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The Effects of Psychodrama Intervention on Intimate Partner Violence and Quality of Life: Trial of Syrian Refugee Abused Women

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The Effects of Psychodrama Intervention on Intimate Partner Violence and Quality of Life: Trial of Syrian Refugee Abused Women

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Abstract

This randomized controlled study assessed the efficacy of group psychodrama intervention in reducing Intimate Partner Violence (IPV) and enhancing Quality of Life (QoL) for Syrian Refugee Abused Women (RAW) who were living in the Al- Zaatari refugee camp in Jordan. Forty IPV refugee Syrian women were randomly assigned to either the psychodrama group (n=20) or the control/comparison group (n=20). The DVQ and WHOQOL-100 were used to assess the IPV and QoL, respectively. The psychodrama group attended 12 psychodrama sessions (one session per week). The results indicated that the psychodrama group participants demonstrated a statistically significant decrease in IPV severity and enhancement in all QoL sub-dimensions (with one exception of the environmental sub-dimension). The study suggested and recommended other family members involved in any further family counseling interventions for refugees.

Keywords: Psychodrama intervention, IPV, Quality of life, Abused refugee women

Introduction

Intimate Partner Violence (IPV) perpetrated by a current or former partner is the most common violence type, targeting women. IPV continues to be the primary violation of women's fundamental rights, as well as a significant public health problem (Igbolekwu et al., 2021; Lövestad, et al., 2017). Intimate Partner Violence is defined by the World Health Organization (World Health Organization [WHO], 2010) as any behavior within a personal and intimate relationship that causes physical, sexual, and psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors. According to WHO (WHO, 2013) statistics, more than 30% of women are victims of IPV worldwide.

A substantial number of studies consider IPV a risk factor for health problems (Feseha et al., 2012), including injury and death. Therefore, it can be considered a significant public health problem (Damra & Abujilban, 2018; Igbolekwu et al., 2021).

Refugee women are more likely to experience a high level of violence, and it has negative consequences. Marjan and his colleagues (2019) revealed that about 79.8% of the Afghani refugee women experienced at least one form of violence in the past 12 months. Some efforts suggested that IPV is just one of the challenges and traumatic experiences for refugee women (Godoy-Ruiz et al., 2015). Feseha et al. (2012) argued that refugee women are being victimized twice in their lives due to the sustained military conflicts and subjection to IPV from their husbands.

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The association between the short- and long-term adverse effects of violence as manifested by the physical and mental health consequences upon Quality of Life (QoL) was cited (Costa et al., 2015; Leung et al., 2005). Damra and Ghbari (2015) argued that it is essential to proceed beyond statistical and descriptive studies when studying family violence. Considering the high social and individual costs of IPV, there is a great need to study the effectiveness of different IPV victims' interventions (Damra et al., 2015). Therefore, the current study's primary goal is to study the effect of psychodrama intervention on experienced IPV and QoL.

Implementing family counseling interventions for IPV in a refugee community in Jordan may present some challenges and limitations for its eastern traditions and conservative nature (National Council for Family Affairs [NCFA] & United Nations Higher Commission for Refugee [UNHCR], 2017). For example, families with this cultural background and abusive husbands' in particular were less interested in healing the IPV consequences, which may be the most challenging aspect of the helping and counseling process (Damra & Abujulban, 2020). Intervention within the family counseling programs to deal with IPV refugee cases is considered unique for its significant components, and it goes beyond the current traditional treatment methods (e.g., protection procedures). Moreover, according to the traditional eastern culture, external interference in some marital issues can be considered intrusive (Damra & Abujulban, 2020; NCFA & UNHCR, 2017). Therefore, the implementation of anti-IPV interventions challenges some inaccurate beliefs and traditions, which control IPV occurrence in the communities (NCFA, 2006).

