Frontiers in Health Informatics www.healthinformaticsjournal.com
ISSN-Online: 2676-7104
2024; Vol 13: Issue 3 Open Access

# MENTAL HEALTH CHALLENGES AND INTIMATE PARTNER VIOLENCE AMONG MARRIED WOMEN IN RURAL AREAS OF SOUTH PUNJAB

**Shahla Naeem,**
Assistant Professor, Family and Community Medicine Department, King Faisal University, Al Hofuf, Kingdom of Saudi Arabia. Email: shahlanaeem010@gmail.com.

**Muneeba Syed,**
Quaid-e-Azam Medical College Bahawalpur, Email: muneebasyed6@gmail.com

**Rehmat Ali,**
Medical Officer, Sadiq Abbasi Hospital/ Quid-e-Azam Medical College Bahawalpur, Email: Chaudhryrehmatali1@gmail.com

Cite this paper as: Shahla Naeem, Muneeba Syed, Rehmat Ali, (2024), Mental Health Challenges And Intimate Partner Violence Among Married Women In Rural Areas Of South Punjab. *Frontiers in Health Informatics*, *13(8) 4880-4890*

**ABTRACT**

**BACKGROUND:** A prevalent worldwide public health concern that needs urgent attention is intimate partner violence (IPV), which is defined as behavior by an intimate partner that has the potential to cause physical, under a different name, sexual. The most prevalent type of violence in Punjab, Pakistan's rural areas is intimate partner violence (IPV).

**MATERIALS AND METHODS:** 565 married women who had been the victims of IPV in South Punjab's rural districts participated in in-depth interviews for this qualitative phenomenological study. Data was gathered using a semi-structured interview guide. Using a snowball sampling technique, these ladies were chosen between October 2022 and March 2023. The interviews were translated into English after being audio recorded in different language. Thematic inductive analysis was used to examine the data.

**RESULTS:** Using the socio-ecological framework, the study has given the many aspects of IPV in Pakistan's rural South Punjab. Culturally contextualized terms such as "protection," "mental delicacy," "physical submissiveness," and "social security" were introduced in the current study. Mental symptoms were common in the entire female population. However, in comparison to women who were not exposed to violence, women who experienced any kind of violence reported much worse mental health. Even after adjusting for sociodemographic variables, there was still a statistically significant difference for practically all of the health measures under study. The largest correlations were observed between sexual abuse, psychological abuse, and suicidal thoughts and physical aggression. According to the interviews, just 27% of the women who experienced violence and also told anyone about it, usually their parents.

**CONCLUSION:** Through public awareness campaigns drives inside public institutions such as the police and judiciary, expectations imposed by orthodoxy and gender-prejudiced roles, misinterpretations of Islamic teachings, and the dominant patriarchy can be challenged. Women

can be empowered through education and employment, which can also assist to question traditional anti-feminist social norms and the function of kinship-based networks in the family and community.
**KEYWORDS:** Intimate partner violence, domestic violence, mental health effects, depression, suicidal thoughts.

## INTRODUCTION

A prevalent worldwide public health concern that needs urgent attention is intimate partner violence (IPV)[1]. UNESCO reports that male intimate partners are responsible for 85% of violence against women [2]. According to statistics from the World Health Organization (WHO), 30% of women worldwide are victims of violence committed by their spouses [3]. IPV affects socioeconomic, religious, and cultural groups and happens in all contexts [4]. Nonetheless, low-and-middle-income countries (LMICs) in the Middle East, South Asia, and Africa have higher rates of IPV incidence as well as a more prevalent social and cultural backdrop [5].

Physical, mental, and reproductive health of women is significantly impacted by IPV [6][7]. Furthermore, the social and cultural phenomenon of IPV is linked to demographic factors like age, family type, number of children and violence risk [8][9], socio-cultural factors like substance or alcohol use, and exposure to parental violence[10], as well as individual factors like socioeconomic status, relationship status, and intergenerational exposure to domestic violence [11][12]. Compared to older groups of women, younger women are more likely to experience intimate partner violence. Similarly, women who live in joint households, have less access to resources, and have lower levels of education are also more likely to experience intimate partner violence[13].

In addition, women are more likely to experience violence in the home if they had an unexpected pregnancy [14][15], a family history of abuse, or insufficient social network support [16].

