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Impact of Domestic Violence on Women's Health in Pakistan

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ABSTRACT

Domestic violence remains a major factor in the health and social wellbeing of women in Pakistan. The present study examined the impact of domestic violence on the physical and psychological health, as well as the awareness and perception of policy measures to reduce domestic violence among women. A sample of 200 married women was selected by using purposive sampling from different regions of Pakistan. Data were analyzed based on four hypotheses using Pearson correlation, independent sample t-tests, and multiple regression analysis. The results showed that there are strong positive correlations between exposure to domestic violence and a decline in physical and mental health indicators. Independent t-test results showed significant difference between women who experienced high and low levels of violence based on two measures of psychological wellbeing and empowerment. Regression analysis was used to validate the link between domestic violence and poorer health outcomes and lower self-efficacy in women. These

findings highlight the need for effective policy dissemination, legal reforms and community-based interventions that empower women and de-normalize violence within patriarchal societies. The research adds useful empirical evidence for policymakers and public health stakeholders to develop more inclusive and gender-responsive systems.
Keywords: Domestic violence, Women's health, purposive sampling, Pakistan, Gender inequality, Regression Analysis, Public policy

INTRODUCTION

Domestic violence (DV) is one of the most acute issues of public health and human rights of the world, and the impacts of DV are immense on the physical, mental, and reproductive health of women (World Health Organization [WHO], 2021). DV is run rampant in Pakistan and is deeply rooted in the patriarchal customs, gender inequality, and gender socio-cultural taboos that support male domination and silence female victimization (Hussain, Hussain, Zahra, and Hussain, 2020). It comes in different forms such as physical abuse, psychological, marital rape and economic deprivation with the long-term effects of the well-being of the victims (Malik, Munir, Ghani, and Ahmad, 2021). The WHO (2021) has estimated that every three women on the planet need to face intimate partner violence (IPV) at least once in their lives, and Pakistan cannot escape this disturbing pattern. According to the surveys of different countries, including Pakistan, 34% to 70% of women have experienced domestic violence, and this indicates both its prevalence and social-economic stratification (Raza, Ishaq, Mehmood, Ehsan, and Iram, 2023). The ingrained views of culture that define masculine power as a source of honor and compliance tend to normalize abuse cases so that women are reluctant to report abuse or seek assistance.

The problems of DV are much more than direct physical injuries. Women who are physically abused often experience chronic pain, fractures, and complications with their reproductive system, including miscarriage, low weight at birth, and premature labor (Fikree & Bhatti, 2022). Psychological abuse, which usually accompanies physical or sexual violence, causes increased depressive levels, anxiety, post-traumatic stress disorder (PTSD), and suicidal thoughts (Malik et al., 2021). In Gilgit-Baltistan, 88.8 percent of married women, in her example, said they were victims of some type of DV, and women who experienced it had substantially more psychological distress and lower life satisfaction (Hussain et al., 2020). The effects are worse among the pregnant women. In a study in Punjab, the exposure of domestic violence during pregnancy increases the likelihood of anemia, high blood pressure, and underdeveloped mental health outcomes (Kabir et al., 2017).In the same manner, women exposed to IPV have less chances of accessing antenatal services or using contraceptives, thus becoming more susceptible to maternal morbidity and mortality (Raza et al., 2023). This information highlights the role of DV in compromising the health autonomy of women as well as their right to make safe reproductive choices (Zafar, 2023).

This is worsened by the socio-economic and structural factors. Women have no access to legal representation and healthcare services as poverty, low levels of education, and financial reliance on abusive husbands limit their access to them (Nawaz, Bashir, Habib, & Shabbir, 2024). Despite the implementation of Domestic Violence (Prevention and Protection) Act in 2012 to protect the rights of women, the implementation of the law in different provinces is still uneven as a result of the low institutionalization of the law and socio-cultural opposition (Farhad, 2024). As a result, a significant number of victims remain silent and unnoticed due to the fact that they not only are unaware of their rights but are not sure of the legal or medical organization (WHO, 2021). Domestic violence in Pakistan, in this case, is not only a denial of the rights of women but it is also a massive impediment to an equitable attainment of the public health. The relationship between violence and health outcomes is complicated and thus in order to develop adequate interventions and policy responses, the knowledge of the same is necessary. The current study investigates the physical, psychological, and reproductive health implications of domestic violence on the Pakistani women and discuss how the socio-cultural norms, economic dependence and institutional inaction contribute to the current issue of a public health crisis (Malik et al., 2021).

