad et al., 2017). At the same time, rigorous evaluation using controlled designs is necessary to determine whether such benefits exceed natural recovery, regression to the mean, or service-as-usual effects, particularly in welfare settings where participants may face ongoing stressors and social constraints (Edmunds et al., 2025; Manzouri et al., 2025). Therefore, the present study aimed to examine the effectiveness of a marital violence model on the psychological well-being of women exposed to marital violence who referred to welfare-related service centers in Kermanshah.

2. Methods and Materials

2.1. Study Design and Participants

The present study was applied in terms of purpose and employed a quasi-experimental method with a pretest–posttest–follow-up design including a control group. The target population consisted of all women who referred to Social Emergency Service centers, counseling centers, and other welfare service institutions for socially vulnerable individuals affiliated with the Welfare Organization of Kermanshah City during 2023–2024. The participants included women who had experienced marital problems and were victims of marital violence and who had sought

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counseling either through self-referral or through referral by Social Emergency Services and the 123 emergency hotline. Previous studies have used different sample sizes, including 36 participants divided equally between experimental and control groups (Soleimani & Khosravi, 2016), 24 participants with 12 individuals in each group (Asadpour, 2017; Alahverdi & Moradizadeh, 2020), and 30 participants with 15 individuals in each group (Yaghoubi & Nesaei Moghaddam, 2019). Similarly, research on quality of life has reported a total sample size of 37 participants (19 experimental and 18 control) (Zabihi Valilabad et al., 2017), while another study included 13 participants in each group (Karimifar, 2017). Other investigations have employed a total sample of 30 participants with 15 individuals assigned to each group (Taba, 2020; Namani et al., 2019). In the quantitative phase of the present study, to enhance external validity, improve generalizability, and prevent participant attrition effects, a total sample of 34 participants was selected, including 17 individuals in the experimental group and 17 individuals in the control group. Inclusion criteria were as follows: (1) willingness to participate voluntarily and cooperate in the research, including sharing experiences and completing questionnaires and research scales; (2) age not exceeding 55 years; (3) minimum educational attainment equivalent to lower secondary education; (4) experience of violence perpetrated by the spouse; (5) participants had not separated and were still living with their spouses; (6) participants were required to be native residents of the region; (7) at least three years had elapsed since marriage; and (8) obtaining a high score on the Haj Yahya Marital Violence Questionnaire. Exclusion criteria included: (1) simultaneous participation in other therapeutic groups or psychological interventions such as counseling services or psychiatric treatments including pharmacotherapy; (2) occurrence of divorce during the intervention period; (3) unwillingness to continue participation; and (4) absence from more than three intervention sessions. These criteria were selected to ensure that participants had experienced marital violence directly, possessed awareness of its underlying causes, and demonstrated willingness to engage in interviews and collaborative participation.

2.2. Measures

Marital violence was assessed using the standardized Haj Yahya questionnaire (1999). The validity of this instrument has been confirmed with a Cronbach's alpha coefficient exceeding .86. This questionnaire is considered one of the most standardized measures of violence against women and has been translated into Persian with confirmed psychometric validity and reliability indices. The instrument consists of 32 items rated on a Likert-type scale with response scores ranging from 1 to 5 and measures violence against women across four dimensions: psychological violence, physical violence, sexual violence, and economic/financial violence. The first factor, psychological violence, includes items 1–16; the second factor, physical violence, includes items 17–27; the third factor, sexual violence, includes items 28–30; and the fourth factor, economic violence, includes items 31–32. Scoring assigns values of 1, 2, and 3 to the response options "never," "once," and "two times or more," respectively. Total scores range from 32 to 96. Psychological violence scores range from 16 to 48, physical violence from 11 to 33, sexual violence from 3 to 9, and economic violence from 2 to 6 (Aslani et al., 2019). The final score for each participant is calculated as the sum of all item scores (Talebpour, 2017). Reliability assessment using Cronbach's alpha yielded coefficients of .71 for psychological violence, .86 for physical violence, .93 for sexual violence, and .92 for economic violence. Previous studies reported reliability coefficients of .97 (Etesami, 2012), .89 (Ghazanfari, 2010), and .86 (Dehghani, 2013) (Aslani et al., 2019). Additionally, total-scale reliability using Cronbach's alpha was reported as .91 in a sample of 130 participants (Khojastehmehr et al., 2014) and .76 in another study (Aslani et al., 2019). In the present study, the reliability coefficient calculated through Cronbach's alpha was .90.

