Psycho-social Correlates of Intimate Partner Violence

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This study is aimed at assessing whether the effects of exposure to intimate partner violence reflects upon the psychological well-being and social functioning of women. The relationship of domestic violence with life orientation, satisfaction with life, self-esteem, social confidence, and social anxiety was specifically explored. A total of 416 women with age range of 18-55 years selected from eighteen towns of Karachi city participated in the study. Findings of study suggested that married women in Pakistan are frequently exposed to oppressive behaviors by their intimate partners. Rates of physical abuse, psychological abuse and sexual abuse were 52%, 84%, and 55%, respectively in this study sample. Correlation analysis indicated significant positive correlation ($p < .001$) between scores of participants on Karachi Domestic Violence Screening Scale Urdu version (Hassan & Anila, 2009) and Siddiqui Shah Depression Scale (Siddiqui & Shah, 1997). Significant negative correlation ($p < .001$) existed between domestic violence and the following indicators of psychological well-being: Self-esteem (Rosenberg, 1989), positive orientation towards life (Scheier, Carver, & Bridges, 1994), and satisfaction with life (Diener, Emmons, Larsen, & Griffin, 1985). A simple regression analysis showed that domestic violence significantly affects psychological well-being of women, particularly their satisfaction with life, self-esteem, and depression scores. The implications of the intimate partner violence as a marker for poor psychosocial well-being in married women are discussed in the context of Pakistani society.

Keywords: domestic violence, psycho-social factors, abuse, women, intimate partners

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Women have central position in any society and their psychological and social well-being is strongly related with overall well-being of any society. For the last two decades, international health agencies are placing special emphasis on women's physical, reproductive, and mental health. Researchers, therefore, focused on investigating the mental health profile of women and factors associated with poor mental health.

Unfortunately, women specifically in less developed societies of the world belong to the underprivileged group who are at high risk of being a victim of domestic violence. Domestic violence committed against women is likely to have serious repercussions on physical and mental health of abused women. Understanding the perpetrators and consequences of domestic violence committed against women is an important area of study. On the basis of observations made by studies on violence against women, some effective measures can be taken to address the issue (Fikree, Razzak, & Durocher, 2005; Rabbani, Qureshi, & Rizvi, 2008).

The association of domestic abuse with negative health outcomes can be estimated by prevalence rates of Intimate Partner Violence (IPV) among women seeking care in family practice and mental health clinics. For example, a study conducted in America reported that 20% of women who seek care at family clinics have actually experienced physical, emotional, or sexual abuse by their intimate partners and received medical care and 10% even required hospitalization because of serious injuries (Coker, Smith, McKeown, & King, 2000). Studies conducted in the West (including America and Europe) (Leone, Johnson, Cohan, & Lloyd, 2004; Taylor, David, & Fields, 2003; Ulrich et al., 2003) and surveys from South-Asian countries (Kumar, Jeyaseelan, Suresh, & Ahuja, 2005; Purewal & Ganesh, 2000) have also provided insights on the sufferings of abused women. The rising rates of mood disorders, specifically depression in women, are one of the major concerns of mental health providers around the world.

The literature from the West has shown that most common psychiatric disorders found among abused women include depression, post-traumatic stress disorder (PTSD), somatization, suicide, eating disorders, substance dependence, antisocial personality disorders, and non-affective psychoses (Campbell, 2002). This has increased the burden on mental health facilities. Golding (1999) conducted a meta-analysis of studies from different parts of the world and found that approximately, more than 18.5 million mental healthcare visits per year are made by women who face domestic violence in their intimate relations.