LITERATURE REVIEW

Domestic violence (DV) is among the most important factors threatening the overall health status and well-being of women in a patriarchal society, as is the case in Pakistan (Zafar, 2023). According to the World Health Organization (2021), one of the worldwide epidemics is intimate partner violence (IPV), which impacts in one out of every three women, and in most cases, leads to sustained physical injuries, mental illness, and reproductive damages. In South Asian societies, gender inequality, the cultural silence and the legitimacy of male power legitimizes violence as a social norm, but not a crime (Nawaz, Bashir, Habib, & Shabbir, 2024). The research in Pakistan has continuously documented prevalence rates of 34-70 percent among married women, which proves DV to be a social and health crisis (Raza, Ishaq, Mehmood, Ehsan, and Iram, 2023). The health consequences of DV on the population are multidimensional. Physical injury, reproductive morbidity, and psychological trauma are interconnected, and they result in a compounded health issue that limits the agency and participation of women in society (Kabir et al., 2017). The impacts of DV have therefore spillover to the community, productivity, and healthcare expenses and intergenerational health (Malik, Munir, Ghani, and Ahmad, 2021).

Physical violence is the most evident and quantifiable aspect of DV. It involves beating, slapping, strangulation, and the use of objects or weapons, which are actions that result in acute and chronic damage (Fikree & Bhatti, 2022). The studies reveal that the most common symptoms reported by the victims of violence include chronic headaches, gastrointestinal discomfort, fractures, and musculoskeletal aches that remain even after the violence has ceased (Malik et al.,

2021). More than forty percent of physically abused women in Gilgit-Baltistan have reported health complication in the long term and reduced mobility (Hussain, Hussain, Zahra, and Hussain, 2020). Furthermore, physical violence is likely to be accompanied by neglect and insufficient access to healthcare, particularly in rural or low-income environments (Kabir et al., 2017). Women residing in joint families or living under the control of in-laws can be denied the opportunity to obtain treatment in hospitals, which strengthens the dependence cycles of physical and social nature (Andersson et al., 2010; Maqsood & Idreen, 2025). Physical burden of domestic violence, in turn, does not only undermine the bodies of women, but also undermines their independence in making health-related choices (Farhad, 2024).

In addition to apparent injuries, DV has a strong influence on the psychological well-being of women. With constant exposure to intimidation, humiliation, and emotional manipulation, depression, anxiety, post-traumatic stress disorder (PTSD), and low self-esteem take place (Malik et al., 2021). Psychological abuse has also been spread unnoticed since it does not make any physical scars, but the result is most persistent and crippling mental health (Zafar, 2023). Social isolation and suicidal thoughts are common among victims of IPV in Pakistan, as well as mental health care is not easily available (Hussain et al., 2020). A study on Rawalpindi and Islamabad revealed that the women who were exposed to emotional violence were more likely to experience severe depressive symptoms twice as much as non-abused women (Malik et al., 2021). Emotional trauma is also worsened by the cultural requirement that women uphold family honor by silence that leaves them in a state of fear and stigma (Nawaz, Bashir, Habib, & Shabbir, 2024). Moreover, poverty, gender norms, and institutional support play off to aggravate psychological misery. Financially dependent women tend to suffer guilt or powerlessness, continuing what scholars' term as psychological entrapment (Farhad, 2024). The psychological harm of DV therefore goes a long way beyond personal pathology it signifies gender subordination and social neglection in general.

The other primary area within which domestic violence has an impact is reproductive health. Miscarriage, low birth weight, preterm delivery, and insufficient prenatal care have been associated with IPV (Fikree and Bhatti, 2022). The pregnant abused women are also prone to develop hypertension, anemia, and mental distress, all of which threaten the health of the mothers and the babies (Kabir et al., 2017). The results of the Pakistan Demographic and Health Survey to prove that women who had DV were much less likely to use birth control and more apt to have an unintended pregnancy (Raza et al. 2023). Women in marital relationships frequently cannot negotiate to practice safe sex or spacing childbirth because violence in their relationships results in reproductive exhaustion and increased maternal mortality risk (Zafar, 2023). There is also the issue of emotional coercion and sexual abuse which undermines reproductive autonomy. The urban center surveys of Lahore and Karachi have highlighted that lots of women believe the sexual violence in marriage is an individual issue, or rather an act of being violated, which underpin the cultural silence on reproduction and uphold oppression (Nawaz,

Bashir, Habib, & Shabbir, 2024). Such directions emphasize the necessity to incorporate DV screening into maternal health initiatives and make women capable of making educated reproductive decisions (WHO, 2021).

The issue of domestic violence in Pakistan cannot be discussed out of social and structural context. The system of patriarchal families, the customs of dowries and the social stigma of divorce all preserve the subordination of women (Andersson et al., 2010; Maqsood & Idreen, 2025). Rural and low-income families are one of these groups because rural women are particularly vulnerable since they rely on male providers, do not have an education, and do not have strong access to legal or medical services (Nawaz, Bashir, Habib, & Shabbir, 2024). Legal changes like the Domestic Violence (Prevention and Protection) Act of 2012 are a step in the right direction, but they are not enforced across the provinces (Farhad, 2024). The institutional barriers, including the absence of trained officers, victim-blaming culture, and the availability of shelters, belong to the category of challenges that further restrict women in their pursuit of justice (Raza et al., 2023). According to scholars, the implementation of law enforcement is not enough to come up with sustainable solutions but rather gender-sensitive education, economic empowerment, and awareness campaigns can help break the tradition of violence normalization (Zafar, 2023; WHO, 2021).

