SOCIAL SUPPORT AND MENTAL HEALTH AMONG PAKISTANI WOMEN EXPOSED TO INTIMATE PARTNER VIOLENCE

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Intimate partner violence (IPV) is highly prevalent in Pakistan. Social support is associated with a reduced risk for violence and adverse mental health. The purpose of this study was to investigate the association between social support and the occurrence of IPV and adverse mental health among Pakistani women exposed to IPV, along with exploring help-seeking behaviour using qualitative interviews. Data from a cross-sectional survey of 759 women, aged 25–60, were analyzed using logistic regression. The results demonstrated that informal social support was associated with fewer occurrences of all forms of IPV and less likelihood of adverse mental health when exposed to psychological violence, whereas formal social support was associated with more occurrences of all forms of IPV and more likelihood of adverse mental health when exposed to psychological violence. The qualitative result showed that fear of social stigma and low autonomy were, among others, obstacles for seeking help. Suggestions for future interventions include strengthening informal social networks and expanding formal resources, as well as raising awareness of IPV in order to address the issue.
found that the lifetime prevalence of IPV among women in the USA lies between 22 percent (nonphysical) and 33 percent (physical violence). In Sweden, 15 percent of all women older than 15 years have been subjected to violence by a boyfriend and 11 percent, again after the age of 15, have been subjected to violence by a current husband (Lundgren, Heimer, Westerstrand & Kalliokoski, 2001). In Asia, the attitudes toward IPV in seven different countries (Armenia, Bangladesh, Cambodia, India, Kazakhstan, Nepal, and Turkey) were investigated by Rani and Bonu (2009). The outcome showed that wife beating was accepted by at least 30 percent of both men and women in all of the countries surveyed. This thesis will focus on IPV in Pakistan and the role of social support. There are different figures on the number of women subjected to IPV in Pakistan. The Human Rights Commission of Pakistan (HRCP) suggests in their report from 2002 that 70 to 90 percent of Pakistani women suffer from domestic abuse, but that the exact figures would be difficult to know since the violence is going on behind closed doors and few cases are being reported (HRCP, 2002). For example, Fikree and Bhatti (1999) found in their study in Karachi that 34 percent of the interviewed women reported physical violence. In a more recent report, it was estimated that domestic violence was one of the greatest threats to Pakistani women’s security, health and well-being (HRCP, 2006).

IPV is defined as any act of physical, sexual or psychological violence by a current or former partner (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006). It refers to violence that takes place within the family sphere between family members or intimate partners (Heise, Raikes, Watts & Zwi, 1994). IPV is regarded to be the most common form of violence against women (WHO, 2002).

In order to understand and attempt to explain violence against women, multiple factors need to be taken into account. An ecological framework conceptualizing the etiology of violence against women on individual, familial, societal and cultural levels has been developed by Heise (1998). On a cultural level, Heise points out several factors including women’s subordination to men, the aggression and dominance linked to concepts of masculinity, the acceptance of the use of violence, and rigid gender roles as contributing factors to the occurrence of IPV. On a societal level, a low socioeconomic status and isolation of the woman from her family are mentioned. On a familial level, male dominance in the family, conflict between the spouses and male control of the family’s financial means are considered contributing factors to IPV. On an individual level, having witnessed violence between the parents as a child, being abused as a child and use of alcohol are mentioned as factors that increase the likelihood of using violence.

The majority of women facing violence seem to suffer from more than one type of abuse and the events that trigger violence in relationships follow a similar pattern globally (Heise & Garcia-Moreno, 2002). Examples of these triggers include the following: disobeying or arguing with the husband; questioning him about other relationships; not having food prepared in time; not taking care of children or the home adequately; refusing sex; and suspicions that the woman is unfaithful. On an individual level, Koenig, Ahmed, Hossain and Mozumber (2003) found that women who didn’t have a paid job, had a low educational level and low level of social support were more likely to experience violence. They also found a correlation between the male partner’s drinking problem and IPV. A study from Pakistan also found that women with no formal education were at a higher risk for abuse. Having no or a low number of children
and poor life circumstances were associated with both physical and sexual violence (Ali, Asad, Mogren & Krantz, 2009).

Contrary to these findings, a study from Togo showed that the risk of being abused increased with the higher level of education the woman had attained. The authors hypothesized that educated women showed more assertive behaviour which, in turn, affected their partner’s sense of power. In order to regain the power balance and control, the husbands would use violence. Additionally, having many children was found to be a protective factor for IPV; the author hypothesized that women with many children have a low chance of surviving on their own and therefore are more willing to compromise in their relationship (Moore, 2008).