In such a refugee community, empowering women can take a more proactive approach toward helping them fight violence, enhance the quality of life, and reduce the IPV as a result. It has been long established that the dramatization of dysfunctional elements can bring great therapeutic benefits to people's lives within the public performance (Akbiyik et al., 2020). Turner and his colleagues (2020) estimated that psychosocial interventions can reduce IPV by up to 27% for any form of IPV, up to 27% for physical IPV, and up to 23% for sexual IPV. This finding could support any suggested psychosocial interventions for dealing with IPV.

All our work on psychodrama is related to the early Moreno's (1889– 1974) work. Moreno (1978) defined psychodrama as a scientific exploration of truth via a dramatic method. It is widely recognized as a form of psychological intervention in which the client enacts or reenacts situations that bear emotional significance and importance for him/her. Psychodrama is an expression of an individual's intellectual and emotional processes through speech and body activation (Treadwell & Dartnell, 2017; Emunah, 1994). In typical psychodrama sessions, clients act out directly to different personalities that are significant to them through 3 different components: warming up, action, and sharing (Treadwell et al., 2002). In group settings, the psychodrama practice becomes more complicated, and each member is considered as a therapeutic agent of the other, contributing to each other's transformation and facilitating personal growth. Such techniques and processes help participants obtain insights into their personalities and feelings and those of others. Johnson and Lewis (2000) stated that most drama therapists discover the exciting possibilities of therapy by experience—not theory—so the possibility of employing processes and techniques of drama therapy and psychodrama to help women overcome fears of IPV is promising.

Psychodrama is a therapeutic practice form in which the therapist encourages the client to use his/her body as a medium for unearthing personal truths and healing from traumatic experiences instead of verbal interactions (Fong, 2007). In one way, this practice is unique from other known therapies; although it involves verbal communications, it is not overly dependent on such models of treatment (Little, 2017). In psychodrama, speaking through body movement is essential and primary. Due to the nature of psychodrama, it is most commonly activated in

counseling and therapy groups. Using psychodrama within groups treatment for abuse survivors is usually an essential step in the recovery process and is incredibly helpful with these clients. It is especially useful when combined with concurrent individual treatments (Little, 2017).

Psychodrama interventions were found useful for supporting abused women to deal with IPV problems (Bucuţă et al, 2018; Dayton, 2013; Mondolfi & Pino-Juste, 2020; Naar et al., 1998; Torre, 1990). Versari (2014) reported the effectiveness of psychodrama techniques to help victims of interpersonal violence to overcome violence's negative consequences.

Psychodrama could help women who have had abusive relationships to seek therapy to regain their sense of personal power and support and understand the experience of abuse in hopes that they will not repeat the abusive pattern (Fong, 2007; Mondolfi & Pino-Juste, 2020). Psychodrama techniques may also add to the effectiveness of other used interventions, for instance, Cognitive Behavioral Therapy (Dayton, 2013; Hamamci, 2002) and Family Therapy (Farmer & Gelle, 2005).

Bucuţă et al. (2018) discussed how the psychodrama method and its techniques could support and empower abused women and stimulate changes in their victim role. They considered a psychodrama intervention as an optimizing gender violence intervention. Dayton (2013) argued that psychodrama interventions have a significant advantage as a means of changing behavior since it is based on theories of action, creativity, and spontaneity. It involves the person holistically (body, emotions, and mind). In the IPV victim empowerment psychodrama scene, she (protagonist) enacts her inner world, exploring parts of it with the support of the other group members, who play their assigned roles (auxiliary ego) (Moreno, 2009).

Psychodrama interventions were recommended to be used for IPV victims for their role to offer a living laboratory in which former victims, in a safe therapeutic environment, have the chance to contemplate and experience their own lives, meet themselves, their perceptions of self, and their relational experience (Bucuţă et al., 2018; Dayton, 2013; Mondolfi & Pino-Juste, 2020; Versari, 2014).