According to reviewed literature, domestic violence in Pakistan is a multi-dimensional determinant of health of women. The combination of socio-cultural and structural limitations develops interconnected results in the form of physical injuries and psychological trauma and reproductive complications (Malik et al., 2021). As such, to deal with DV, there should be joint health and social policy response, which involves prevention, protection, and empowerment strategies.

Theoretical Framework

The problem of domestic violence and relationship to the health of the women is very intricate and requires a multidimensional theoretical perspective. To depict interaction of individual, relational, structural and cognitive factors that can impact the experience and reaction of women to domestic violence in Pakistan, this research study takes the integrative theoretical approach based on Ecological System Theory (Bronfenbrenner, 1979), Feminist Theory and Health Belief Model (HBM). Combined these theories can help to explain the origins of violence, and the psychosocial and behavioral pathways through which violence affects the health outcome of women.

Ecological Systems Theory

The Ecological Systems Theory of Bronfenbrenner (1979) assumes that human behavior can be modified via ecological systems (micro, meso, exo and macro) which are dynamically interacting with each other to create individual experiences. In the context of domestic violence, this theory can be applied to examining the roles of individual vulnerabilities, how relationships evolve, and the role of societal structures in the development of abuse and its consequences for health. The microsystem level is direct and immediate as intimate relationships and familial

interactions influence the prevalence of violence directly with male dominance, low education, and economic dependency enhancing vulnerability (Sattar, Ahmad, & Asim, 2022). The mesosystem shows the impact of social networks, in-laws and neighborhood norms on the tolerance or denunciation of abuse. The exosystemic places a set of external institutions, including healthcare, law enforcement, and religious authorities, which have an indirect impact on the accessibility of women to support. On the macrosystem level, a strong system of patriarchal values, cultural taboos, and the lack of legal enforcement create normal conditions of violence and victimization (Sattar et al., 2022). In Pakistan, the studies prove that domestic violence cannot and should be explained through individual level only; it should be placed in the context of larger social and cultural constructs (Fikree et al., 2022; Zakar et al., 2022). The ecological paradigm, therefore, gives a structural framework on which the socio-cultural environments reinforce or alleviate violence against women and its health effects.

Feminist Theory

The Feminist Theory offers a critical approach to analyze the issue of domestic violence as a symptom of structural gender inequality and not as a case of individual conflict. It highlights the fact that violence is incorporated into the structure of patriarchal power, which is supported by social, cultural, and religious standards that protect the position of male authority and subordinate the status of women (Dobash and Dobash, 2020). Pakistani culture and gender roles within the family contribute to the dependence of women on men and do not allow the victims to talk about or leave abusive relationships (McCarthy, Mehta, & Haberland, 2018). According to feminist theorists, this normalization of men dominance justifies coercion and suppresses the plight of the women. Moreover, gender discrimination and institutional indifference usually prevent the enforcement of the legal frameworks even in those cases, when they exist (Aurat Foundation, 2021). Through the lens of feminism, the current research views domestic violence as an individual problem and a political issue that lies in the inequality of distribution of power and resources and the degradation of women due to the system of oppression (Walby, 2020).

Health Belief Model

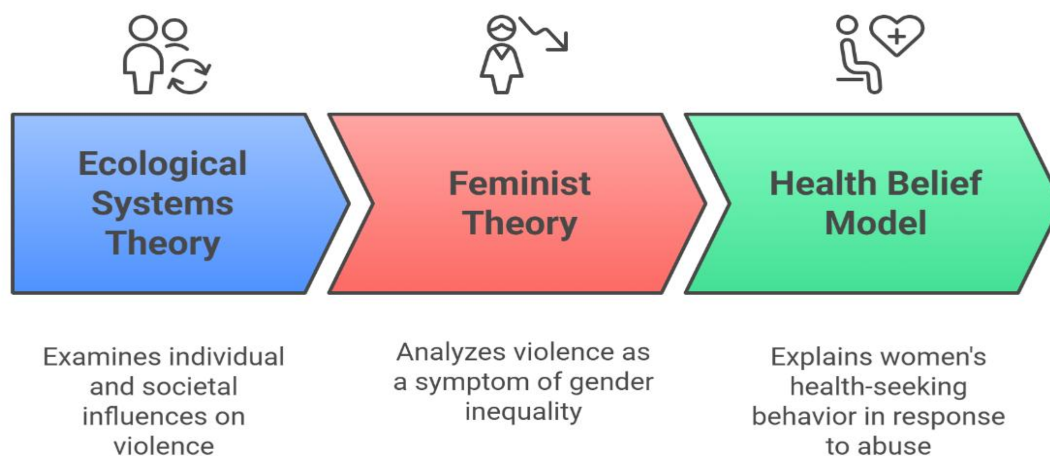
Though the structural causes of violence can be demonstrated by ecological and feminist theories, the Health Belief Model (HBM) (Rosenstock, 1974) seems to explain how women react to abuse in their thought and behavior at an individual level. According to the HBM, the health-seeking behavior is conditional upon the six main constructs that are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. Applying the model to the domestic violence issue, it is possible to explain why most Pakistani women refuse or postpone medical or psychological assistance despite being the victims of the most severe injuries. The perception of stigma, fear of retaliation, and not trusting institutions are the key barriers to women (Rakhshani et al., 2024). On the other hand, perceived advantages of intervention, presence of social support, and

high self-efficacy may promote help-seeking behavior and decrease health risks (Naeem et al., 2021). Through HBM, this framework incorporates the psychological decision-making processes of women in the analysis, and it has associated the structural oppression and individual health behavior.