A study conducted in Bangladesh by Naved and Persson (2005) showed that one of the strongest factors associated with the husband abusing their spouse was a history of family abuse, specifically if the mother of the husband had been abused by the father. The second most important factor associated with IPV was spousal communication; the men tended to resort to physical violence when the communication between themselves and their partners broke down. Another risk factor identified for abuse in the study was the dowry or other marital demands. When investigating age as a risk factor, the authors found that younger women were more at risk for violence if living in urban areas, whereas women living in rural areas were at equal risk regardless of age. The wife’s income could be both a protective and a risk factor for violence depending on the level of earning and social context.

Different forms of intimate partner violence

**Physical violence.**

It can be difficult to separate different types of violence and the separation is often more theoretical than practical (Lundgren, Heimer, Westerstrand & Kalliokoski, 2001). For example, there is often a combination of physical and sexual violence (Ellsberg, Jansen, Heise, Watts & García-Moreno, 2008). Theoretically, definitions have emerged as research about IPV has developed. Physical violence can be defined as an assault on a woman’s person and includes hitting, slapping, kicking or otherwise physically hurting the individual (Bogat, Levendosky & von Eye 2005; Bauer, Rodriguez & Pérez-Stable, 2000). In another study, the definition of physical violence was described as, “…an aggressive physical act which either caused or had the potential to cause physical harm” (Follingstad, Brennan, Hause, Polek & Rutledge, 1991 p. 84). Women are not always the victims of violence; one research review by Kimmel (2002) points out that there are many surveys in the USA indicating that males and females are equally likely to commit less severe forms of IPV; still, it seems that women are more likely to be the targets of more severe forms of physical violence leading to austere consequences.

**Sexual violence.**

Sexual violence is defined by forced sexual intercourse (Krug, Mercy, Dahlberg & Zwi, 2002; Garcia-Moreno, Heise, Jansen, Ellsberg, & Watts, 2005). In one of the largest Swedish studies on IPV by Lundgren, Heimer, Westerstrand, and Kalliokoski (2001), the authors emphasized looking at sexual violence as a continuum of physical, verbal and sexual harassments against the partner. Available data suggest that in some countries nearly one in four women report sexual violence by an intimate partner (Heise
Poverty is a contributing factor to the occurrence of sexual violence as are communities where a general tolerance and weak sanctions against sexual violence exist (Rozee, 1993). Sexual violence is also more likely to occur in locales where beliefs in male sexual entitlement are strong, where gender roles are more rigid, and in countries where rates of other types of violence are high (Heise & Garcia-Moreno, 2002).

Psychological violence.

Psychological violence is defined as acts that cause the decline of the emotional well-being of the woman or that keep the well-being at a subjectively unhealthy level. It includes threats, destruction of property and belittling comments (O’Leary, 1999). It can also include controlling behaviour, economic abuse and social isolation (Krug, Mercy, Dahlberg & Zwi, 2002; Garcia-Moreno, Heise, Jansen, Ellsberg & Watts, 2005). Psychological abuse is somewhat vague, and its presence is determined by the woman’s perception and the stressfulness of the experience, not the event itself. It is possible that psychological abuse prevails without physical or sexual violence, but it is unlikely that physical or sexual violence exists without psychological abuse (O’Leary, 1999). In one study, Follingstad, Rutledge, Berg, Hause and Polek (1990) found ridicule to be the form of psychological abuse reported as the most destructive, arguing that this kind of psychological abuse might attack the woman’s sense of self-esteem.

Intimate partner violence and mental health

A meta-analysis of more than 40 studies of mental-health effects of domestic violence by Golding (1999) showed that IPV has a large impact on mental health, leading to depression, suicide attempts, anxiety and PTSD. The same meta-analysis showed that across 18 studies, the weighted mean prevalence of depression among battered women was 47.6 percent, compared to the general population of women where it ranged from 10.2 percent to 21.3 percent. Several studies showed that depression in the last 12 months was noted in 35 to 70 percent of female IPV victims in the United States (Gerlock, 1999; Peterson, Gazmararian & Clark, 2001; Stein & Kennedy, 2001) compared to 13 percent of women in the general population (Kessler et al., 1994). In addition, it has been shown that depression can affect women’s life conditions in various ways; for example, it can contribute to isolation, affect their ability to establish and maintain relationships and decrease access to social support (Carlson, McNutt, Choi & Rose, 2002).