Because women play a multifaceted role in the home, IPV against them has become more common since the 1960s [17]. Worldwide, between 10% to over 60% of women will experience physical abuse at some point in their lives at the hands of their intimate partners [21]. A national poll conducted in Pakistan found that 26% of men and 38% of women defend "wife beating" when a wife disputes [22].

Ironically, in Pakistan, women are more likely than males to defend IPV. The fact that 80% of Pakistani homes encounter some sort of IPV provides illuminating information on this social and cultural issue. According to reports, 70% of Pakistani women have been taught to conceal domestic abuse because doing so would embarrass their family [23, 24]. Furthermore, sociocultural norms teach women to tolerate or defend IPV [25, 26]. Data on the sociocultural aspects of IPV in South Punjab's domestic realm is not directly accessible. Family arrangements are ingrained in the region's strict cultural beliefs. The majority of women have little control over domestic affairs, and serious vulnerabilities create an environment that is conducive to tense power dynamics.

Due to the cultural backdrop of male supremacy in the South Punjab region, men have total control over all aspects of the home. Through its hierarchical and unequal systems, patriarchal society upholds men's dominance over women in subordination. The individual and cultural origins of IPV have received little attention from earlier theoretical feminist regimes in the field. When discussing the socio-cultural dynamics of IPV, the feminist approach highlights the vast efforts of gender and power. In order to advance women's equality and empowerment, the related solution calls for social and cultural change. Through women's lived experiences and

perceptions of IPV, the current study aims to detangle IPV from normative cultural patterns. It has also studied the socio-ecological dynamics of IPV in rural South Punjab, Pakistan.

## MATERIALS AND METHODS

To conduct the current study, a qualitative phenomenological study design was employed. A concept or social phenomenon's shared meanings for several people based on their lived experiences are the focus of phenomenology [27, 28]. The daily base experiences of married women who were victims of IPV were investigated using this research approach. Furthermore, researchers can purposefully bracket or drop their preconceived notions, beliefs, experiences, and ideas from the phenomenon under study thanks to this approach [29]. Ten districts - Multan, Dera Ghazi Khan, Rahim Yar Khan, Layyah, Bahawalpur, Khanewal, Rajanpur, Lodhran, Muzaffargarh, and Bahawalnagar—make up Pakistan's Southern Punjab. 34% percent of Punjab province's population lives here. Saraiki is the native tongue of the research region. In three districts, 42 in-depth interviews were carried out. One village was chosen from Khanewal and Vehari districts, while two were chosen from Multan and Lodhran districts. In actuality, Khanewal and Vehari have smaller populations than the other two districts, whereas Multan and Lodhran have higher population densities. Consequently, we chose one hamlet from the low-population areas and two from the densely inhabited districts. We performed in-depth interviews (IDIs) with the victimized abused women in the study environment since the study neighborhood included orthodox cultural norms [24, 30]. Women with victims of intimate partner violence (IPV), lived with their spouse, and consented to engage willingly in the study were eligible to participate. In order to locate and enroll the participants, the researchers enlisted the assistance of gatekeepers, who are Lady Health Workers (LHWs) from community health programs in their individual communities. Approaching the LHWs as the gatekeepers to recruit eligible participants was motivated by a number of factors, including their simple access to every home (ii), their intimate engagement with women in their catchment area (ii), and their understanding of the dynamics of family affinity (iii). Additionally, LHWs, who typically offer primary health care services at the home level, are aware of the majority of families in which women have suffered IPV. In order to identify the families where women encounter IPV, LHWs were contacted at the outset. The LHWs assisted in setting up a meeting with the participants after identifying the families that were worried. As a result, the LHWs found 125 houses in total, and with their assistance, they approached 565 women. 57 women who reported experiencing IPV were screened by researchers during their meeting with the identified women. Regretfully, six ladies (11.53%) declined to take part in the study because they were afraid of their husbands and didn't want to discuss their domestic issues. As a result, N = 46 women who had been victims of IPV and agreed to take part in the study were contacted.