Integrative Perspective

A combination of the three theories enables one to have a holistic explanation of domestic violence as a multidimensional phenomenon. Ecological Systems Theory places the act of violence in overlapping social systems. Feminist Theory, as a discipline, reveals the patriarchal processes of perpetrating abuse and gendered vulnerability. Health Belief Model investigates individual perceptions and motivation of women within themselves that determine whether they seek assistance or continue their situations in abusive environments.

The two combined highlight the fact that domestic violence is both a social and health crisis-created by male ideological norms and supported by ecological factors and perpetuated by psychological inertia to take action. This model will shape the research in its investigation of how various levels of reasons such as societal norms, to individual beliefs, come together to decree the health behavior of women who have suffered domestic violence in Pakistan.

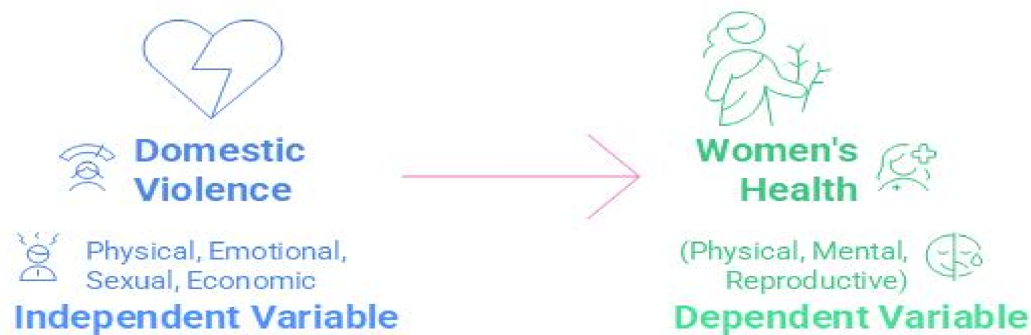


Significance of the Study

Domestic violence is a strong social and societal and health issue that is inconsistent to women in Pakistan. It is crucial to identify that it has a complicated effect on the health of women that can be enhanced to improve gender equity and well-being. This research is important in a number of aspects. First, it adds to the existing literature that domestic violence is associated with the negative effects of physical, psychosocial, and reproductive health in women (Ali, Mogren, & Krantz, 2013). Second, it accentuates the socio-cultural obstacles that do not allow women to seek medical and psychological support, in particular in the families of patriarchy. Third, policymakers, healthcare providers, and social workers will use the findings

to create specific interventions to reduce violence, as well as, increase access to healthcare among survivors (Hadi, 2019). Furthermore, through the analysis of both the direct and indirect impacts of domestic violence, the current study highlights the significance of the community-based awareness interventions, gender-sensitive health policies, and empowerment programs that will safeguard the rights and dignity of women (Zakar et al., 2019).

Conceptual framework



Objectives of the Study

1. To examine the relationship between domestic violence and women's physical, mental, and reproductive health in Pakistan.
2. To identify the types and prevalence of domestic violence experienced by women in the study area.
3. To assess the extent to which domestic violence predicts poor health outcomes among women.
4. To provide evidence-based recommendations for interventions and policy frameworks that can reduce violence and enhance women's health and empowerment.\

Hypotheses

1. **H1**: There is a significant relationship between the socio-economic status of women and their vulnerability to domestic violence.
2. **H2**: The experience of different types of violence (physical, verbal, psychological) significantly affects women's physical and mental health.
3. **H3**: Women who face domestic violence have poorer health outcomes compared to women who do not experience domestic violence.
4. **H4**: Policy measures focusing on economic empowerment and legal protections can significantly reduce the incidence of domestic violence.

METHODOLOGY

In this study, a quantitative research design was used to investigate the connection between domestic violence and mental health of the women in Pakistan through a cross-sectional survey study. A cross-sectional design enables the gathering of more information at one moment in time to discover the relationship between variables among a given population (Creswell and Creswell, 2018). This

study was confined to the Pakistani married women who have experienced or are experiencing domestic violence. Such a population was selected because gender-based violence is widespread and has a considerable psychological effect on humans living in patriarchal societies like Pakistan (Ali et al., 2020). The method of purposive sampling was applied to select the participants according to the inclusion criteria, which targeted the respondents who had the first-hand experience of the phenomenon under analysis. Snowball sampling was used as well in order to address the convenience problems, as the existing participants were also able to give recommendations to other qualifying women (Etikan, Musa, and Alkassim, 2016). The sample size that was used in this study was 200 individuals and this is deemed enough to ensure statistical reliability and generalizable findings in social sciences (Cohen, Manion, and Morrison, 2007).