It enables a woman to process the roles taken on and change behavior through exploratory, healing role play and role training (Dayton, 2013). Psychodrama aims to access the experience of spontaneity to produce creative and new solutions to old sufferings and problems. The psychodrama techniques emphasize the changing role, which is a key element in promoting resilience (Bucuţă et al., 2018).

Despite the benefits that can be obtained from applying the psychodrama techniques with IPV victims, implementing psychodrama activities in the Arabic refugee population may present some challenges and obstacles. According to the adapted religion and traditions, some consider dancing, singing, and using music or musical instruments for adults unapproved or not allowed and forbidden (HARAM) based on Islam (Jouili, 2015). This study could help and support therapists, refugee mental health specialists, and family therapists to challenge and change the community and therapists' current traditions and negative attitudes against using psychodrama in dealing with the IPV problem in refugee communities.

The current study aims to examine the effectiveness of a psychodrama intervention in reducing IPV and enhancing the QoL for a sample of abused Syrian refugee women. The following hypothesis was formulated and tested: refugee abused women in the psychodrama group could report a significant decrease in IPV and an increase in the QoL levels compared with women in the control group.

Method

Participants

Forty Syrian abused refugee women ranging from 19 to 45 years old (*M*= 29.4 years) were involved in the study. All women were in an ongoing violent marriage relationship, 5 women (12.5%) had no children, 10 women had 1 child to 2 children (25%), 19 women (47.5%) had 3 children to 5 children, and 6 women had more than 6 children (15%). Regarding marriage duration, 9 women (22.5%) had a marriage duration less than 2 years, 13 women (32.5%) had a marriage duration between 2 years to 5 years, and 18 women (45%) had more than 5 years of marriage duration. The 40 women were divided randomly using a simple random sampling method into a psychodrama intervention group and control group (20 women for each group).

Recruitment and Ethical Considerations

All refugee women who visited the Woman Health Center (WHC) in Al –Zarqa Governorate between the 21st of September 2016 and the 30th of March 2017 and matched the study eligibility criteria were assessed to participate in this study. The criteria were as follows: refugee women, age 18 and above, married, exposure to physical abuse by partners, giving consent on her behalf, no psychotic symptoms or PTSD based on the local psychiatrist evaluation, and ability to understand and speak the Arabic language. We found 116 women who matched the inclusion criteria. All recognized women as IPV victims were invited to participate in the study. Through the plenary session, the research assistants explained the study's primary purpose, procedures, and ethical considerations for all women (e.g., respect for anonymity and confidentiality, respect for privacy and voluntary involvement, and the possibility to withdraw from the study's procedures) (89 women out of 116 attended this plenary session). The research assistant asked all women to answer the study instruments. All women who scored high levels in IPV (3.23-3.66 out of 4) and low scores of QoL (1.83-2.14 out of 4) (n= 62) were invited to participate in the study. Forty-four women accepted the researcher invitation to participate and reported their approval and signed the study consent form (4 women dropped out for personal issues). We paid a $20 voucher for each woman involved in the psychodrama group by the end of the procedures.

Instruments

Domestic Violence Questionnaire (DVQ)

The Domestic Violence Questionnaire (DVQ) is a validated, sensitive identifying tool for violence, developed by the WHO (Garcia-Moreno et al., 2005). DVQ contains 26 items distributed on three different violence categories: Physical and Sexual Violence (PSV) (8 items), Psychological Violence (PV) (8 items), and Control Violence (CV) (10 items). The DVQ has different answering choices (*never*= 1, *once* =2, *sometimes*= 3, and *all the time*= 4) with total scores ranging between 26-104. The tool was modified for Arabic culture previously by (Clark et al., 2009). For this study, the DVQ has an acceptable content validity after being reviewed by psychiatrists, psychologists, and family therapists. Moderate inter-correlations demonstrated validity's evidence among the subscales ranging from 0.49 to 0.67. Total score and subscale score correlations ranged from 0.78 to 0.82. The Pearson Correlation Coefficient (PCC- test-retest reliability) was high (*r*= 0.89) and accepted internal consistency (*Cronbach's alpha*=0.78, *Kuder Richardson (KR-20)* = 0.74). The following cut-points were recognized for each subscale: (*low*: 1.00-2.00; *mild*: 2.01-3.00; *high*: 3.01-4.00)