Data collection was conducted between October 2022 and March 2024. Women who had been victim of IPV were interviewed in a total of N = 565 information was gathered in-person at women's houses in a specific location via interviews conducted in the Saraiki (local) language. Women were able to freely and fearlessly discuss their experiences with IPV because to this method. Because she was familiar with the local culture, the first author collected the data with two female researchers. The data was gathered from the victims without their abusive partners present in order to protect their privacy and confidentiality. These volunteers were made available to us by LHWs because the victims, husbands, and family members had complete faith in them. Before the holding of each interview, written consent was sought to confirm their willingness to engage in the research, recording the interviews, and note taking. Every conversation was recorded on audio, and the research assistants also took notes to record the participants' spoken and unspoken communication. The second author promptly transcribed the

recorded data into English, and the third author verified the legitimacy of the data by double-checking it. To find preliminary coding and address coding problems, a debriefing session was arranged following each interview [31]. The duration of the in-depth interviews was 60 to 90 minutes. The transitional phases of in-depth interviews included inquiries about domestic disputes, such as physical and sexual abuse. The first step in the data analysis procedure was a thorough thematic analysis of all field notes and transcripts. When analyzing the data, the researchers applied the bracketing approach. Prior to the data analysis, the authors wrote all of their preconceived notions, firsthand observations, and reflective notes [32]. Important motifs were found using the inductive technique [33]. In order to compile the primary themes, sub-themes, and interpretation of participant replies, this method enabled a thorough examination of the raw data. A tentative list of topics was created after a thorough analysis of every transcript. Sub-themes were later developed from these initial themes. Thematic analysis was used to identify themes, and prospective categories were coded and further classified based on the research's dimensional variations. Analytical conduction and continuous comparison techniques were also used by methodically looking at the parallels between various IPV-related dynamics in the home environment of the study area. All of the participants described comparable experiences, which led to the finalization of an extensive list of themes. Furthermore, following a thorough debate among academics, overlapping themes were eliminated from the final analysis. When preparing the manuscript, similar codes or recurrent participant statements were left out [34,35,36]. Additionally, the findings regarding the individual, relationship, community, and societal level aspects of IPV were presented using the socio-ecological framework.

## RESULTS

The majority (62%) of the 564 women were in the 23–32 age range. Women were less likely than men to have gone to school (54.9 versus 66.1%, respectively). The majorities of the ladies followed Islam and were housewives. The majority of the husbands (63%) were unskilled laborers, and nearly all of them (95%) had jobs. Of the women, just 12.7% worked for a living. Physical, sexual, and psychological violence were prevalent throughout life in 53.4%, 52.9%, and 87.3% of cases, respectively.

**Table 1 : Violence with Percentage**

| Types of Violence | Physical | Sexual | Psychological |
|---|---|---|---|
| **Percentage** | 53.4% | 52.9% | 87.3% |

In the study population, the mental health condition most commonly was reported with suicidal thoughts (52.4 %), with by feelings of worthlessness (48.9%) and difficulty in decision-making (38.6%). 52.2% of respondents reported having "fair, poor, or very poor general health."

**Table 2 : Mental Health Condition of Women with Percentage**

| Mental Health Condition | Suicidal Thoughts | Feeling of Worthlessness | Difficulty in Decision Making |
|---|---|---|---|
| **Percentage** | 52.4 % | 48.9% | 38.6 |

For the majority of the health disorders examined, there were statistically significant variations in the prevalence of poor mental health between women who had experienced violence and those who had not.

Up to 72.8%, 79.2%, and 61.8% of the women who experienced physical, sexual, and

psychological abuse, respectively, reported having suicidal thoughts. The category of "feelings of worthlessness" was also very common; 48.9% of victims of physical violence, 52.9% of victims of sexual assault, and 43.6% of victims of psychological abuse reported experiencing such feelings.

All health characteristics showed statistically significant correlations with physical aggression in the multivariate analysis, even after controlling for sociodemographic factors. "Loss of interest in previously enjoyed things" was not found as a statistically significant predictor for psychological violence, and only "memory and concentration problems" did not exhibit statistically significant odds ratios (OR) in the case of sexual violence.

The high correlation between suicidal ideation and the three types of violence was a startling discovery. The likelihood of suicidal ideation was three times higher in cases of physical and sexual violence than in those who were not exposed to any of the forms of violence. The odds ratio for psychological violence was 4.46.An effort was undertaken to look into some underlying causes because suicidal thoughts were very common in the entire study population and were closely linked to all types of violence. The most common cause of suicide ideation, according to women who had experienced abuse in any form, was "family problems" (49%), followed by "household work" (15%), and "husband's behavior" (10%). Several causes were mentioned, including the death of a son, family arguments, being tired of life, childlessness, illness, and sadness. For the entire population, the pattern remained consistent.