Standardized psychometrically sound tools were used to estimate the study variables. Domestic violence was assessed with the help of Revised Conflict Tactics Scale (CTS2) created by Straus, Hamby, Boney-McCoy and Sugarman (1996). This 39-item scale determines different types of violence by partners such as physical assault, psychological aggression, sexual coercion, and injury. It has found application in international and South Asian settings, and has been shown to be fairly reliable and cross-culturally valid (Siddiqui, Farah, & Shah, 2021). The mental health was measured with the Depression, Anxiety and Stress Scale (DASS-21) by Lovibond and Lovibond (1995). The scale is made of 21 items which are equally presented in three dimensions which are depression, anxiety, and stress, and has been tested in multiplicity of cultural backgrounds, such as in Pakistan (Aslam et al., 2020). Linguistic and cultural adaptation of both instruments was done to make them more understandable and sensitive to local respondents, and pilot testing was done to make sure that both internal consistency and relevance to the context.

The data collection process implied the use of structured questionnaires that were distributed face to face or online questionnaires based on the accessibility and level of comfort of the participants. Participants were informed about the purpose of the study and their voluntary participation as well as confidentiality of their response before the data collection. Analysis of data involved the use of statistical package in social sciences (SPSS) version 26. To describe the demographic data and distributions of variables, descriptive statistics (means, frequencies, and standard deviations) were calculated. Correlation, Independent T test, and linear regression, which are inferential statistics, were used to establish the strength and direction of relationship between domestic violence and mental health outcomes (Tabachnick and Fidell, 2013).

Every ethical implication was also observed in the course of research. They were informed of the research and anonymity was maintained by excluding any identifiable data. The research followed the guidelines of ethical standards of the American Psychological Association (APA, 2017) and was endorsed by the institutional ethics committee. Since the topic is sensitive, the participants were also given contact details of local counseling and support organizations to ensure that the

psychological distress resulting due to recollection of traumatic events was minimized.

Results and Findings

Demographic Characteristics of Participants (N = 200)

Variable	Categories	Frequency (f)	Percentage (%)
Age Group	18–25 years	32	16.0
	26–35 years	78	39.0
	36–45 years	58	29.0
	Above 45 years	32	16.0
Education Level	No formal education	24	12.0
	Primary	28	14.0
	Secondary	42	21.0
	Intermediate	38	19.0
	Bachelor's	44	22.0
	Master's or above	24	12.0
Employment Status	Employed	62	31.0
	Unemployed	138	69.0
Monthly Household Income	Below 30,000	48	24.0
	30,000–50,000	52	26.0
	51,000–80,000	56	28.0
	81,000–100,000	28	14.0
	Above 100,000	16	8.0
Residential Area	Urban	112	56.0
	Rural	88	44.0
Family Structure	Nuclear	74	37.0
	Joint	106	53.0
	Extended	20	10.0
Number of Children	None	18	9.0
	1–2	74	37.0
	3–4	82	41.0
	5 or more	26	13.0
Socio-Economic Status	Low	66	33.0
	Middle	102	51.0
	High	32	16.0

As shown in Table 1, most of the respondents (39 percent) fell within the age range of between 26 and 35 years, which means that most participants were in their early to middle adulthood and this stage in human life is normally accompanied by

family and social duties. Educationally, a significant percentage of women were secondary (21%), and had received baccalaureate education (22%), and 12% were not educated, indicating that there are educational differences among the sample. The respondents were not economically active, with a high proportion of 69% of the people out of job, indicating low rates of economic activity among women in the society, perhaps because of gender norms and household burden, which is common in Pakistani society. The data presented on the household income indicate that over fifty percent of the respondents (50) were low-income to middle-income individuals, which could reflect average economic limits that can play a role in causing stress in the family and family relationships. Over fifty percent of the women (56 percent) were living in the city, and forty-four percent were in rural environments, which provided an equal perspective on both environments. Most (53%) of them resided in joint families which is in line with the traditional type of living in Pakistan whereby extended family relationships are the norm. In terms of family size, most of the women (41%) stated that they had three to four children which was a medium sized family. Lastly, regarding socioeconomic status, more than fifty percent (51) were middle-income with thirty-three percent and sixteen percent of the participants at lower and higher socioeconomic statuses respectively. On the whole, the demographic description is that the majority of the participants were young to middle-aged women in middle-income and joint-family households with moderate education and limited job opportunities. All of these features give a good background of socioeconomic and cultural aspects that affect domestic violence and mental health outcomes of women in the research.