A study on pregnant women revealed that women who had violent marital relationships were more depressed, and had higher levels of stress and anxiety scores than other women (Reel, 1997). Some studies have recommended that physical abuse is the single most important risk factor for depression resulting in 70% of mental health problems among women (Campbell & Lewandowski, 1997; Cascardi, O'Leary, & Schlee, 1999). Other studies have indicated that psychological abuse is also a contributing factor and significant correlations of psychological violence with depressive symptoms in victimized women are reported (Christian-Herman, O'Leary, & Avery-Leaf, 2001; Murphy & Cascardi, 1999). Taylor et al. (2003) found that IPV was indicated in 55% of a sample of depressed women. Hegarty, Gunn, Chondros, and Small (2004) interviewed more than one thousand women in general practice surgeries and found that 18% of these women were currently depressed, and 24% were experiencing or had experienced physical, psychological, or sexual abuse in their intimate relationship.

A World Health Organization (WHO, 2002) report on violence and health also showed that women are the prime victims of domestic violence in most of the countries of the world. Women who were abused by their partners had higher rates of depression, anxiety, and phobias than nonvictimized women. The most common symptoms of psychological distress included crying easily, inability to enjoy life, and fatigue. These women were also at heightened risk for suicide and suicidal attempts. A few studies have also indirectly provided evidences of impacts of various acts of violence on quality of women's lives. For instance, Wittenberg, Joshi, Thomas, and McCloskey (2007) conducted a qualitative study in Philadelphia on abused women and demonstrated that marital partners often exhibit controlling behaviors and restrict their wives to participate in activities outside the home. A variety of restrictions are imposed on women like work, social gatherings or any other type of community work. This might result in reduced quality of life for these women. Findings of this study also reported that domains of health influenced by IPV include physical, emotional, psychological, and social functioning. Violent husbands often impose restrictions on the social activities of their wives and these women do not enjoy freedom in their lives. These restrictions are a violation of both their dignity and integrity (Bunch, 1993). The most severely effected domain was psychological health. Leone et al. (2004) reported that working women who are subjected to intimate terrorism are unable to pay proper attention or continue with their work which can be indirectly associated with social anxiety and lack of confidence. These women are also at an

increased risk of being unable to achieve and maintain self-sufficiency.

Previous literature has shown that IPV is a serious public health issue and has serious repercussions on women's psychological functioning. However, there is a paucity of data on this aspect from Pakistan as only few studies are available at present (Aftab & Khan, 2011; Rabbani et al., 2008; Shaikh, 2003). By the time (2003) this study was designed and conducted no data was available from Pakistan which has specifically assessed the psychological and social functioning of abused women. This study is aimed at assessing whether the effects of exposure to IPV reflect in form of poor psycho-social well-being. Satisfaction with life, llife-orientation, social anxiety, and social confidence are some of the dimensions of psycho-social well-being which have been assessed in this study. It is hoped that the findings of this study will be able to provide insight about the consequences of abuse experiences. The study has broad scope and long-term implications as paying attention to sufferings of abused women will ensure better psychological and socio-economic conditions for current and future generations of Pakistan.

Method

Participants

The sample for study comprised of 416 women living in Karachi city. Karachi is a big city. At the time of data collection, Karachi was geographically divided into 18 towns. Approximately 20-25 women as per convenience were selected from each town. The inclusion criteria for sample in this study were 1) at least one year of marriage, 2) presently living with husband, and 3) must be able to understand Urdu language. The age of the participants ranged between 18 to 55 yrs. ($M = 33$; $SD = 9.5$). Thirty three percent ($n = 138$) have completed education up to primary level; 99(24%) up to matriculation; 67(16%) up to intermediate level; 76(18%) up to graduation level; 12 (3%) up to masters level, and 24(6%) have completed professional degrees. The years of marital relation range between 2 to 30 years ($M = 13$; $SD = 9.5$). The number of children range between 0 to 8 children ($M = 3.0$; $SD = 2.9$). Eighty percent ($n = 333$) of women were housewives. The age of husbands range between 24 to 60 yrs. ($M = 39$; $SD = 10.1$). Percentage of husbands who have completed education up to primary level was 11%($n = 46$), up to matriculation level 23%($n = 96$), and 10%($n = 42$) up to Masters' level and rest had

professional degrees. All of them were employed, 33%(n = 137) percent were doing very low-paid jobs. Low-paid jobs mean that they were working as sweepers, guards, drivers, cooks, and office peons.