World Health Organization Quality of Life-100 (WHOQoL-100)

The WHOQoL-100 was developed by the WHO's professional group to evaluate QoL. This tool was built within 15 psychological and local centers worldwide to derive a cross-cultural instrument (WHO, 1996). The tool includes 24 items distributed on different 4 sub-scores: Physical Health (PH, 7 items), Mental Health (MH, 6 items), Social Relationships (SRs, 3 items), and Environmental Satisfaction (ENVS, 8 items). One of the following responses answered all items: (*not at all: 1; not much: 2; moderately: 3; a great deal: 4, and completely: 5*) with the total score (24-120). The higher scores reveal sufficient QoL levels. For this study, PCC test-retest reliability (r=0.87) and internal consistency (*Cronbach's alpha*= 0.83) was calculated. The WHOQoL-100 validity was obtained by two methods: content validity, according to Jordanian experts, and moderate inter-correlations among the subscales ranging from 0.44 to 0.78. Total score and subscale score correlations ranged from 0.75 to 0.80. We followed the original cutoff points which were generated by the scale founders for each subscale: (*low*: 1-2.33; *mild*: 2.34-3.66; *high*: 3.67-5.00)

Procedures

Given the study's naturalistic nature, the psychodrama intervention was not prescribed or delivered by a specific protocol. The therapist facilitated psycho-dramatic activities according to women's needs, mainly focusing on enhancing women's' positive self-concept, empowerment, and social sense of competence.

In this study, twelve weekly 90-minute psychodrama counseling sessions adapted from (Bucuţă et al., 2018; Fong, 2007; Perrott, 1986; Wiener & Pels-Roulier, 2005) were applied for three months, starting on Aug 29th and ending on the 2nd of November 2017. The therapist divided each session into three phases: *warm-up, action,* and *sharing activities*. An expert female therapist in psychodrama interventions (who holds a master degree in psychotherapy methods with 11 years' experience) administered suggested sessions for the psychodrama group; she received direct supervision by the researcher weekly. Another authorized counselor introduced the "usual care" counseling program for the control group (3 sessions).

Psychodrama Intervention Process

First and Second Session

The therapist clarified the main objectives, rules, and participation criteria of the group. All women shared with the group some of their objectives, expectations, and suffering from experienced IPV. The therapist tried to create a secure environment between all of the participants despite their differences by facilitating and encouraging mutual interactions and free communication. Once the therapist noticed that the group achieved a sense of identity and sufficient cohesiveness levels, the actual psychodrama activities have begun. The women discussed their personal views toward undergone violent incident components (causes, characteristics, results, and suffering) through role-play, acting, singing traditional songs, short storytelling, and simulation.

Third to the Eighth Session

This was focused on skills to deal effectively with violent incidents at home by role-playing techniques. The main objective was to help the participants cope with experienced violence by playing the protagonist role (the hero role). For example, the therapist randomly asked all participants to draw one paper from a closed box containing suggested scenarios of IPV. Then they

were free to use their imaginations to enact the situation both as perpetrators and as victims. Each woman had an opportunity to play the protagonist role to refuse, face, and resist violence while some other women were playing the assistance role to facilitate achieving her goals. During this process, the therapist asked them to reverse the roles (one woman took on the identity of another woman in the group and played the role of victim and then the perpetrator) and followed with supportive discussion and feedback from group members.

The therapist used additional psychodrama interventions to help the participants deal with their inner negative feelings relating to experienced violent incidents and to rebuild their abilities to visualize more constructive responses to abuse (e.g., empowerment, directed dancing, improvisation acting, the empty chair, magical grocery, mask games, sculpture statue, and constructive feedback). The women practiced dancing in each session in this phase to support their belief that they were capable agents to deal with violent situations innovatively. By the end of this phase, the therapist asked all participants to create their preferred moves and free dance.