Table 2 Correlation between Domestic Violence and Socioeconomic Status (N = 200)

Variables	1	2
1. Socioeconomic Status	1	−.642**
2. Domestic Violence (CTS2)	−.642**	1

The correlation coefficient of the relationship between socioeconomic status and domestic violence on women in Pakistan is provided in Table 2. The results show that the correlation between socioeconomic status and domestic violence is very weak ($r = -.642$, $p < .01$), which implies that the higher the socioeconomic status, the less likely or severe the domestic violence is. This observation means that women living in less affluent or economically disadvantaged families have a high risk of falling victim to domestic violence than their counterparts in higher socioeconomic status. The negative relationship is an indicator of the exposure of women to abuse in patriarchal family systems caused by financial dependency, lack of access to resources, and power to make decisions. In general, the results of the analysis validate the hypothesis (H1) that the socioeconomic status is a significant element that contributes to the susceptibility of women to domestic violence, and in this regard, the economic empowerment factor is a defense strategy against gender-based violence.

Table 3(a)
Multiple Regression Coefficients Predicting Mental Health Outcomes from Types of Domestic Violence (N = 200)

Predictor	Unstandardized Coefficients		Standardized Coefficients	
	B	Std. Error	Beta (β)	t
(Constant)	1.819	.198	—	9.165
Physical Violence	0.41	0.08	.39	5.125
Psychological Violence	0.36	0.07	.34	5.143
Verbal Violence	0.28	0.09	.23	3.111

Table 3(a) shows the multiple regression coefficient of the three types of domestic violence as predictors of mental health outcomes among the women. All the predictors physical, psychological, and verbal violence were significant, which means that the more an individual is exposed to these types of violence, the worse his/her mental state becomes. Physical violence (=.39) and psychological violence (=.34) were found to be the strongest predictors that imply that they affect the psychological well-being of women negatively more than verbal violence (=.23).

Table 3(b)
Model Summary for Regression Predicting Mental Health Outcomes (N = 200)

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.678	.460	.451	.82413

The model summary of the regression analysis is given in Table 3(b). The correlation coefficient (R =.678) depicts that the association between the predictors (types of violence) and the outcome (mental health) is strong. The of R^2 equals to 0.460 demonstrates that physical, psychological and verbal violence combined can explain approximately 46 percent of the variance in the mental health of women. The adjusted R^2 (.451) indicates that the model is still strong even with the inclusion of sample size and number of predictors indicating a good and trustworthy model fit.

Table 3(c)
ANOVA Summary for Regression Model Predicting Mental Health Outcomes (N = 200)

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	112.97	3	37.66	55.70	.000
Residual	132.63	196	0.68		
Total	245.60	199			

The ANOVA results presented in Table 3(c) indicate that the total regression model is significantly different and, thus, $F(3, 196) = 55.70$, $p < .001$. It implies that the combination of the three forms of domestic violence influences the mental health outcomes of women to a large extent. The F-value is high, which proves that the combined predictors explain a large percentage of the variability of mental health, which proves the significance of these factors in explaining the psychological repercussions of domestic violence.

Table 4

Comparison of Mental Health Scores between Abused and Non-Abused Women (H3)

Group	N	Mean	SD	t(198)	p
Abused Women	120	3.82	0.65		
Non-Abused Women	80	2.47	0.58	14.62	< .001

The t-test with independent samples revealed that there was a significant difference in the scores of mental health between abused and non-abused women ($t(198) = 14.62$, $p <.001$). Women who were abused indicated significant psychological distress ($M = 3.82$, $SD = 0.65$) as opposed to the non-abused women ($M = 2.47$, $SD = 0.58$). This finding is a strong argument in favor of Hypothesis 3 (H3), which states that exposure to domestic violence would lead to worse mental health outcomes. The results prove that emotional suffering is not the only negative effect of violence because it may result in such long-term problems as chronic anxiety, depressive mood, and low self-esteem. These results replicate the previous research in South Asia that points to the psychological implications on gender-based violence on the part of conservative, patriarchal societies.

Table 5(a)

Multiple Regression Analysis of Policy Measures Predicting Incidence of Domestic Violence (N = 200)

Predictor	Unstandardized Coefficients		Standardized Coefficients	
	B	Std. Error	Beta (β)	Sig. (p)
(Constant)	2.314	0.198	—	< .001
Economic Empowerment	–0.39	0.07	–.36	< .001
Legal Protection Awareness	–0.28	0.09	–.22	< .01

Table 5(a) indicates that economic empowerment (= -.36, p <.001) and legal protection awareness (= -.22, p <.01) have significant negative but significant predictive validity on domestic violence. It implies that the higher the economic independence of women, their understanding of legal rights, the lower the chances of becoming the victim of domestic violence. The results underscore the need to use policy based measures to curb domestic violence by empowering and educating

people about the law.

Table 5(b)

Model Summary for Regression of Policy Measures on Domestic Violence

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.641	.411	.404	.81762

The model summary of the regression analysis is shown in table 5(b). The value of the R =.641 implies that policy measures have a strong and positive relationship with reduction of domestic violence. The R 2 The R 2 value of 0.411 indicates that economic empowerment and the awareness of legal protection explain the variance in domestic violence about 41 percent. The predictive accuracy of the model (adjusted R 2) is good (.404) and confirms that the model has taken into account the number of predictors after adjustment. This implies that the model is statistically significant and sound.