Psychological well-being was measured using the short form of the Psychological Well-Being Scale developed by Ryff (1989). The scale contains 54 items rated on a six-point Likert scale ranging from "strongly disagree" to "strongly agree." The instrument assesses multiple dimensions including autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Ryff and Keyes (1995) reported a Cronbach's alpha coefficient of .52 for the overall scale. Jowshanloo, Rostami, and Nosratabadi (2007) evaluated the validity, reliability, and factor structure of the instrument within the Iranian population and reported a Cronbach's alpha of .60. Chalmeh (2011) also obtained an overall reliability coefficient of .72 using Cronbach's alpha (Chalmeh & Abdollahi, 2019). Items with negative scoring are reverse-coded during final scoring. No fixed cutoff score exists for defining high or low psychological well-being; instead, classification may be derived from the distribution

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of collected data. For example, high well-being may be defined as scores 1.5 standard deviations above the mean, whereas low well-being may be defined as scores 1.5 standard deviations below the mean (Majdabadi, 2015). In the present study, Cronbach's alpha reliability coefficient for the scale was .91.

2.3. Intervention

The marital violence model training program, designed by Walker et al. (2010), consisted of a ten-session intervention, each lasting 90 minutes, aimed at increasing couples' awareness of the cycle of violence, enhancing communication skills, and preventing harmful behaviors. Each session pursued a specific objective, including identification of triggers, anger management, empathy enhancement, and learning conflict-resolution strategies. Session content included psychoeducation on the violence cycle, analysis of dysfunctional beliefs, introduction of healthy communication strategies, relaxation training, and emotional regulation techniques. Intervention techniques included group discussion, role-playing, cognitive restructuring, communication skills training, thought monitoring, and breathing and relaxation exercises. To consolidate learning, participants received homework assignments at the end of each session, such as recording stressful situations, practicing healthy dialogue, performing breathing exercises, or documenting conflict-related cognitive patterns. The ten sessions were sequentially structured to enable participants to gradually develop awareness, interpersonal skills, and behavioral self-regulation necessary for breaking the cycle of violence.

2.4. Data Analysis

Data analysis was conducted using repeated-measures analysis of variance, and statistical analyses were performed using SPSS software, Version 26.

3. Findings and Results

The demographic characteristics of the sample based on educational level indicated that in the control group (n = 17), one participant had completed lower secondary education (5.88%), two participants held a high school diploma (11.76%), one participant had an associate degree (5.88%), ten participants held a bachelor's degree (58.82%), and three participants possessed a master's degree (17.64%). In the experimental group (n = 17), two participants had completed lower secondary education (11.76%), three participants held a high school diploma (17.64%), two participants had an associate degree (11.76%), nine participants held a bachelor's degree (52.94%), and one participant possessed a master's degree (5.88%). These findings indicate that, in both groups, the highest frequency corresponded to the bachelor's degree educational level.

Table 1

Mean and Standard Deviation of Psychological Well-Being and Its Components in the Experimental and Control Groups at Pretest, Posttest, and Follow-Up

Variable	Group	Study Phase	Mean ± SD
Autonomy	Control	Pretest	23.25 ± 2.43
		Posttest	25.52 ± 2.64
		Follow-up	25.82 ± 2.94
	Experimental	Pretest	26.23 ± 2.53
		Posttest	33.29 ± 2.05
		Follow-up	32.76 ± 2.10
Environmental Mastery	Control	Pretest	22.58 ± 1.97
		Posttest	22.35 ± 1.83
		Follow-up	22.17 ± 1.42
	Experimental	Pretest	23.76 ± 1.88
		Posttest	33.00 ± 2.76
		Follow-up	32.82 ± 2.57
Personal Growth	Control	Pretest	20.29 ± 2.61
		Posttest	20.17 ± 2.21
		Follow-up	20.58 ± 2.12
	Experimental	Pretest	21.58 ± 2.01
		Posttest	27.58 ± 2.12
		Follow-up	27.82 ± 1.87

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Positive Relations with Others	Control	Pretest	24.01 ± 3.00
		Posttest	24.23 ± 2.61
		Follow-up	23.76 ± 2.61
	Experimental	Pretest	25.70 ± 2.73
		Posttest	35.11 ± 1.32
		Follow-up	34.52 ± 1.97
Purpose in Life	Control	Pretest	21.52 ± 2.21
		Posttest	21.70 ± 1.92
		Follow-up	21.58 ± 1.62
	Experimental	Pretest	22.64 ± 1.21
		Posttest	30.58 ± 1.80
		Follow-up	31.47 ± 1.69
Self-Acceptance	Control	Pretest	21.69 ± 1.69
		Posttest	21.35 ± 1.22
		Follow-up	21.49 ± 1.63
	Experimental	Pretest	21.05 ± 1.43
		Posttest	29.70 ± 2.88
		Follow-up	30.17 ± 2.92
Total Psychological Well-Being	Control	Pretest	134.64 ± 6.07
		Posttest	135.35 ± 5.67
		Follow-up	135.88 ± 5.51
	Experimental	Pretest	140.75 ± 5.00
		Posttest	186.29 ± 6.18
		Follow-up	189.58 ± 4.79