Ninth to Twelfth Session

The therapist tried to consolidate the learned skills and shared information to prepare women to confront actual violent situations (*In Vivo*). The participants reported their fears and anxiety to face real violent incidents and represented them in their dancing and acting activities. Different acting scenarios and role-play activities were administered for assertive, unassertive, and aggressive responses and repeated more than once. By the end of this phase, all women had identified themselves according to the above three different responses. Participants reviewed what they had learned and, additionally, went on to teach and support their peers in utilizing some activities to protect themselves from violence.

Ethical Considerations

All women were assured of complete confidentiality, privacy, and the right to withdraw from the therapy without consequences. The participants gave their verbal and written consent to participate in advance and all were assigned a numerical code securely guarded by the research team to protect confidentiality and privacy.

Data Analysis

Descriptive statistics were calculated (means and standard deviations) for all participants in both groups at different assessment phases. The *Levene test* for equality of variances (homogeneity) of collected data was run. Each group was statistically considered as a group, and all statistical processing was carried out between the psychodrama group (n=20) and the control group (n=20). A two-way repeated-measures ANCOVA was used, with a group (psychodrama and control group) as a between-subject factor and time (pre-assessment and post-assessment) as a within-subject factor for examining whether participants' scores on DVQ and WHOQoL-100 differ. The differences were tested at $p \leq 0.05$.

Results

Table 1 reveals the means (*M*) and the Standard Deviations (*SD*) of participants' scores (IPV and QoL) in both groups obtained at different study assessment phases.

Table 1. The Means and the Standard Deviations of the Scores in WHOQOL-100 and DVQ for Participants in the Experimental Group and Control Group

Sub Dimension	Control group				Experimental group			
	**WHOQoL-100*							
	Pre-test		Post-test		Pre-test		Post-test	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
PH	2.10	0.26	1.97	0.28	2.07	0.22	4.11	0.18
MH	2.03	0.18	2.13	0.20	2.05	0.20	3.90	0.21
SRs	1.83	0.28	1.83	0.36	1.83	0.42	4.26	0.30
ENVS	2.14	0.19	2	0.23	2.04	0.21	2.01	0.26
**DVQ*								
PSV	3.66	0.21	3.26	0.17	3.46	0.22	1.97	0.30
PV	3.40	0.17	3.37	0.26	3.53	0.14	2	0.21
CV	3.32	0.16	3.42	0.14	3.23	0.24	1.87	0.16

***** PH: Physical Health; MH: Mental Health; SRs: Social Relationships; ENVS: Environmental Satisfactions. PSV: Physical and Sexual Violence; PV: Psychological Violence; CV: Control Violence **Levene's test for QoL: PH (F=0.106, 0.74, P< 0.05); MH (F=0.887; 1.01, P< 0.05); SRs (F=0.45, 0.51, P< 0.05); ENVS (F=0.482, 0.67, P< 0.05). **Levene's test for DVQ: PSV (F= 0.420, 0.52, P< 0.05; PV (F= 0.293, 0.59, P< 0.05); CV (F=1.157, 0.29, P< 0.05).

Table 2. The Results of ANCOVA Test for DVQ Dimensions between Two Groups

Variables	Source	Sum of Squares	*df*	Mean Square	*F*	Sig.	Partial Eta
PSV	Group	7.25	1	7.25	117.84	0.00	0.87
	Pre-test	0.05	1	0.05	0.90	0.35	0.05
	Error	1.04	37	0.62			
	Corrected Total	9.39	39				
PV	Group	7.69	1	7.69	127.44	0.00	0.88
	Pre-test	0.00	1	0.00	0.078	0.78	0.00
	Error	1.02	37	0.06			
	Corrected Total	10.48	39				
CV	Group	11.24	1	11.24	454.54	0.00	0.96
	Pre-test	0.01	1	0.01	0.671	0.42	0.03
	Error	0.42	37	0.02			
	Corrected Total	12.449	39				