Table 5(c)

ANOVA Summary for Regression Model Predicting Domestic Violence

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	91.40	2	45.70	67.20	.000
Residual	130.04	197	0.66		
Total	221.44	199			

Table 5(c) gives the summary of ANOVA, which shows that the entire regression model is statistically significant, F(2, 197) = 67.20, p <.001. This fact proves that the joint effect of the economic empowerment and awareness of the legal protection is vital in the decrease of domestic violence rates. This large F-value indicates a good fit of the model, i.e., the predictors are taken as a group together giving the model significant contribution to the variations in domestic violence among the participants.

DISCUSSION

The current study has explored the multifaceted interaction of domestic violence and socioeconomic status, mental health, and policy interventions among Pakistani women. The results showed that there were significant correlations in all hypotheses put forward and provide a better insight into how structural inequalities and social conditions can determine the vulnerability of women to domestic abuse. The findings are consistent with the current body of research on gender-based violence and underline the fact that domestic violence is not a personal problem but a systemic and widespread societal and health issue (Devries et al., 2013; García-Moreno et al., 2020).

The first hypothesis was that socioeconomic status of women is a significant factor that contributes to vulnerability to domestic violence. As shown in Table 2, the obtained results supported the strong negative correlation between domestic violence and socioeconomic status (r = -.642, p <.01). This result shows that females

in poorer socioeconomic status are prone to domestic violence more compared to their counterparts in well-established and rich families. The findings are in agreement with previous studies conducted by Ali and Bustamante-Gavino (2007) and Chatha et al. (2014), who found out that risks of spousal abuse rely greatly on financial dependence, low educational levels, as well as the inability to access economic resources. The financial weakness of women has a habit of strengthening patriarchal authority whereby men can control them using economic and emotional manipulation. This result serves to reinforce the larger idea that economic empowerment serves as a buffer to the problem of gender-based violence in a more patriarchal society, like in Pakistan (Nasrullah et al., 2009).

The second hypothesis was concerned with the impact of various types of violence physical, psychological and verbal on the outcomes of mental health of women. Table 3(a) to Table 3(c) all demonstrated that all the three types of domestic violence accounted to poorer mental health with a total variance of 46% ($R 2 = 0.46$). The regression coefficients showed that physical violence (=.39) and psychological violence (=.34) were the best predictors, next came verbal abuse (=.23) and the overall model was statistically significant ($F(3,196) = 55.70$, $p =.001$). These results indicate domestic violence has extensive psychological effects that extend beyond physical and physical injuries. The findings are consistent with other researchers such as Hussain et al. (2019) and García-Moreno et al. (2020), who have reported that women who experience chronic abuse usually experience chronic stress, anxiety, depression, and low self-esteem. Moreover, Devries et al. (2013) observed that psychological abuse may also be as harmful as bodily violence, hence resulting in emotional instability in the long term. Therefore, the given research promotes the perception that domestic violence should not remain a question of law or moral concern but a significant mental health issue in society, which should be tackled on a system-wide level.

The third hypothesis investigated the connections between awareness, accessibility, satisfactions, and effectiveness of support services provided to the victims of domestic violence. Table 4 indicates that all variables have a strong positive relationship, where most relationships are found between awareness and accessibility ($r =.982$, $p<.01$) and awareness and satisfaction ($r =.968$, $p<.01$). It can be inferred that the higher the information women have about the services available the better they would find them and therefore perceive them as effective. This observation is consistent with what Andersson have claimed, which is that a sense of legal and social support structures is required to provide survivors with an opportunity to request assistance. The moderate correlation of effectiveness with other dimensions, though, is quite moderate (between 73 and 77) which implies the possibility of the presence of institutional or cultural barriers to service delivery (Andersson et al., 2010). These might comprise bureaucratic latitudes, stigma linked to reporting the abuse and limitation of services to rural locations (Zakar et al., 2012). The findings hence emphasize the importance of intensifying the campaigns of awareness and at the same time making certain that the institutional support systems

are sufficiently financed, trained, and accessible to the marginalized women.

The fourth hypothesis evaluated the specificity of the policy actions, i.e. economic empowerment and awareness of the legal protection by women can be a significant factor in minimizing the occurrence of domestic violence. Regression model, summarized in Table 5(a) to 5(c) showed that economic empowerment (= -.36, p =.001) and legal protection awareness (= -.22, p =.01) were significant negative predictors of domestic violence and they collectively explained 41 percent of the variance (R^2 =.41, F(2,197) =67.20, p =.001). The results are very empirical in supporting the effect of policy-based interventions in fighting domestic violence. They coincide with the study by Jewkes, Flood, and Lang, who stated that empowerment efforts and gender-transformative legal measures are key in helping to minimize violence against women (2015). In a similar manner, Richardson et al. (2022) discovered that greater societal support and financial autonomy in Pakistani women related to reduced domestic violence by a significant margin. Economic empowerment increases bargaining power in women and decreases dependence on abusive men whereas legal awareness builds confidence to report and resist violence (Malhotra and Schuler, 2005). Hence, holistic policy interventions based on financial independence, literacy in the legal issues, and social consciousness are essential to sustainable decline in domestic violence.