There is a great variation regarding the impacts from IPV and not all survivors report long-term mental health symptoms. Among others, two factors have been found that might explain this disparity: severity of exposure and quantity of types of exposure. It has been found that the severity of abuse predicts the severity of mental health symptoms and that exposure to different types of violence may be the reason for greater symptomatology (Golding, 1999). In a study by Babcock, Green, Roseman and Ross (2008) examining the PTSD symptomatology of IPV, two other factors also helped to explain the variation: the context of the social support network and the woman’s ability to regulate her own emotional responses. In the same study, it was shown that even though both physical and psychological abuse were risk factors for PTSD symptomatology, physical abuse accounted for more of the variance in traumatic symptoms. Because symptoms of PTSD and depression overlap (Friedman & Schnurr, 1995; Hammarberg, 1992), depression detected in some studies may actually represent
symptoms of PTSD; therefore, symptoms need to be looked at together (Golding, 1999). In another study, Beeble, Bybee, Sullivan and Adams (2009) examined the effect of social support on the well-being of women being subjected to IPV. Through this study, the authors found that psychological abuse had a higher explanatory power, which they argued might be an indicative of the severe impact of this kind of abuse. In another study by Follingstad et al. (1991), it was found that even past incidents of IPV can affect the present-day mental health of an abused woman, despite the destructive relationship being over.

There is rarely a simple cause-and-effect relationship between a violent act and its consequences, particularly where psychological abuse is concerned. Even in extreme cases, reactions and effects can differ widely since people respond to adversity in distinctly individual ways. Different factors like age and temperament of the person, and whether or not he or she has emotional support, will affect the outcome of violent events (Heise & Garcia-Moreno, 2002).

**Social support**

Social support can be defined as a resource that helps through interpersonal interactions and social relationships. It serves three major functions: emotional support, through the sharing problems and emotions; informational support, by providing guidance and advice; and instrumental support, exemplified by the lending of money or offering a place to stay (Heaney & Israel, 1997). Social support can be subdivided into two categories: informal and formal. Informal social support is provided by relatives or friends whereas formal social support is provided by institutionalized sources, i.e., the police, healthcare professionals or staff working at a shelter for battered women (Liang, Goodman, Tummala-Narra & Weintraub, 2005).

There is significant evidence linking social and emotional support with a reduced risk of mortality, as well as physical and mental illness, even in populations other than those exposed to IPV (Strine, Chapman, Balluz, Mokdad & Ali, 2008). A study by Cohen and Wills (1985) showed that those who received informal social support that provided both psychological and material resources had a better mental health status than those with less informal social support. Perception of the supportiveness and size of the social network were also shown to be predictors of mental health. Social support is considered to have a positive impact on psychological well-being through an enhanced sense of stability, perceived control and personal competence (Langford, Bowsher, Maloney & Lillis, 1997).

**Social support and overcoming abuse.**

Social support is one of the most commonly studied potential protective factors in relation to women exposed to IPV. Both informal and formal social support has been shown to be an important resource for women trying to end ongoing violence in their lives. Women with good social resources are considered to be in a better condition to get the help and information needed to increase their own safety. Social support can serve as a protective factor for ongoing violence by operating directly to protect against future violence or indirectly by encouraging the woman to use strategies and recourses more effectively (Goodman, Dutton, Wienfurt, & Vankos 2005). Another study by Ellsberg, Winkvist, Pena and Stenlund (2001) that investigated women’s strategic responses to violence in Nicaragua showed the importance of social context for shaping
the woman’s notion of her options. Their study highlighted the critical impact that family support and the immediate support from the community had on a woman’s attempt to overcome violence.

Examples of instrumental social support from family and friends, such as providing money, a temporary place to stay, child care or transportation to formal resources, was shown to be crucial for the woman’s ability to take the actions necessary to end ongoing violence (Goodman, Bennet & Dutton, 1999). The importance of accessing formal resources in order to end violence is also stressed in Sullivan and Bybee’s (1999) longitudinal study of abused women exiting a shelter. According to their results, the women who received a 10-week volunteer advocacy intervention, helping the women to access resources in the community that could reduce the risk for future violence, were less likely to be re-abused over the next two years than the control group. The participants also reported a higher level of social support than the control group. The authors suggested that social isolation, along with a lack of community resources, put the women at risk for re-abuse. In another study by Goodman, Dutton, Wienfurt and Vankos (2005) examining the relation between women’s resources and their ability to stay safe over time, they reported that social support from family and friends often protected the participants against future violence. Additionally, the study showed that a higher level of social support was linked to less re-abuse: Women with the least amount of social support had a 65 percent predicted probability of re-abuse over a one year period, compared with a 20 percent predicted probability for women reporting the highest level of social support. Nevertheless, for the participants who experienced the most severe forms of violence, re-abuse was likely at every level of social support. This indicates that while the effectiveness of social support is dependent on its degree, it is not enough to stop or prevent re-abuse in cases of severe violence.