The results presented in Table 2 indicate a statistically significant difference between the experimental and control groups in the total psychological well-being score. To determine the source of differences, repeated-measures multivariate analysis of variance was conducted on total psychological well-being scores

Table 2

Summary of Repeated-Measures Analysis of Variance for Pretest, Posttest, and Follow-Up Psychological Well-Being Scores

Test	Value	F	Hypothesis df	Error df	p	Effect Size
Pillai's Trace	0.961	380.033	2	31	≤ .001	0.961
Wilks' Lambda	0.039	380.033	2	31	≤ .001	0.961
Hotelling's Trace	24.518	380.033	2	31	≤ .001	0.961
Roy's Largest Root	24.518	380.033	2	31	≤ .001	0.961

The findings presented in Table 3 demonstrate that repeated-measures analysis of variance for the total psychological well-being variable was statistically significant. Therefore, a significant difference exists between the mean psychological well-being scores of the experimental and control groups.

Table 3

Repeated-Measures Analysis of Variance for Psychological Well-Being Scores in Experimental and Control Groups

Dependent Variable	Effect	SS	df	MS	F	p	Effect Size	Statistical Power
Psychological Well-Being	Time Effect	13618.843	2	6809.422	634.665	≤ .001	0.952	1.00
	Group Effect	34283.333	1	34283.333	454.364	≤ .001	0.934	1.00
	Time × Group Interaction	12534.490	2	6267.245	584.132	≤ .001	0.948	1.00

Based on the results reported in Table 4, significant differences were observed between pretest and posttest scores (intervention effect) as well as between pretest and follow-up scores (time effect) in psychological well-being ($p \leq .001$). A significant difference was also observed between posttest and follow-up mean scores, indicating that the intervention effect was not entirely stable over time. In other words, psychological well-being scores in the experimental group did not maintain a completely constant effect across the posttest and follow-up measurements.

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Table 4

Bonferroni Post Hoc Test for Comparing Pretest, Posttest, and Follow-Up Psychological Well-Being Scores in the Experimental Group

Variable	Comparison	Mean Difference	SD	p
Psychological Well-Being	Pretest vs. Posttest	−23.50	0.891	≤ .001
	Pretest vs. Follow-Up	−25.412	0.886	≤ .001
	Posttest vs. Follow-Up	−1.91	0.562	≤ .005
	Posttest vs. Pretest	23.50	0.891	≤ .001

4. Discussion and Conclusion

The present study examined the effectiveness of a marital violence intervention model on improving psychological well-being among women exposed to marital violence who had referred to welfare service centers. The findings demonstrated that participation in the intervention led to a statistically significant improvement in total psychological well-being and all its components—including autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance—compared with the control group. Repeated-measures analysis confirmed significant time effects, group effects, and interaction effects, indicating that the observed improvements were attributable to the intervention rather than natural change or measurement fluctuation. The Bonferroni comparisons further showed meaningful differences between pretest and posttest scores and between pretest and follow-up measurements, supporting the immediate effectiveness of the model. However, the difference between posttest and follow-up scores suggested partial decline or instability of effects over time, highlighting the dynamic nature of recovery from marital violence and the need for sustained support.

One of the central interpretations of these results relates to the multidimensional impact of marital violence on psychological functioning. Psychological well-being is closely linked to perceived agency, emotional safety, relational trust, and self-worth. Exposure to chronic violence undermines these domains by creating persistent fear, learned helplessness, emotional exhaustion, and identity erosion. The observed improvement in autonomy and environmental mastery among participants in the experimental group indicates that the intervention likely strengthened participants' sense of personal control and coping capacity. These findings align with theoretical explanations emphasizing that intimate partner violence disrupts emotional regulation systems and cognitive appraisal processes, which subsequently diminish psychological adjustment (Azam Ali & Naylor, 2013). By targeting awareness of the violence cycle, emotional triggers, and communication skills, the intervention appears to have helped participants reinterpret relational experiences and reestablish adaptive self-regulatory mechanisms.