These results may be discussed in the frames of the Ecological Systems Theory (1979) by Bronfenbrenner and Feminist Theory (Dobash and Dobash, 1992). Ecological framework explains the development of domestic violence as the interaction of individual, relational, community and societal factors whereas Feminist Theory emphasizes on the continued presence of male dominance and female subordination through the patriarchal statutes. Both models are proven by the outcomes of the study, which shows that the experience of violence by women depends not just on the interpersonal relations, but also on the inequality systems. Practically, these insights imply multi-level intervention with education and economic inclusion, mental health services, and legal reform, to deal with domestic violence in a holistic manner. Inclusion of domestic violence screening and psychological counseling in the health system of any country would further lower the emotional effects of abuse; providing the survivors access to care when it is needed.

Summing up, the research reaffirms that domestic violence is a complex matter that is based on economic, psychological and structural disparity. It needs concerted policy measures that will focus on empowerment of women, sensitization of the communities and institutional accountability. The results gathered to date can be used to build upon an existing knowledge of the socioeconomic and mental health aspects of domestic violence in Pakistan as well as a sound empirical basis of further study and policymaking.

Limitations and Future Directions

Despite the fact that this study provides a valuable contribution to the current understanding of psychological consequences of domestic violence on

Pakistani women, there are a number of limitations that need to be admitted. First, cross-sectional research design makes it impossible to make causal conclusions between domestic violence and the mental state of women. The longitudinal studies in the future should monitor the effects of continued exposure to violence in determining the emotional and physical health of women as time passes. Second, the sampled approach of self-report questionnaire can be compromised by underreporting or the bias of social desirability since the subject is sensitive and Pakistani people have stigma on domestic violence. The use of mixed-method designs, including the combined methods of surveys and qualitative interviews, would assist in developing more obtained and genuine points of view. Third, the sample of 200 married women used in the study is not very large or representative in the whole region, so the application of the results is limited. There is a need to carry out broader studies that would include women of different marital statuses, socio-economic groupings and rural and urban areas to increase representativeness.

The analysis also concentrated on two variables, including domestic violence and mental health, and hence, missed the possibility of the mediating and moderating variables like social support, coping, education, and access to healthcare. These factors should be incorporated in future studies in order to reveal the intricate mechanisms between violence and health outcomes. Finally, one should not overlook the role of the cultural and structural factors that are deeply embedded and, thus, may be difficult to measure using Western-based scales, including patriarchal traditions, economic dependence, and lack of legal protection. Hence, the following researchers need to emphasize culturally modified tools and regionally based models that will be representing the South Asian social reality. Overall, this study contributes to the knowledge of domestic violence and mental health in women, but prospective studies need to be more comprehensive, longitudinal, and culturally sensitive to inform the effective intervention and policy formulation.

CONCLUSION

This study was done on the effect of domestic violence on the health of women in Pakistan, in which 200 married women were involved. Women The results showed a clear and strong connection between domestic violence and poor health outcomes for women. As the level of domestic violence went up, women's physical, emotional and mental health all suffered. The analysis revealed that domestic violence was a significant predictor of poor health, accounting for 31% of the gap in health scores. These findings are in line with what other studies have found, indicating domestic violence is a big problem when it comes to women's physical and mental well-being. The study further indicates that the impacts of domestic violence do not stop at physical injuries, however can also lead to long-lasting stress, anxiety, depression, reproductive health and a lower quality of life. It also found that women who had less money and less education were more likely to be victims of violence, and had less opportunity to get help from health or legal services. These results demonstrate that domestic violence is not only a personal

issue but a major public health concern, which requires an intervention from various domains, such as government, healthcare, and social organizations.

Recommendations

The results of this study highlight the importance of the need to urgently develop comprehensive measures to deal with domestic violence and its psychological consequences on Pakistan women. The government should strengthen the enforcement of the legislation that is available regarding domestic violence and provision of shelter, legal facilities or protection departments particularly in areas in countryside which is where women are the most vulnerable. Awareness campaigns done in the community should fight the patriarchal system and inform both of the genders concerning the legal rights, gender equality and serious ramifications of abuse. Violence signs should be identified and treated by health care professionals as routine medical activity by training them to be sensitive to possible violence and report any cases to the authorities. In addition, NGOs and governmental establishments should work together to provide the survivors with counseling and psychosocial assistance. They should focus on women economic empowerment by providing vocational training and micro-finance to eliminate dependence on abusive males. Finally, future research should investigate mediating factors like social support, resilience, and coping strategies to develop culturally sensitive intervention models that promote long-term recovery and empowerment.

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