In another study, Horton and Johnson (1993) examined the profiles and strategies of 185 women who had overcome IPV. They found that the majority of the survivors had used friends and family as a resource to end the abuse. Respondents reported that friends, professional counsellors and shelters were the most effective resources to help end the abuse.

Social support, intimate partner violence and mental health.

While informal and formal social support has been shown to improve the mental health of women exposed to IPV, it has also been linked with an increased ability and readiness to seek help from formal sources (Gondolf & Fisher, 1988; Horton & Johnson, 1993; referenced in Liang, Goodman, Tummala-Narra & Weintraub, 2005). Women who reported higher levels of social support were significantly less likely to report post-traumatic stress symptoms, anxiety, depression and suicidal thoughts and actions than women who reported lower social support (Coker et al., 2002). Similar findings were presented in two other studies where social support was positively associated with a better mental health outcome among women exposed to violence (Carlson, McNutt, Choi & Rose, 2002; Thompson et al., 2000).

In a study, Beeble, Bybee, Sullivan and Adams (2009) found that women with higher social support reported a higher quality of life, lower depression and greater improvements to depression over time. Although social support did not buffer the impact of abuse on depression, the protecting effect of social support was stronger for
women who reported lower levels of abuse. This suggests that the level of violence experienced might have an impact on the effect of the social support. Similar findings were made by Carlson et al. (2002) who found that greater numbers of protective factors, including social support, mitigated the effects of lifetime abuse. Women reporting chronic lifetime abuse were less likely to benefit from protective factors regarding their mental health status than those reporting lower levels of lifetime abuse.

It is important to emphasize that perceived optimal social support varies between individuals (Jacobson, 1986). In a study, Thompson et al. (2000) found that women exposed to IPV tend to have low levels of perceived social support. Furthermore, high levels of IPV were reported to be related to lower levels of perceived emotional, informational and instrumental support. Additionally, they found that low levels of perceived social support were associated with higher reported levels of psychological distress. The authors suggested that one possible explanation for low levels of perceived support is that the abuse itself negatively impacts the abused woman’s social network. Friends and family may avoid the woman for fear of the abusive partner themselves, or keep distance because of the perception that violence is a private matter (Lepore, Evans & Schnider, 1991). The abusive partner may also isolate the woman from her social network in order to have control over her, thus minimizing the risk that someone will witness the violence, and also limit the woman’s access to assistance and support (Levendosky et al., 2004).

Receiving social support does not ensure a positive effect; some people may offer help, but in an accusatory or judgmental way and therefore increase the woman’s stress level. A study by Levendosky et al. (2004) investigated the role of social networks in a sample of pregnant women exposed to IPV. They found that the participants exposed to IPV had less practical and emotional support and were more often criticized by their social network than other women. Emotional support had a significant correlation to criticism and, in contrast to previously mentioned findings, was not a significant predictor for mental health. On the other hand, practical aid, which was not significantly correlated to criticism, had a positive relation to both anxiety and self-esteem.

The importance of how the woman is received when seeking social support is highlighted in the study by Coker et al. (2002). Their findings showed that among the women who disclosed abuse, the ones who were at a reduced risk of suicidal ideations and actions were the women who perceived the reactions to their disclosure as consistently supportive.

Help-seeking behaviour

The abused woman’s appraisal of her situation shapes her decision to seek help. Three stages focusing on the cognitive processes of the help-seeker have been described: first, defining and recognizing the problem; second, making a decision to seek help or not; and third, selecting the provider of help (Liang, Goodman, Tummala-Narra & Weintraub, 2005).

Factors that have been found to impact help-seeking of abused women are severity and frequency of abuse, perceived sense of self-efficacy and the receptiveness of the formal help resources (Rhodes & McKenzie, 1998). In a study by Ellsberg, Winkvist, Pena and Stenlund (2001) investigating women’s strategic responses to violence in Nicaragua showed that help-seeking was significantly associated with; severe abuse, physical or
emotional abuse of children, being over 35 years of age and having access to social support. Furthermore, all the women who sought help were living in urban areas, reflecting the limited access to services for women living in the rural areas. Their findings also indicated that the vast majority of women exposed to IPV did not seek outside help and were subsequently not receiving the support or services needed to stop the abuse.