**Table 3 : Cause of Suicidal Thoughts**

| Cause of Suicidal Thoughts | Family Problems | Household Work | Husband's Behavior |
|---|---|---|---|
| **Percentage** | 49% | 15% | 10% |

If you can do it without worrying about the consequences, confiding in someone is a crucial coping strategy. Of the 565 women who experienced violence of any kind, only 226 confided in someone, namely their parents (n=286), acquaintances (n=40), and in-laws (n=13).

The parents (n=138; 19.8%), in-laws (n=25; 5.7%), siblings (n=19; 2.8%), friends (n=18; 1.5%), and kids (n=12; 3.2%) were the primary sources of the assistance and protection that only 25.7% (n=204) had actively get. Only a small percentage (n=17, 1.5%) had turned to any official authority for help, including the healthcare system, the courts, or a religious leader. Eight of these women had resorted to religious leaders, five had contacted social services, two had sought legal counsel, and only one had resorted to the health care system.

## DISCUSSION

Feminism is a key theoretical explanation of IPV in the home, according to the current study [40]. The results supported the husband's right to his wife and the oppression of women in marriage as a norm. Unbalanced power relations, discriminatory gender role expectations, and traditional social processes in marriage served as the foundation for these normative patterns [41]. Using gender-biased anti-feminist viewpoints, women were explained as representing "honor" and "prestige" in Pakistan. Married women ceded basic marital rights to their husbands in order to preserve this customary status quo. As a result, they had to deal with emotional failures, verbal abuse, physical coercion, and psychological oppression from intimate partners [42, 43]. The terms "wife battering," "spousal abuse," "family disequilibrium," and "marital violence" were employed by feminists to raise awareness of IPV against married women. These theoretical discussions clarified that IPV is a social-psychological problem that is structurally anchored rather than a personal issue involving couples. IPV is tolerated by women in

patriarchal society through a variety of power-oriented strategies that their spouses imply [44]. The feminist viewpoint clarified how women were constrained in a complicated arrangement of patriarchy and anti-feminism by their submissive and obedient indoctrination. According to the empirical results, a good wife is subdued, subdued, submissive, compliant, and subservient to her husband. These gender-asymmetrical responsibilities originated from male-dominant frameworks in which a wife's self-sacrificing behavior is expected to preserve marital peace in the home [45]. As is clear, a socio-ecological model was employed in this study to explain the different dynamics of IPV in the contextualized study area. The results of the current study supported those of earlier studies that showed brides who get married before the age of 20 were most of them to experience intimate partner violence [44, 46]. Nonetheless, there was a lower likelihood of young married wives reporting IPV against them. Additionally, prior research has shown that as women mature, the prevalence of IPV decreases [47]. The phrase "patriarchal bargain," which refers to the idea that women receive more security and authority within their marriages as they age, was demonstrated in earlier research [48,49,50].

As is clear from the study's setting, women's aging protected them from their husbands' misogynistic repressive behaviors. Through patriarchal agreements, these older women (in the mother-in-law relationship) now perpetuate the cycle of abuse against their daughter-in-law [48].

Similarly, married women's residency was the other individual component of IPV prevalence. Compared to urban people, rural women experienced higher levels of IPV exposure [43,51,52]. Low levels of education were the primary cause of IPV among rural women. Additionally, comparatively to women with high levels of education, those who were illiterate or less educated were more likely to experience intimate partner violence. Additionally, their lack of education caused the husbands to adopt patriarchal and orthodox beliefs, which in turn led them to abuse their wives. In a similar vein, prior research has confirmed that unwanted pregnancies, child count, and child sex are the root causes of intimate partner violence [53]. Furthermore, according to feminist viewpoints, females who experienced frequent acts of violence from their husbands and in-laws developed psychological depression, emotional abuse, and cognitive helplessness [54, 55].