The significant enhancement in positive relations with others and self-acceptance observed in the intervention group is consistent with relational and interpersonal theories of marital functioning. Research suggests that marital well-being extends beyond satisfaction and is strongly associated with emotional security and supportive interaction patterns (Cao et al., 2017). Violence distorts these relational processes through coercion, humiliation, and isolation, leading women to internalize blame and withdraw socially. Interventions that promote empathy, assertiveness, and constructive dialogue can therefore reverse relational damage and restore interpersonal confidence. Similar improvements have been reported in domestic violence–focused couple therapy interventions, which demonstrated reductions in violence and improvements in relational functioning following structured therapeutic engagement (Aslani et al., 2019). The present findings reinforce the view that psychological recovery in violence survivors is inseparable from relational reconstruction and emotional validation.

The improvement in personal growth and purpose in life observed in the experimental group also deserves attention. Survivors of marital violence often experience disrupted life narratives, diminished future orientation, and restricted goal-setting capacity due to prolonged exposure to threat and control. Trauma-informed intervention frameworks emphasize rebuilding meaning and fostering empowerment as essential mechanisms of recovery (Williams et al., 2024). The structured training sessions implemented in the present study—particularly those focusing on cognitive restructuring, emotional awareness, and conflict resolution—likely facilitated cognitive reframing processes that enabled participants to perceive themselves as active agents rather than passive victims. Evidence from

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empowerment-based educational programs similarly demonstrates improvements in resilience and emotion regulation among women experiencing domestic violence, supporting the effectiveness of skill-based psychosocial models (Vejdani et al., 2025).

The results are also consistent with cognitive-behavioral perspectives suggesting that maladaptive beliefs and dysfunctional interaction patterns play a central role in sustaining violence cycles. Teaching communication and problem-solving skills can reduce escalation patterns and emotional reactivity within intimate relationships (Goodarzi et al., 2018). Prior research has shown that cognitive-behavioral therapy improves quality of life and reduces distress among women victims of domestic violence, indicating that psychological interventions targeting cognition and behavior can produce meaningful mental health outcomes (Zabihi Valiabad et al., 2017). The present study extends these findings by demonstrating that a structured marital violence model implemented within welfare settings can generate measurable improvements across multiple psychological well-being domains.

Another important interpretation concerns emotion regulation as a mediating mechanism. Empirical evidence has shown that emotion regulation strategies play a mediating role between personality vulnerability and marital violence dynamics (Aftab et al., 2014). Women exposed to violence often adopt maladaptive coping strategies such as emotional suppression or avoidance, which may temporarily reduce conflict but perpetuate psychological distress. The intervention's focus on recognizing triggers, managing anger, and practicing relaxation techniques likely enhanced adaptive regulation strategies, thereby improving emotional stability and psychological functioning. These findings correspond with qualitative studies reporting that survivors' recovery trajectories depend heavily on developing awareness of emotional patterns and acquiring effective coping skills (Saeidi et al., 2020).

The significant differences between experimental and control groups also highlight the importance of structured institutional support. Studies conducted in social emergency service contexts demonstrate that women who seek assistance frequently face complex socio-cultural barriers, including stigma, economic dependency, and fear of social judgment (Bagherzaei et al., 2017). Without targeted intervention, psychological distress may persist despite access to services. The improvement observed among participants receiving the intervention suggests that welfare centers can serve not only as crisis-response institutions but also as therapeutic environments promoting long-term psychological recovery. This interpretation aligns with broader analyses emphasizing that domestic violence requires coordinated psychosocial responses integrating therapeutic, social, and institutional dimensions (Manzouri et al., 2025).

The partial reduction in intervention stability observed at follow-up provides another meaningful insight. Recovery from marital violence is rarely linear; ongoing exposure to relational stressors, social pressures, or unresolved legal and economic challenges may weaken initial gains. Legal and social structures surrounding marriage, divorce, and family recognition can influence women's sense of security and autonomy, indirectly affecting psychological outcomes (Febrianty et al., 2024; Khairuddin, 2022). Moreover, emotional divorce and chronic relational dissatisfaction may persist even after behavioral improvements, requiring longer-term intervention or booster sessions (Zahrakar et al., 2019). These findings are consistent with literature suggesting that violence-related trauma involves enduring cognitive and emotional patterns requiring sustained therapeutic engagement rather than short-term treatment alone (Edmunds et al., 2025).