In Lempert’s qualitative study (1997), it showed that battered women only sought help and made the violence public when they had used up their own resources and alternatives and lost the belief in their own ability to stop the violence. According to Moe’s (2007) qualitative study of battered women’s perspective on their help-seeking efforts, seeking help or support from family and friends was one of the most common initial help-seeking strategies. With regards to seeking help from formal sources, 79 percent of the participants had sought help from shelters, hotlines, support groups and advocacy centres. More than half of the women were physically injured due to violence, but only 40 percent sought medical treatment. Some of the given reasons for not seeking medical care included the following: a lack of money to pay for medical bills; a lack of safe transportation to the health facility due to poverty or the partner’s controlling behaviour; self-medication by using drugs and; fear of being arrested. The responses to their help-seeking were also explored; women who received help in a supportive manner were empowered to use constructive coping strategies against the violence. Meanwhile, women who had been ignored or put down when seeking help were more likely to blame themselves and return to the abusive partner.

A study examining different formal sources where women sought help carried out by Vatanar and Bjorkly (2009) showed that the type of IPV and severity of violence significantly impacted the help-seeking behaviour. For example, none of the participating women had contacted the police after being exposed to sexual IPV. Women who perceived their lives to be endangered were more than three times more likely to contact the police than those who didn’t perceive the violence as life threatening. Severe physical and psychological injuries were similar predictors for contacting the family doctor or a psychologist.

In Schuler, Bates and Islam’s (2008) qualitative study exploring responses to IPV from Bangladeshi women living in rural areas it was stressed that gender inequality, poverty and patriarchal attitudes in both formal and informal resources discouraged women experiencing IPV from seeking recourse. They found that only one percent of the women had sought help the last time they were exposed to IPV. The women interviewed expressed that they had few options or resources available to stop the violence. Instead, a commonly used strategy was to conform to their husband’s demands in order to avoid future violence. The study reported that, occasionally, neighbours would interfere but often they didn’t help them due to the cultural norm that a man has the right to discipline his wife. The respondents stressed the need for outside interventions from formal resources in order to stop the violence.

Among other factors Fox, Blank, Rovnyak and Barnett (2001) found that the cost and availability of healthcare were frequently endorsed barriers to seeking help. Furthermore, women exposed to IPV were hindered from seeking help by other elements such as concern for their children, fear of reprisal from the partner, isolation from their social network along with stigma and shame (Rhodes & McKenzie, 1998). In
their study, Williams and Mickelson (2008) investigated abuse-related stigma in 177 women exposed to IPV and how it affected help-seeking behaviour. They found that the perceived stigma and fear of rejection from one’s social network was linked to the unwillingness to directly seek support and, rather, seek help indirectly. Perceived stigma was related to indirect support seeking and indirect help-seeking behaviour was paradoxically related to unsupportive social network responses.

Living in a community where religious and social norms regard IPV as a private matter between partners rather than a crime may lead to difficulties for women recognizing that IPV is a problem for which help could be sought. Women living in poverty might also be less prone to conceptualize IPV as intolerable, due to the few help options available. Asian cultural traditions emphasize family privacy, fear of divorce and gender roles that places men in a superior social status; these are components that may hinder women from seeking help outside the family (Liang, Goodman, Tummala-Narra & Weintraub, 2005).

Cultural norms may also influence help seeking behaviour and to whom the woman is disclosing the abuse. Asian culture also has a strong sense of collectivism and familialism (Yoshioka, Gilbert, El-Bassel & Baig-Amin, 2003). Within a collectivistic culture, the individual puts the well-being of the community and/or the family over their own (Sastry & Ross, 1998). Familialism can be defined as putting importance and high value on the family and that the family bonds are characterized by strong feelings of loyalty and solidarity (Triandis, Marin, Betancourt, Lisansky & Chang, 1982). These are cultural components that can affect the likelihood of seeking help. A study in the USA comparing South Asian, Afro-American and Hispanic women’s help seeking behaviour when exposed to IPV conducted by Yoshioka, Gilbert, El-Bassel and Baig-Amin (2003) showed that mothers and sisters were highly represented in terms of the person the abused women turned to for assistance. However, they found that South Asian women (from India, Pakistan, Bangladesh, Sri Lanka and Bhutan) were more likely to seek help from, and disclose the abuse to, the sibling of the abuser and to their brothers or fathers. The authors suggested that South Asian women, in general, are unwilling to seek help from outside the family and that they turn to their informal social network for assistance. Culturally based family roles, where brothers take responsibility for their sisters, were also discussed as an explanation for the findings.