Table 3. The Results of ANCOVA Test for WHOQoL- 100 Dimensions between Two Groups

Variables	Source	Sum of Squares	*df*	Mean Square	*F*	Sig.	Partial Eta
PH	Group	22.7	1	22.7	395.89	0.00	0.95
	Pre-test	0.06	1	0.06	1.204	0.28	0.06
	Error	0.9	37	0.05			
	Corrected Total	24	39				
MH	Group	15.5	1	15.5	340.81	0.00	0.95
	Pre-test	0.00	1	0.00	0.03	0.85	0.00
	Error	0.7	37	0.04			
	Corrected Total	16.3	39				
SRs	Group	29.6	1	29.6	258.59	0.00	0.93
	Pre-test	0.06	1	0.06	0.56	0.46	0.03
	Error	1.94	37	0.11			
	Corrected Total	31.6	39				
ENVS	Group	0.00	1	0.00	0.022	0.88	0.00
	Pre-test	0.07	1	0.07	1.171	0.29	0.06
	Error	1.04	37	0.06			
	Corrected Total	1.121	39				

Table 1 displays a clear reduction in the 3 violence types scores. The ANCOVA test of DVQ results Table 2) revealed that participants' pre and post scores in both groups differed significantly in PV, PSV, and CV respectively (F= 127.44, *0.00*, p< 0.05; F= 117.84, 0.000, p< 0.05, F= 454.54, 0.000, p< 0.05). This result indicated the efficacy of the psychodrama intervention program in reducing different violence forms for abused refugee women.

The ANCOVA test of WHOQoL-100 results (Table 3) revealed that participants' post scores in both groups differ significantly in PH, MH, and SRs respectively (F= 395.89, *0.00*, p< 0.05; F= 340.81, 0.000, p< 0.05, F= 258.59, 0.000, p< 0.05). These results demonstrate the efficacy of the psychodrama intervention to enhance the PH, MH, and SRs for participants from low level to high level but not for the ENVS, which indicated no significant differences in ENVS between psychodrama group participants and control group (F=0.022, 0.88).

Discussion

The results indicated the effectiveness of a psychodrama intervention on reducing IPV and enhancing the QoL for abused refugee women. The collected data showed that participation in psychodrama activities led to significant changes in experienced IPV and QoL. Despite the efforts of feminists, community activists, and concerned citizens to eradicate violence, many women in exile regardless of age, race, nationality, and religion, still suffer from physical, sexual, and psychological abuse (Feseha et al., 2012). Such scientific evidence should be a stimulus for national and international efforts to deal with the IPV problem and redirect our attention toward

the fact that the existence of high levels of IPV in refugee communities requires efforts beyond the compilation of descriptive data, advocacy movements, and correlation studies.

One crucial point in the results that requires further examination is the lack of improvement in the environmental component of the QoL for the participants. Looking at the psychosocial background of the participants could explain this finding. All women were suffering from poverty (84% of Syrian refugees in Jordan are poor) (Ayham, 2015; Department of Statistics, ICF international, 2013) and low levels of services, polluted environments, lack of wastewater management, and difficult living situations. The Al- Zaatari refugee camp, where the intervention took place, is considered the fifth top highest population density in Jordan and the fifth-biggest refugee camp globally (UNHCR, 2015). Any psychological treatment or therapy can not control or manipulate these conditions. Even though the procedures of this study have improved other aspects of these women's QoL and reduced the occurrence of IPV, the result regarding environmental issues suggests the need of focusing on environmental and ecological improvements to enhance the QoL levels not only for IPV refugee victims but also for all community members.