The current research findings were confirmed by earlier studies, which also suggested that the wife must give up her identity to her husband and in-laws [56]. The main explanation was that because of his protecting and earning function, husband supremacy was regarded as a basic marital prerogative. Furthermore, women were supposed to be quiet and subservient in front of their husbands according to gender-sensitive norms. The wife's socialization codes made it more likely for her to put up with her husband's violent behavior and dominance in the home [5].

During data collecting, we also discovered that clashes, tensions, and disputes with in-laws were the other aligned cause behind IPV. Women were supposed to be selfless and submissive in front of in-laws, according to earlier scholarly discussions [57, 58].

In Pakistani households, the newlywed bride poses a threat to her sisters-in-law and mother-in-law. In addition to causing arguments and tensions between couples, these concerns forced the women to take advantage of the just wedded bride. These disputes led to violent acts and reproductive subordination in matrimony since the husband held a dominant position in marital relations. According to the facts, elder women establish and oversee a new kind of patriarchy that is fueled by the power and control game and fear of reliance in order to preserve their status and authority in domestic affairs [41, 42, 45]. According to these relationship elements, the second wave of feminism explained that the victim (wife) is under the authority and control of the offender (husband). In a male-dominated home setting, these dominating supremacies established a domination-tolerance connection between offenders and victims [59].

Furthermore, related theoretical considerations in the "cycle of violence" further clarified that victims of violence continued to experience the cycle of violence in three primary stages: (i) the stage of tension buildup; (ii) the stage of abusive relationships; and (iii) the stage of forgiveness or honeymoon. According to a theoretical explanation, the tension that is created in a marriage from the beginning of the marriage continues until a man is unable to manage and use violence. After letting out his emotions, the offender feels calmer and then apologizes to the victim for his violent actions. As a result, the victim forgot the violent acts of the perpetrator and gave them another chance. The honeymoon period, during which the victim believes the abuser won't use violence again, then begins. Feelings of powerlessness, poor decision-making, and the emergence of fear were the outcomes of continuous exposure to violent acts [41, 60].

According to the findings, groups that upheld conventional patriarchal gender norms and beliefs had higher rates of women being exposed to IPV. In this sense, an IPV victim feared that the police would accuse, humiliate, and make fun of them. The earlier exploratory study also confirmed that patriarchal societies were primarily where police mockery of IPV victims was most prevalent [61]. Additionally, the judiciary looked into and examined the police records on IPV. As a result, victims must deal with issues and hold-ups when it comes to law enforcement agencies providing IPV aid. The primary cause was the criminal justice system's reliance on IPV stereotypes [62, 63].

The results of this study supported the socio-ecological model, which explains the incidence of IPV in the study setting by combining social structure, cultural beliefs, and network linkages [64, 65]. The prior theoretical framework confirmed that the main components of patriarchy were power and domination. These factors guaranteed male dominance in society, which permeated households [59]. According to the study environment, the patriarchal values encouraged husbands to use their masculine authority to manipulate their spouses using a variety of strategies, from physical coercion to psychological abuse [66]. Furthermore, the main underlying cause of IPV in Pakistan is now conventional gender role expectations. By upholding their "honor," "prestige," "submission towards the husband," "obedient to in-laws," "confining them to household work," and "abiding by men's control over women," these expectations place pressure on women to uphold traditional values and family standards [41].

According to a prior study by Zakar et al., religious leaders counsel married women to embrace the "forgive and forget approach" in marriage, which is consistent with the current research theme. According to the patriarchal conventional standards that are currently in place, these religious leaders also hold the victim accountable for starting IPV by neglecting their marital duties. These religious authorities misunderstand the teachings of Islam and label women as "short-tempered," "emotional," and "physically docile" [5]. According to these religious leaders, "the set of paternalistic stereotypes which confined them in restricted status" [67] should be the limit for women. Debates over feminism clarified that in civilizations dominated by men, extreme religious doctrines, patriarchal structures, and traditional gender role expectations predominated. Women were forced to maintain their subordination in front of their husbands under these oppressive regimes. The historical background of male power in the research region can be linked to varying perspectives on IPV.

## CONCLUSION

In conclusion, a high prevalence of many types of violence, particularly sexual violence and the combination of sexual and physical violence, and this prevalence is still rising. Among the frequent factors found in the chosen articles were familial issues, joblessness, miscommunications between couples, and the normalization of violence by women and its justification by males. The documented repercussions include bodily harm, gynecological

diseases, miscarriages, psychological stress, and extreme mental health issues that lead to suicidal thoughts.