**Pakistan - general facts, women’s situation and IPV**

Pakistan is a country with approximately 180 million inhabitants, the majority of whom are Muslim (BBC, country profile, 2009). One third of the population is considered to be poor, 35 percent of the population is living in urban areas and the largest concentration of urban poor live in Karachi, the country’s largest city with over 10 million inhabitants. One indication of the poverty in Pakistan is that 44 percent of the total housing in the urban areas consists of squatter settlements (Zingel, 1998). Illiteracy is rife in Pakistan and in 2005 only 36 percent of women and 63 percent of men were able to read and write. Around 30 percent of Pakistani women are in the workforce compared to 64 percent of men (Gapminder World, 2005).
Women’s situation in Pakistan.

A study by Shaikh (2000) highlights the patriarchal values that are embedded in the Pakistani society and points out that violence within the family traditionally is considered a private matter in which outsiders, including formal authorities, should not intervene. In their quantitative study, Mumtaz and Salway (2009) found empirical data supporting the assertion that, as regards social ethics, Pakistan is a country based on collectivism rather than individuality. They point out that the concept of togetherness is of great importance on a community level. One of the manifestations of this is the joint family system, which is the basis of the idea of self and the socially recognized identity for the people. Social relationships have great importance for the gender dimension. Social ties are for men, in accordance with patriarchal norms and based on blood relationship, while a man’s relationships based on marital ties not are so important. On the other hand, social ties for women are based on marital ties, making the woman more vulnerable since she has to build and constantly maintain the “new” relationships with the man’s family (Mumtaz & Salway, 2009).

In 2008, a criminal bill seeking to broaden the definition of domestic violence, the Muslim Family Laws and Domestic Violence (Prevention and Protection) Bill 2008, was awaiting approval. The new law was approved in 2009, which now makes it illegal for a man to violate his wife.

In Pakistan, dowry issues are often involved in domestic violence affairs (HRCP, 2008). Dowry is the payment in form of money or other materials made to the groom's family at the time of the wedding and it takes different forms in different cultures. However, the size of the dowry is found to be one of the most common reasons for disputes, with the groom's family demanding more than the bride's family can offer, resulting in domestic violence not only from the husband but also his family (Krantz & Garcia-Moreno, 2005).

Intimate partner violence in Pakistan.

In a report from 2008, the HRCP wrote that various NGOs across the country were showing statistics reflecting high incidence of violence against women. It was postulated that inadequate government policies, non-implementation of law, and failures on the part of law enforcement agencies were the main causes of the widespread violence against women. In the report it was also stated that many crimes against women were committed in the name of tradition. It was reported that, due to disappointment with the existing administrative and judicial system, Pakistanis resolved their conflicts with jirgas (a form of local extra-judicial forums). The jirgas often found against women and, in some cases, often ordered the immediate execution of those declared guilty of a crime (HRCP, 2008).

Other factors highlighting the increased risk for women to be subjected to IPV included their low education level, not participating in political activities, misconceptions about Islamic ideas and traditional norms, misuse of women in the name of honour, low socioeconomic level and poverty, the existence of an unjust dowry system, male alcoholic addiction and the common belief in the inherent superiority of men (Ali & Khan, 2007).

IPV is highly prevalent in Pakistan and, to our knowledge, no studies have investigated protective factors regarding the occurrence of IPV and adverse mental health among
Pakistani women. Social support is a commonly studied protective factor but has never been explored in Pakistan. Furthermore, it is interesting to investigate if there is any difference between the roles of informal and/or formal social support in this specific cultural context. Help-seeking is an important step in obtaining social support, and exploring this behaviour can further illustrate the process of coping with IPV.

The aim of this study is to examine the association between social support, both informal and formal, and the occurrence of IPV and adverse mental health of a particular group of Pakistani women who are exposed to IPV.

The aim can be further elucidated through the following questions:

1. Is social support associated with fewer occurrences of intimate partner violence?
2. Is social support associated with less likelihood of adverse mental health in women who already are exposed to intimate partner violence?

An additional objective of this study is to explore Pakistani healthcare professionals’ perception of help-seeking behaviour of women exposed to IPV, as well as their methods for receiving and helping victims of abuse.

**Method**

Two different methods—quantitative and qualitative—were chosen to investigate the two aims of this thesis. A quantitative method was used to explore the aim of the study regarding the role of social support. The database used for the quantitative segment of the thesis is from data already collected from an ongoing PhD project by Tazeen Saeed Ali, School of Nursing, Aga Khan University, called, “Living with violence in the home - a normal part of Pakistani women's life or a serious transgression of human rights.” The PhD project is part of a collaborative effort on higher education with the research done between two institutes in Sweden and one university in Pakistan. The collaborating parties include the Department of Community and Public Health/Social medicine at The Sahlgrenska Academy, Gothenburg University; Division of International Health (ICAR) at Karolinska Institute, Stockholm; and Department of Community Health Sciences and School of nursing, Aga Khan University, Karachi, Pakistan. The method of the study of origin is described below.