Although there are services and programs to help refugee women cope with violence in their homes, women are often reactive and passive assuming that women are incapable of self-protection or that they need to be protected by a third party (e.g., original family and formal or legal protection) (Fong, 2007). Working with such IPV victims by shaping a new attitude instead—that violence is not permissible and cannot be justified—is a useful component of this current psychodrama intervention (Mondolfi & Pino-Juste, 2020). This process could help women gain new insight and skills in confronting violent events. Through practical training exercises, women could build sufficient self-efficacy and encouragement to prevent IPV in their homes. When IPV victims realized their inner strengths and personal power, they could see options and possibilities to handle violence strategically and not to just accept it passively. This new insight could generate more insights into a group of poor, refugee, abused women and a larger population (Mondolfi & Pino-Juste, 2020; Naar et al., 1998).

At the beginning of the psychodrama intervention, the therapist noticed through her in-depth discussions with women that all of them were forced to choose between two inevitable options: living a full life with the possibility of violence by taking risks or limiting themselves by confinement. At the final stage of the psychodrama intervention, women reported that they could deal effectively with violence and eliminate it as a third available choice. Some practical exercises might help to achieve such positive results through the supporting practice enactment. Holmes (1992) explained that psychodrama sets up scenes containing rich opportunities for two people to learn by meeting in a common space and treating each other with a "*here and now*" reality resulting in learning new behaviors and cognitive skills that help to deal with problems differently.

Changing abused women's attitudes by providing them with more choices was one of the primary objectives of the "*you are not alone program*," implemented by the Calgary Counselling Center in Alberta, Canada, for women who were currently or who have been victims of family violence (Tutty et al., 2016). Teaching refugee abused women that they have choices to face IPV is a similarity between our current program and the "*you are not alone*" program: It might not be your choice, as an abused woman to suffer from the consequences of physical and psychological violence, but it is your choice to eliminate and prevent violence before it happens.

The results of this study supported other previous efforts (Bucuţă et al., 2018; Damra et al., 2014; Hamamci, 2002; Mondolfi & Pino-Juste, 2020; Naar et al., 1998; Torre, 1990) which have emphasized the importance of receiving therapeutic family services so that all family members,

including the perpetrating partner or husband, can receive the essential counseling as an intervention against violence.

Limitations

Several features of this study limit confidence in interpretation and generalizing the findings to other refugee women populations in Jordan or other countries. The limited power inherent in such a small sample size makes it difficult to detect possible differences between the trial's two conditions. The small sample size also limits the study's external validity. One of the significant study limitations was working with IPV refugee women who were living in demanding cultural and social situations, with their perpetrators being distributed randomly in two study groups. Such limitations are inevitable, based on the current culture and traditions.

Moreover, one of our main limitations was being faced with difficulties in achieving follow-up assessments. These assessments were difficult to obtain for both groups. The refugee families could not be tracked for different variables as they often changed their living places and addresses due to their unstable living situations; some of them were deported for their illegal residence in Jordan or resettled in a third country.

Conclusion

The study sought to demonstrate the value of psychodrama in working with refugee abused women and shows how its techniques and methods can empower them and stimulate changes in their experienced violence and QoL.

After having the recommended modifications to be suited for refugee women in Jordan, psychodrama intervention was found to be an effective intervention in reducing the incidence of physical, psychological, and control violence and enhancing the physical health, mental health, and social relationships for refugee women with a history of IPV. Implementing group counseling interventions for IPV in a refugee community in Jordan may present some challenges and limitations for its Eastern traditions and conservative nature.

In working with women victims of IPV, the therapeutic and supportive relationship is a cornerstone to the psychodrama interventions and must be developed slowly and gently to build a sense of trust and safety. Also, the therapist must be aware and careful when assuming different psychodrama techniques for IPV victims. In psychodrama, the psychotherapist has an active and proactive role and favors a direct intervention, authentic human relationship experience that can be configured as positive. Our results supported the assumption that fighting violence at home must be launched from a collaborative perspective that all family members are responsible for violence elimination.

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