Measures

Following measures were used in this study.

Demographic Sheet. The demographic sheet was used to obtain information about participants' age, education, employment status, years of marital relation, number of children, husband's age, education, employment status, family income, and living system.

Karachi Domestic Violence Screening Scale Urdu Version (KDVSS-U). The exposure to IPV was assessed by women's scores on KDVSS-U (Hassan & Anila, 2009). This scale was originally developed in Urdu language and assesses exposure to Physical Abuse, Psychological Abuse, Sexual Abuse, Characteristics of Abusers, and Characteristics of Victims in intimate relation. It comprises of 35 items. There are 5 items to tap Physical Abuse, 5 items for Sexual Abuse, 15 items for Psychological Abuse, 5 items for Characteristics of Abuser, and 5 items for Characteristics of Victim. Each item is rated on a 4-point Likert scale (0 = *Never*; 1 = *Rarely*; 2 = *Sometimes*; 3 = *Most of the time*). The minimum and maximum range of scores on whole KDVSS-U is 0-105. The range of score in this study sample on KDVSS-U is 0-98. The minimum and maximum range of scores on Physical Abuse scale, Sexual Abuse Scale, Characteristics of Victims, and Characteristics of Abuser subscales are 0-15. The range of scores obtained in this study sample on Physical Abuse, Sexual Abuse, Characteristics of Victims, and Characteristics of Abuser subscales are 0-12. The minimum and maximum range of scores on Psychological Abuse scale is 0-45. The range of scores obtained in this study sample on Psychological Abuse subscale is 0-33. To discriminate between abused and nonabused women a score of >3 was taken as cutoff score. It was suggested by experts on women issues that zero tolerance policy should be adopted regarding presence or absence of abusive behaviors. Therefore, any woman who has scored 1 or above than 1 should be taken as abused women. There were only 2 women who had scored 0 on this scale. This make it difficult to compare the abused and nonabused women for mean differences, therefore a score of 3 was taken as a cut-off score as per suggestion of experts. The Cronbach alpha of the scale on this study sample was .89.

Rosenberg Self-Esteem Scale (RSE). It is a 10-item measure (Rosenberg, 1989) of global self-esteem. The translated Urdu version of RSE (Sardar, 1998) was used in this study. Items on RSE are rated

on a 4-point Likert type rating scale ranging from *strongly agree* to *strongly disagree*. The overall score ranges from 0-30. The high score on scale indicates high self-esteem and low score indicate low self-esteem. The Cronbach alpha reliability for this study sample was .91.

Revised Life Orientation Test (LOT-R). It is a 10-item measure developed by Scheier, Carver, and Bridges (1994). The Urdu translated version by Anila and Ismail (2005) was used in this study. Items are rated on a 5-piont Likert type scale. The response categories are *strongly disagree* = 0 to *strongly agree* = 4. The responses on items 1, 3, 4, 7, 9, and 10 are summed up to obtain an overall score of the participants. Item 2, 5, 6, and 8 are filler items and not scored in the revised scale. The minimum score is 0 and the maximum score is 24. Higher scores on LOT-R indicate the respondent's optimistic attitude towards life, whereas, lower scores indicate pessimism. The Cronbach alpha on this study sample was .69.

Satisfaction with Life Scale (SWLS). Developed by Diener, Emmons, Larsen, and Griffin (1985), SWLS consisted of five statements about life satisfaction. The Urdu translated version by Anila and Ismail (2005) was employed in this study. Respondents rate each item on a 7-point Likert type scale (1 = *strongly disagree* to 7 = *strongly agree*). Total score is obtained by summing up score on each item. The minimum score is 5 and maximum score is 35. Low scores indicate less satisfaction with life and high scores indicate more satisfaction with life. The Cronbach alpha for this study sample was .92.