In order to explore the subsequent aim regarding help-seeking behaviour and healthcare professionals’ methods for receiving and helping women exposed to IPV, a qualitative method was used.

**Quantitative**

**Participants.**

The participants in the original population-based cross-sectional study were 756 married women between the ages of 25 and 60 years, recruited from lower and middle socioeconomic areas in urban Karachi (see Table 1).
Procedure.

Through a multi-stage, simple, random sampling technique—with the assistance of local community midwives—participants were recruited from lower and middleclass districts of urban Karachi. The community midwives, employed by “The Pakistan Hands and Nutrition Development Society” (HANDS)—a non-governmental organization in the health sector—set up a surveillance system using computer generated numbers from EPI Info (version 6) in order to select the households that were recruited. If a woman declined to participate, the next woman on the list was selected and if more than one eligible woman lived in the household, the youngest one was selected. In total, 800 women were contacted and out of them 41 declined to participate. Those who refused were not replaced.

It is estimated by governmental criteria that the selected study population was representative of 65 percent of the total population of urban Karachi. The data collection instrument contained questions on intimate relations, and with regard to the cultural notion about sexual relations prior to marriage, unmarried women were excluded from the study.

The duration of each structured interview based on the questionnaire was 30–40 minutes and implemented either at the respondent’s home or at a nearby school facility where privacy could be ensured. The interviews were conducted in Urdu, the local language, and before the interview started an individual consent form and introduction were given to the participant. A subsequent re-interview of about five percent of the total number of interviewees was conducted for comparison of data purposes.

Six female community midwives were trained for one week to administer the questionnaire. The rationale of the study, ethical consideration, prevalence and causes of IPV were included in the training (Ali, Asad, Mogren & Krantz, 2009).

Data collection instrument.

The Multi-Country Study on Women’s Health and Life Experiences (World Health Organization (WHO), 2003, version 10), a questionnaire developed by WHO for studies on interpersonal violence, was used.

The questionnaire was designed with 12 sections in order to obtain information on the following: the respondent and her community; her general and reproductive health; her financial autonomy; her partner; her children; her experiences with IPV and non-intimate partner violence; and attitudes, coping strategies and the impacts of violence on her life (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005).

The instrument was translated into Urdu and some minor changes to adapt the language to the cultural context were made. Face and content validity for the final questionnaire were performed by a psychologist, epidemiologist, sociologist, medical community-based doctor, field supervisor, data collectors and a public health specialist (Ali, Asad, Mogren & Krantz, 2009).
Measures.
The occurrence of violence was measured in the study of origin by questions regarding type of violence (physical, psychological and sexual) and when the violence occurred (lifetime and past year exposure).

Experience of any violence as opposed to no experience of physical, sexual, psychological violence or violence in general was dichotomized for bivariate analyses.

Past year prevalence measurement of violence was used in this study, defined as occurrence of violence within the past 12 months.

Physical violence was defined as slapping, throwing things, pushing or shoving, hitting, kicking, dragging, beating or burning.

Sexual violence was measured by two items: performance of sexual acts against one’s will and by the husband physically forcing sexual intercourse.

Psychological violence was measured by four items: the respondent’s intimate partner purposely acting to scare or intimidate her; threats to hurt the respondent or someone she cares about; insults or talking down to the respondent; or belittling or humiliating the respondent in front of others.

Violence in general is defined as exposure to any or all of the three forms of violence. Physical violence, sexual violence and psychological violence were merged together.

To suit the purpose of our study, the following variables were formulated from the questionnaire:

In order to construct a measurement of the participants’ mental health status, items corresponding with the diagnostic criteria of clinical depression, according to the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV, 2005), were selected from the questionnaire. Diagnostic criteria from DSM-IV (2005) that corresponded with items from the questionnaire included the following: loss of interest for most of the day; feelings of worthlessness; troubles thinking or concentrating; repeated thoughts about death; and clinically significant distress or impairment in important areas of functioning.

Mental health status was measured by the following yes or no questions: In the past 12 months, have you had problems with performing usual activities? In the past 12 months, have you had problems with your memory or concentration? Did you lose interest in things that you used to enjoy? Do you feel worthless? Do you have thoughts of ending your life? Responses were dichotomized into adverse mental health (three symptoms or more) and no adverse mental health (zero to two symptoms).

Informal social support was measured by two dichotomized items. Respondents were considered to have informal social support if they reported that they had both sought help from family members (siblings, in-laws, parents, children) or friends and also had received help from any of those mentioned above. Responses were dichotomized into yes (had sought and received informal social support) or no (had not sought and received informal social support).
**Formal social support** was measured by one dichotomized item: Did you ever go to any of the following for help? Police, hospital/health centre, social services, legal advice, court or religious leader. Responses were dichotomized into yes (had sought formal social support) or no (had not sought formal social support).