**REFRENCES**

1. Colombini M, Mayhew S, Watts C. Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. Bull World Health Organ. 2008;86:635–42.
2. MacDonald E, Wong R, Sheldon D. Gender profile: mozambique. 2015.
3. World Health Organization. Prevention and elimination of disrespect and abuse during childbirth. World Health Organization, Geneva; 2014. Available from: http:// www. who. int/ reproductivehealth/ topics/ maternal_ perin atal/statement-child birth/ en/
4. Organization WH. Understanding and addressing violence against women: Intimate partner violence. World Health Organization; 2012.
5. Zakar R, Zakar MZ, Kraemer A. Men's beliefs and attitudes toward intimate partner violence against women in Pakistan. Violence Women. 2013;19(2):246–68.
6. Babu BV, Kar SK. Domestic violence in Eastern India: factors associated with victimization and perpetration. Public Health. 2010;124(3):136–48.
7. Campbell JC. Health consequences of intimate partner violence. The lancet. 2002;359(9314):1331–6.
8. Koenig MA, Ahmed S, Hossain MB, Mozumder AKA. Women's status and domestic violence in rural Bangladesh: individual-and community-level effects. Demography. 2003;40(2):269–88.
9. Visaria L. Violence against women: a field study. Econ Polit Wkly. 2000;1742–51.
10. Rocca CH, Rathod S, Falle T, Pande RP, Krishnan S. Challenging assumptions about women's empowerment: social and economic resources and domestic violence among young married women in urban South India. Int J Epidemiol. 2009;38(2):577–85.
11. Wolfe DA, Crooks CV, Lee V, McIntyre-Smith A, Jaffe PG. The effects of children's exposure to domestic violence: a meta-analysis and critique. Clin Child Fam Psychol Rev. 2003;6(3):171–87.
12. Ikekwuibe IC, Okoror CE. The pattern and socio-cultural determinants of intimate partner violence in a Nigerian rural community. Afr J Prim Health Care Fam Med. 2021;13(1):8.
13. Boyle MH, Georgiades K, Cullen J, Racine Y. Community influences on intimate partner violence in India: Women's education, attitudes towards mistreatment and standards of living. Soc Sci Med. 2009;69(5):691–7.
14. Farid M, Saleem S, Karim MS, Hatcher J. Spousal abuse during pregnancy in Karachi. Pakistan Int J Gynecol Obstet. 2008;101(2):141–5.
15. Karaoglu L, Celbis O, Ercan C, Ilgar M, Pehlivan E, Gunes G, et al. Physical, emotional and sexual violence during pregnancy in Malatya, Turkey. Eur J Public Health. 2006;16(2):149–56.
16. Peedicayil A, Sadowski LS, Jeyaseelan L, Shankar V, Jain D, Suresh S, et al. Spousal physical violence against women during pregnancy. BJOG Int J Obstet Gynaecol. 2004;111(7):682–7.
17. Ruiz-Pérez I, Plazaola-Castaño J, Álvarez-Kindelán M, Palomo-Pinto M, Arnalte-Barrera M, Bonet-Pla Á, et al. Sociodemographic associations of physical, emotional, and sexual intimate partner violence in Spanish women. Ann Epidemiol. 2006;16(5):357–63.
18. Valladares E, Pena R, Persson LÅ, Högberg U. Violence against pregnant women: prevalence and characteristics: a population-based study in Nicaragua. BJOG Int J Obstet Gynaecol. 2005;112(9):1243–8.