Self-Confidence Scale (SCS) and Social Anxiety Scale (SAS). This scale was developed by Khalilque, Khan, Jahangir, and Iqbal (2003). It was designed to measure two aspects i.e. self-confidence and social anxiety through one scale. The items on scale were translated into Urdu by following standard procedures of translation. This scale has total 20 items. Since the scale attempts to measure social anxiety and social confidence in one attempt, all the responses to items are scored on 5-point Likert type scale (*Always* = 5 to *Never* = 1). Scores obtained on items are summed scale-wise. The minimum score on each scale is 1 and maximum is 50. High scores on SCS show more social confidence and high scores on SAS show higher levels of social anxiety. The Cronbach alpha for SCS was .69 and Cronbach alpha for SAS was .89 in this study sample.

Siddiqui Shah Depression Scale (SSDS). This scale was originally developed in Urdu by Siddiqui and Shah (1997) to screen depression. The scale has total 36 items. Each item is rated on 4-point rating scale from 0-3 (0 = *Never* to 3 = *Most of the time*). The total score is obtained by summing scores on all items. The scores range

0-108. Low scores indicate absence or lower levels of depression and high scores indicate higher levels of depression. The internal reliability for this study sample was .87.

Procedure

In context of increased rates of crimes in Karachi city; concerns of women about their safety and confidentiality of information; it was not possible to directly access and interview women at their homes. If women were interviewed at their homes, chances were high that they could not provide true information about abusive behaviors of their intimate partners due to fear in the presence of other family members. Therefore, data was collected in clinical settings. The Out-Patient Departments (O.P.D.) of General Medicine and General Reproductive Health from one private hospital and one government hospital in each town of Karachi city was randomly selected. Women who came to hospitals/clinics to seek healthcare for their health-related issues were requested to participate in the study. A rapport was established with the help of available duty doctors and duty nurses. An informed consent was obtained and confidentiality of information was assured. Interviews were conducted in a separate small room or space provided by hospital administration on request. All the interviews were conducted by first author. Items on questionnaires were read by interviewer and responses were noted in order to maintain consistency in data collection method. It took approximately 30 to 35 minutes in completing one assessment.

Results

The mean score of participants on domestic violence screening scale was ($M = 23$; $SD = 22.1$). The minimum score on KDVSS-U is 0 and maximum score on KDVSS-U is 105. To discriminate between abused and nonabused women a score of >3 was taken as cutoff score. As a consequence, 65(16%) women are identified as nonabused and 351(84%) as abused. Overall, a high percentage of women reported psychological abuse 84%($n = 349$), physical abuse 52%($n = 216$), and 55%($n = 253$) of women reported sexual abuse in this study sample. There is overlap in reporting of abuse experiences.

In Table 1, notable differences exist between mean scores of abused and nonabused women on most of the scales assessing psycho-social distress and psychological well-being of women. The difference is nonsignificant in case of SCS only.

Table 1
Mean, Standard Deviations, and t-value for Scores of Abused and Nonabused Women on Psychological Health Measures (N = 416)

Variables	Nonabused (*n* = 65) M(SD)	Abused (*n* = 351) M(SD)	*t*(414)	*p*	95% CI LL	UL	Cohen's d
SSDS	11.1(8.8)	30.1(21.0)	6.34	.000	12.3	23.3	.80
SAS	30.1(10.6)	30.8(8.2)	1.98	.048	-4.81	-.026	.29
RSE	26 (6.2)	21.49(6.8)	3.52	.000	-4.68	-.936	.40
SCS	30.0(7.2)	27.1(6.8)	1.39	.160	-3.28	.555	.21
LOT	14.7(2.6)	13.4(3.4)	2.59	.010	-2.30	-.311	.30
SWLS	29.1(5.3)	21.21(8.7)	6.74	.000	-10.0	-5.51	.80

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; SSDS = Siddiqui Shah Depression Scale; SAS = Social Anxiety Scale; RSE=Rosenberg Self-esteem Scale; SCS = Social Confidence Scale; LOT = Life Orientation Test; SWLS = Satisfaction with Life Scale. SSDS and SAS measure psychological distress. RSE, SCS, LOT and SWLS measure psychological well-being.