The findings also support cross-cultural evidence demonstrating that domestic violence is embedded within broader social contexts, including gender norms, economic inequality, and cultural expectations surrounding marriage (Alesina et al., 2016). Studies examining violence prevalence and determinants across societies confirm that psychological consequences are remarkably consistent despite cultural variation (Smith et al., 2017). Iranian research similarly identifies social and relational determinants such as conflict patterns, gender expectations, and socio-economic pressures as contributing factors to violence against women (Mohammadi & Mirzaei, 2014; Sadeghi et al., 2017; Yaghoubi & Raoufi, 2013). The effectiveness of the intervention in the present study therefore demonstrates that culturally adapted psychological programs can mitigate the impact of these structural risks by strengthening individual coping and relational skills.

Another noteworthy implication concerns the role of intimacy and sexual satisfaction within marital relationships. Research shows that relational dissatisfaction, intimacy difficulties, and sexual dysfunction are associated with marital conflict and maladaptive relational attitudes (Soltanizadeh & Bajelani, 2020). Psychological well-being improvements observed in the present study may partly reflect increased emotional communication and mutual

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understanding fostered through intervention activities. Evidence linking sexual schemas and psychological well-being among married women supports the view that relational intimacy and emotional security are closely interconnected components of mental health (Chalmeh & Abdollahi, 2019). Therefore, interventions addressing violence must consider emotional, cognitive, and intimate dimensions simultaneously.

Furthermore, broader theoretical models emphasize that family violence often intersects with psychiatric vulnerability and stress-related disorders, reinforcing the importance of integrated psychosocial treatment approaches (Labrum & Solomon, 2016). Violence exposure may exacerbate existing mental health difficulties, while improved psychological well-being can serve as a protective factor reducing vulnerability to future abuse cycles. Narrative reviews of domestic violence literature highlight the importance of comprehensive responses addressing prevention, recovery, and long-term resilience (Lawler et al., 2025). The positive outcomes of the present study contribute to this growing evidence base by demonstrating that structured educational and therapeutic programming within welfare systems can play a meaningful role in recovery.

Overall, the findings indicate that the marital violence intervention model effectively enhanced psychological well-being among women exposed to violence by improving emotional regulation, interpersonal functioning, cognitive appraisal, and perceived empowerment. The results corroborate existing national and international research demonstrating that targeted psychosocial interventions can mitigate the psychological harms associated with marital violence and promote recovery trajectories grounded in resilience and agency (Apatinga et al., 2021; Lawler et al., 2025; Nurul Hikmah, 2020). These outcomes underscore the necessity of integrating evidence-based psychological programs into social welfare services and highlight the potential of structured interventions to transform crisis services into pathways toward sustained psychological health.

Despite its valuable contributions, the present study had several limitations. The relatively small sample size limits the generalizability of findings to broader populations of women experiencing marital violence. Participants were recruited from welfare service centers, meaning that the sample may not represent women who experience violence but do not seek formal help. Self-report measures may also have introduced response bias due to social desirability or fear of disclosure. In addition, environmental and relational conditions outside the intervention sessions—such as ongoing marital conflict or economic stress—were not fully controllable and may have influenced follow-up outcomes. The follow-up period was relatively short, preventing assessment of long-term sustainability of intervention effects.

Future studies should employ larger and more diverse samples across multiple regions and service contexts to improve external validity. Longitudinal research with extended follow-up periods is needed to examine durability of psychological well-being improvements and relapse patterns. Comparative studies evaluating different intervention models—such as trauma-focused therapy, empowerment-based programs, and couple-oriented interventions—would clarify mechanisms of change. Incorporating mixed-method designs could provide deeper insight into participants' lived experiences and perceived pathways of recovery. Future research should also examine mediating variables such as resilience, social support, attachment style, and emotion regulation to better understand how psychological interventions influence recovery trajectories among survivors of marital violence.

Practically, welfare organizations and counseling centers should integrate structured marital violence intervention programs into routine services for women exposed to violence. Training mental health professionals in trauma-informed, empowerment-oriented approaches may enhance service effectiveness. Continuous follow-up sessions or booster interventions are recommended to maintain therapeutic gains over time. Collaboration between psychological services, legal support systems, and social welfare agencies can create comprehensive support networks addressing both psychological and socio-economic needs of survivors. Preventive educational programs aimed at couples and communities may also reduce normalization of violence and promote healthier relationship patterns, ultimately contributing to improved psychological well-being and family stability.

Authors' Contributions

All authors significantly contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

In this study, to observe ethical considerations, participants were informed about the goals and importance of the research before the start of the interview and participated in the research with informed consent.

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