19. Wickrama KAS, Lorenz FO, Conger RD, Elder GH Jr, Abraham WT, Fang SA. Changes in family financial circumstances and the physical health of married and recently divorced mothers. Soc Sci Med. 2006;63(1):123–36.
20. Ergonen AT, Salacin S, Karademir S, Gursel Y, Musal B. A domestic violence course for medical students: a study on its effectiveness. J Fam Violence. 2007;22(6):441–7.
21. Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. Popul Rep. 1999;27(4):1–1.
22. Tayyab F, Kamal N, Akbar T, Zakar R. Men and women's perceptions of justifications of wife beating: evidence from Pakistan Demographic and Health Survey 2012–13. J Fam Violence. 2017;32(7):721–30.
23. Ali P. Researching intimate partner violence using a constructivist grounded theory approach. SAGE Publications Ltd; 2020
24. Karmaliani R, Asad N, Bann CM, Moss N, Mcclure EM, Pasha O, et al. Prevalence of anxiety, depression and associated factors among pregnant women of Hyderabad, Pakistan. Int J Soc Psychiatry. 2009;55(5):414–24.
25. Gennari M, Giuliani C, Accordini M. Muslim immigrant men's and women's attitudes towards intimate partner violence. Eur J Psychol. 2017;13(4):688.
26. Sayem AM, Begum HA, Moneesha SS. Attitudes towards justifying intimate partner violence among married women in Bangladesh. J Biosoc Sci. 2012;44(6):641–60.
27. Flasch P, Murray CE, Crowe A. Overcoming abuse: a phenomenological investigation of the journey to recovery from past intimate partner violence. J Interpers Violence. 2017;32(22):3373–401.
28. Crann SE, Barata PC. The experience of resilience for adult female survivors of intimate partner violence: a phenomenological inquiry. Violence Women. 2016;22(7):853–75.
29. Humbert TK, Bess JL, Mowery AM. Exploring women's perspectives of overcoming intimate partner violence: a phenomenological study. Occup Ther Ment Health. 2013;29(3):246–65.
30. Sattar T, Ahmad S, Zakar R, Maqsood F. Watering the plant in another's courtyard: an ethnographic exploration of daughters' devaluation through sex-selected abortions among the rural married females in South Punjab, Pakistan. J Interpers Violence. 2021;36(9–10):4490–519.
31. Chinh B, Zade H, Ganji A, Aragon C. Ways of qualitative coding: a case study of four strategies for resolving disagreements. In: Extended abstracts of the 2019 CHI conference on human factors in computing systems. 2019. p. 1–6.
32. Asim M, Karim S, Khwaja H, Hameed W, Saleem S. The unspoken grief of multiple stillbirths in rural Pakistan: an interpretative phenomenological study. BMC Womens Health. 2022;22(1):1–11.
33. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. Am J Eval. 2006;27(2):237–46.
34. Hennink M, Hutter I, Bailey A. Qualitative research methods. Sage; 2020.
35. Band-Winterstein T. Aging in the shadow of violence: a phenomenological conceptual framework for understanding elderly women who experienced lifelong IPV. J Elder Abuse Negl. 2015;27(4–5):303–27.
36. Soomar SM, Soomar SM. Determinants of domestic violence among women of reproductive age (15–49 years) in Quetta, Balochistan a mixed-method protocol. BMJ Open. 2022;12(5):e057299.
37. Heise LL. Violence against women: an integrated, ecological framework. Violence Against Women. 1998;4(3):262–90. https:// doi. org/ 10. 1177/10778 01298 00400 3002.