In Table 2, all three forms of abuse (physical, psychological, and sexual abuse) positively correlate with domestic violence providing evidence for construct validity of scale. Nonsignificant negative correlation exists between social anxiety and all three forms of abuse. Negative correlation is indicated between social confidence and physical abuse. Social confidence is negatively associated with psychological and sexual abuse; however, the relationship is nonsignificant.

Table 2
Inter-correlations for Scores on SSDS, SAS, RSE, SCS, LOT, SWLS, and KDVSS-U with Subscales (N = 416)

	1	2	3	4	5	6	7	8	9	10
1 KDVSS										
2 Physical Abuse	.88	-								
3 Psychological Abuse	.98	.83	-							
4 Sexual Abuse	.90	.84	.86	-						
5 SSDS	.73	.67	.70	.68	-					
6 SAS	-.08	-.04	-.08	-.10	-.03	-				
7 RSE	-.48	-.43	-.47	-.44	-.50	.04	-			
8 SCS	-.07	-.10	-.07	-.07	-.12	-.48	.08	-		
9 LOT	-.40	-.37	-.38	-.36	-.44	-.05	.34	.05	-	
10 SWLS	-.67	-.55	-.66	-.60	-.67	.03	.45	.10	.48	-

Note. KDVSS = Karachi Domestic Violence Screening Scale Urdu Version; SSDS = Siddiqui Shah Depression Scale; SAS = Social Anxiety Scale; RSE = Rosenberg Self-esteem Scale; SCS = Social Confidence Scale; LOT = Life Orientation Test; SWLS = Satisfaction with Life Scale. SSDS and SAS measure psychological distress. RSE, SCS, LOT, and SWLS measures assess psychological well-being.
Values .10 to .12 are significant at *p* < .01. from .34 to .98 is significant at *p* < .001.

Table 3

Summary of Simple Linear Regression Analysis for Women Psychological and Social Well-being (N = 416)

Variable	B	SE	β	t	p	R^2	95% CI
LOT	-.063	.007	-.40	-8.87	.000	.16	-.077-.049
SWLS	-.247	.014	-.667	-18.2	.000	.44	-.274-.221
SAS	-.031	.018	-.083	-1.69	.091	.007	-.067-.005
SCS	-.022	.015	.074	-1.51	.130	.006	-.051-.006
RSE	-.142	.013	.479	-11.1	.000	.23	-.167-.117
SSDS	.659	.031	.728	21.6	.000	.53	.599-.719

Note. β = Standardized beta; CI = Confidence Interval; LOT = Life Orientation Test; SWLS = Satisfaction with Life Scale. SAS = Social Anxiety Scale; SCS = Social Confidence Scale; RSE = Rosenberg Self-esteem Scale; SSDS = Siddiqui Shah Depression Scale. SSDS and SAS measure psychological distress. RSE, SCS, LOT, and SWLS measures assess psychological well-being.

In Table 3, a simple linear regression analysis is performed. Domestic violence is taken as the independent variable and measures of psychological well-being as dependant variables. Findings indicate that domestic violence significantly affect life orientation, satisfaction with life, self-esteem, and depression scores of participants.

Discussion

Findings of this study add to the growing body of evidence demonstrating that IPV is positively associated with women's poor psychological functioning. Findings of this study revealed that all types of abuse (physical, psychological, and sexual abuse) were experienced by women. High rate of reporting about physical and sexual violence in marital relation is explained by the nature of items on KDVSS-U. Some items on subscales assessing physical abuse and sexual abuse asked direct and indirect questions. Combination of direct and indirect questions about exposure to physical or sexual abuse stimulates some degree of response from the respondents as supported by Sagot (2005). She reviewed domestic violence case studies from 10 countries of the world and suggested that domestic violence investigations should be made by direct and indirect questions. She noticed that in countries with more conventional family systems, women talk about exposure to sexual and physical abuse by intimate partner in response to direct questions from the researchers.