38. High-Level Deep Dive On South Punjab Report On Conference Proceedings. Government of Punjab; Available from: https:// pakis tan. un. org/ sites/defau lt/ files/ 2022- 04/ South% 20Pun jab% 20Deep% 20Dive% 20Rep ort_Final. pdf.
39. Ellsberg M, Heise L. Bearing witness: ethics in domestic violence research. Lancet. 2002;359(9317):1599–604.
40. De Coster S, Heimer K. Unifying theory and research on intimate partner violence: a feminist perspective. Fem Criminol. 2021;16(3):286–303.
41. Ali PA, McGarry J, Maqsood A. Spousal role expectations and marital conflict: perspectives of men and women. J Interpers Violence.2020;0886260520966667.
42. Ali PA, Naylor PB, Croot E, O'Cathain A. Intimate partner violence in Pakistan: a systematic review. Trauma Violence Abuse. 2015;16(3):299–315.
43. Iqbal M, Fatmi Z. Prevalence of emotional and physical intimate partner violence among married women in Pakistan. J Interpers Violence. 2021;36(9–10):NP4998–5013.
44. Rose E. A feminist reconceptualisation of intimate partner violence against women: a crime against humanity and a state crime. In: Women's Studies International Forum. Elsevier; 2015. p. 31–42.
45. Ali PA, O'Cathain A, Croot E. Not managing expectations: a grounded theory of intimate partner violence from the perspective of Pakistani people. J Interpers Violence. 2019;34(19):4085–113.
46. Kidman R. Child marriage and intimate partner violence: a comparative study of 34 countries. Int J Epidemiol. 2017;46(2):662–75.
47. Fikree FF, Jafarey SN, Korejo R, Afshan A, Durocher JM. Intimate partner violence before and during pregnancy: experiences of postpartum women in Karachi. Pakistan J Pak Med Assoc. 2006;56(6):252–7.
48. Herrero-Arias R, Truong AN, Ortiz-Barreda G, Briones-Vozmediano E. Keeping silent or running away: the voices of Vietnamese women survivors of Intimate Partner Violence. Glob Health Action. 2021;14(1):1863128.
49. Schuler SR, Lenzi R, Badal SH, Nazneen S. Men's perspectives on women's empowerment and intimate partner violence in rural Bangladesh. Cult Health Sex. 2018;20(1):113–27.
50. Wilson N. Socio-economic status, demographic characteristics and intimate partner violence. J Int Dev. 2019;31(7):632–57.
51. Ali TS, Asad N, Mogren I, Krantz G. Intimate partner violence in urban Pakistan: prevalence, frequency, and risk factors. Int J Womens Health. 2011;3:105.
52. Dalal K, Dahlström Ö, Timpka T. Interactions between microfinance programmes and non-economic empowerment of women associated with intimate partner violence in Bangladesh: a cross-sectional study. BMJ Open. 2013;3(12):e002941.
53. Ali TS, Mogren I, Krantz G. Intimate partner violence and mental health effects: a population-based study among married women in Karachi. Pak Int J Behav Med. 2013;20(1):131–9.
54. Marshall AD, Holtzworth-Munroe A. Recognition of wives' emotional expressions: a mechanism in the relationship between psychopathology and intimate partner violence perpetration. J Fam Psychol. 2010;24(1):21.
55. Spencer C, Mallory AB, Cafferky BM, Kimmes JG, Beck AR, Stith SM. Mental health factors and intimate partner violence perpetration and victimization: a meta-analysis. Psychol Violence. 2019;9(1):1.
56. Bell KM, Naugle AE. Intimate partner violence theoretical considerations: moving towards a contextual framework. Clin Psychol Rev. 2008;28(7):1096–107.
57. Hamid S, Johansson E, Rubenson B. "Who am I? Where am I?" Experiences of married young women in a slum in Islamabad, Pakistan. BMC Public Health. 2009;9(1):1–8.

58. Nasrullah M, Zakar R, Zakar MZ, Abbas S, Safdar R. Circumstances leading to intimate partner violence against women married as children: a qualitative study in Urban Slums of Lahore, Pakistan. BMC Int Health Hum Rights. 2015;15(1):1–7.
59. George J, Stith SM. An updated feminist view of intimate partner violence. Fam Process. 2014;53(2):179–93.
60. Eriksson L, Mazerolle P. A cycle of violence? Examining family-of-origin violence, attitudes, and intimate partner violence perpetration. J Interpers Violence. 2015;30(6):945–64.
61. DeJong C, Burgess-Proctor A, Elis L. Police officer perceptions of intimate partner violence: an analysis of observational data. Violence Vict. 2008;23(6):683–96.
62. Leisenring A. Victims' perceptions of police response to intimate partner violence. J Police Crisis Negot. 2012;12(2):146–64.
63. Twis MK, Nguyen AP, Nordberg A. Intimate partner violence myths in police reports: a directed content analysis. Violence Vict. 2018;33(2):351–67.
64. Haj-Yahia MM. Beliefs about wife beating among Palestinian women: the influence of their patriarchal ideology. Violence Women. 1998;4(5):533–58.
65. Hunnicutt G. Varieties of patriarchy and violence against women: resurrecting "patriarchy" as a theoretical tool. Violence Women. 2009;15(5):553–73.
66. Madhani FI, Karmaliani R, Patel C, Bann CM, McClure EM, Pasha O, et al. Women's perceptions and experiences of domestic violence: an observational study from Hyderabad, Pakistan. J Interpers Violence. 2017;32(1):76–100.
67. Jafar A. Women, Islam, and the state in Pakistan. Gend Issues. 2005;22(1):35–55.