The data collection places selected for this study could also be one factor for high rates of abuse reported in this study sample. The

data was primarily retrieved from family health clinics, where mostly women came to seek reproductive healthcare services. Previous studies have shown that rates of domestic abuse are high in clinical populations (Taylor et al., 2003). Most of the women who participated in this study were referred by on-duty doctors and it became easy for the researcher to establish rapport with them. These settings helped women to share their painful experiences without any fear and reluctance. Prior evidences also suggest that women are comfortable with domestic violence screening in urban family medicine settings (Chen et al., 2007). The rates of abuse for physical, psychological, and sexual abuse in this study sample are in-line with the rates reported in previous surveys. Surveys conducted in seven cities of India during 1997-99 showed that 40-44% of women experienced physical and psychological domestic violence in their married lives, and 15% of women were forced for sex by their husbands (International Center for Research on Women [ICRW] & International Clinical Epidemiologists Network [INCLEN], 2000).

Results have also shown that IPV is significantly associated with depression in this study sample. This is in-line with the indications made by previous studies which have shown that IPV is linked with depression, fear, guilt, shame, and an increased risk of suicide (Romito, Molxan, & De Marchi, 2005). Findings of this study showed that all three types of abuse i.e. physical, psychological, and sexual abuse strongly correlate with high rates of depression. This is in accordance with the statistics reported by previous surveys (Ellsberg, Calerada, Herrera, Winkvist, & Kullgren, 1999; Purewal & Ganesh, 2000; Wittenberg et al., 2007). It has been indicated that physical abuse as well as other types of abuse are the important risk factors for emotional distress and responsible for more than 70% of mental health problems among women including depression (Purewal & Ganesh, 2000; Wittenberg et al., 2007). The regression analysis carried out in the present study also supports previous study findings by showing that 53% of the variation in depression scores was explained by domestic violence.

It was presumed that domestic violence will be significantly associated with increased social anxiety and decreased social confidence of women. This was assumed on the basis of prior evidences which suggest that IPV results in development of generalized anxiety, phobia, and fear (Holtzworth-Munroe, Bates, Smutzler & Sandin, 1997). Contrary to expectations, the analysis of findings indicated a negative but nonsignificant correlation of domestic violence with social anxiety. It seems that this negative nonsignificant relation is attributable to the nature of items on the

scale. Items on SAS elicit information from participants about the anxiety that they experience while attending social gatherings. Women's responses to these items can be interpreted in context of their socio-demographic backgrounds. The majority of women in this study sample were housewives and they might have provided responses to items of SAS in the context of social gatherings attended by them like marriage ceremonies, funerals, and get-togethers with friends or relatives. In Pakistani society, very often there are separate arrangements and socialization places for ladies and gents. Women experience little reluctance to socialize with each other and frankly share their personal concerns and issues. Most of the women have common family problems and thus are able to relate with each other. This social network of women is, in fact, very strong; very often it provides major support to housewives. It is quite probable that participants of study responded to the items on SAS by relating their positive experiences of social gatherings. However, this aspect needs further exploration.

Social confidence is an important feature of social well-being. The comparison of mean scores of abused and nonabused women on SCS showed that nonabused women showed slightly higher social confidence as compared to abused women. As hypothesized, social confidence is found to negatively correlate with domestic violence in this study sample; however the relationship was nonsignificant. All types of abuse - physical, psychological, and sexual abuse - also negatively correlate with social confidence. The most significant negative correlation was with physical abuse which is understandable and justified. Physical abuse very often results in facial and other types of injuries which are more evident as compared to psychological and sexual abuse. Secondly, many aspects of psychological abuse and forced sex are very often taken as part of marital relation among Pakistani women. The social confidence of women is likely to be shattered because of abuse related injuries. Hitting and slapping an adult person are expected to cause more distress. The presence of physical abuse in intimate relations itself erodes the trust of a person on others which ultimately results in decreased social confidence.

This study not only focused on assessing the negative mental health outcomes of domestic violence on women's lives but also assessed some aspects of psychological and social well-being. In the last few decades, increased emphasis has been placed by international world health agencies on complete human well-being and security. As hypothesized and synchronized with previous findings (Kirkwood, 1993) results of this study also revealed that domestic violence correlated negatively with self-esteem. Ruiz-Pérez and Plazaola-

Castaño (2005) also demonstrated negative association of IPV and psychological health. They compared a group of abused women with never-abused women and found that psychological abuse solely was more likely to present with lowered self-esteem. Papadakaki, Tzamalouka, Chatzifotiou, and Chliaoutakis (2009) also demonstrated that women are unable to break the cycle of violence because of their low self-esteem.

Dispositional optimism and life-satisfaction are important components of persons' psychological and social functioning. Findings of this study indicated negative correlation of domestic violence with satisfaction with life. Findings of the present study have also demonstrated that all types of abuse — physical, psychological, and sexual — had negative correlation with these two attributes. These findings are consistent with prior research findings. A study by Mercy, Krug, Dahlberg, and Zwi (2003) indicated that IPV is coupled with lower life satisfaction and lower quality of life. Present study findings not only add to prior evidence but also raise questions about the direction of impact. Lower levels of satisfaction with life, low self-esteem, and negative life orientation can also be contributing factors for poor marital relations. Couples who have overall negative orientation towards life are unable to see the positive aspects of their marital relation since marriage is a mutual contract and both partners have to make some contributions for its success. An overall negative approach towards life could result in the view that the marital relation is filled with flaws. Minor disagreements between husband and wife sometimes lead to conflicts which might result in abusive episodes. Husband being physically powerful very often use physical abuse to express their maleness and wives because of their feminity or weak physical structure are at risk of facing violence (Dhawan et al., 1999; Rabbani, Querishi, & Rizvi, 2008; Resick & Reese, 1986).

It was not possible to obtain any base-line or follow-up data for this study, therefore, inferences regarding low self-esteem, negative life orientation, low satisfaction with life as a causative factor or a consequential element cannot be drawn from findings of this study. Simple linear regression analysis indicated that domestic violence significantly predict lower levels of satisfaction with life, low self-esteem, and high rates of depression in effected women. Retrospective studies of victimized women can provide detailed and more appropriate explanations regarding nature of association between these psychological attributes and domestic violence victimization. This fact cannot be ignored that such detailed studies are sometimes not very much feasible due to cultural constraints in conventional societies like Pakistan.

Lee (2002) pointed out that Asian women generally do not expose their experiences of violence because reporting means shaming family name and violating the perseverance and endurance in relationship. Retrospective or follow-up studies require more than one interaction with study participants which is very often not possible for an average Pakistani woman due to family and cultural constraints. In this scenario, findings of cross-sectional studies can contribute significantly to obtain some data and devising strategies to control this menace. This study has achieved its objectives by providing information about rates and nature of domestic abuse faced by women which is later reflected upon their lives as poor psychological and social functioning.

Limitations and Suggestions

The study has few limitations. Firstly, the data was collected from a multi-ethnic city of Pakistan, but the demographic information lacked data upon race and ethnicity of participants, which could be useful to identify high-risk population. Secondly, the data was primarily collected from health care settings where women may tend to over-report symptoms of depression.

The research agenda was rooted in addressing the problem from public health perspective, which focused on risk factor identification for various physical or mental health problems. Keeping in view the high prevalence and distressing outcomes of domestic violence upon victims' psychological health, as demonstrated by this study findings, it is necessary that in Pakistan health policy makers develop basic knowledge and expertise in order to provide culturally competent leadership regarding prevention, intervention, and health policy in family violence. Hospitals are the best places which can be involved in providing some services to victimized women. Hospital-based programmes are beneficial because women can easily utilize these health centers as an entry point for variety of services women need to come out of abusive relationships.

Conclusion

Women in Pakistan are vulnerable to mental health problems and poor psycho-social well-being because they are regularly exposed to physically, psychologically, and sexually oppressive behaviors carried out by their intimate partners. As clinical settings provide effective

environment for screening of abuse in women, some effective preventive measures and intervention strategies can be made available to women in clinical settings.

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