**Data analysis.**

The Statistical Package for the Social Sciences (SPSS) version 10.0 was used for all statistical calculations. Descriptive statistics were carried out for age and years of schooling, and for categorical variables—such as occupational status, socioeconomic status, number of children and number of family members—a percentage was calculated. A bivariate logistic regression analysis was used to determine the effect of selected variables on the outcome variables. In order to assess if social support was associated with fewer occurrences of IPV, a bivariate analysis was performed on the complete sample, N=759 (Table 2) including the following variables: receiving or not receiving informal social support or seeking or not seeking formal social support combined with the occurrence of past year prevalence of physical violence, sexual violence, psychological violence, and violence in general. Additionally, to assess if social support was associated with less likelihood of adverse mental health when exposed to IPV, a bivariate analysis was made on those who had experienced violence (Table 3). The association between past year prevalence of physical violence, sexual violence and psychological violence and violence in general, with the variables receiving or not receiving informal or seeking or not seeking formal social support and adverse mental health or no adverse mental health outcome was assessed. Odds ratios (OR) were estimated with a 95 percent confidence interval level.

**Qualitative**

Most commonly, qualitative data is gathered as a preparation statistic for launching research projects, but in this case the qualitative portion of the study was added to the quantitative to gain a better understanding of the implications of the findings according to Malterud’s (2001) method. At first, the objective was to interview the community midwives who had collected the data for the quantitative part of the original study. The midwives were difficult to reach and, due to the language barrier, the interviews would have to be conducted through a translator. Therefore, it was decided to interview healthcare professionals who meet women being exposed to IPV.

The interview guide was constructed in parallel to analyzing the quantitative data; therefore the findings from the quantitative data influenced the formation of the interview guide. For the interview guide, three themes were decided upon: coping of the healthcare professionals, help-seeking and social support, and future interventions. The first theme explores the healthcare professionals’ methods for handling IPV. The second theme deals with their thoughts regarding the help-seeking behaviour and perspectives of the women exposed to IPV and the third with their thoughts regarding IPV in the future. In order to explore these themes, semi-structured interviews were conducted (see interview guide, Appendix 1).

**Participants.**

The participants in the qualitative portion of this study were four middle-aged women ranging from 30 to 44 years of age (M=39). All four of them were employed as healthcare professionals by Aga Khan University hospital in Karachi, Pakistan. One of
the main criteria for the sample selection was to interview people working at the field sites, where the quantitative data had been collected. The participants were chosen according to recommendations and availability and were recruited from their departments: the department of psychiatry and the department of community health science. One participant was a psychologist, another a senior community health nurse, the third a community health nurse, and the fourth a community coordinator.

Procedure.
The healthcare professionals were first contacted by e-mail and asked to participate in the study, and subsequently asked in person if answers were not received. All of the healthcare professionals agreed to participate. Each interview was conducted at Aga Khan University by one of the authors and privacy was secured for their duration. The interviews were conducted in English and before each interview, an oral introduction and consent form were given to the participant. The interviews lasted between 20 and 30 minutes and were recorded on an mp3 player (Sony, ICD-MX20) before they were transcribed.

Data analysis.
The qualitative data retrieved from the interviews were analyzed using thematic analysis according to Hayes (2004). Each author listened to and transcribed the interviews they conducted. After transcription, the material was read through several times to identify preliminary themes. This step of the analysis was also controlled by triangulation, and that the procedure was performed by a third person (the supervisor) who found similar themes. These initial stages of analysis were conducted independently by each author and were next merged and modified. Thereafter, the themes were clustered into more general categories and subcategories. The quotes related to each theme were placed beneath each subcategory headline. The categories were then further analyzed, and modified themes were eventually sorted into five main categories and 16 subcategories.

Throughout the study, the ethical principles for research of the humanities and social sciences (Vetenskapsrådet, (Swedish Research Council), 2009) were adhered to and all interview participants provided verbal informed consent to the interviewers and were informed that they were free to withdraw from the study at any time. Data gathered from the interviews were made anonymous. The participants were informed that the recordings would be destroyed after the completion of the study.

Result

Quantitative

Sociodemographics.

Of the 756 participating women, 54.6 percent were from low to medium low socioeconomic backgrounds and the mean age was 35.28 (SD=7.84). The majority of the participants were housewives (85.6%) and about half of them had not received any formal education. The majority of the women (65%) lived with five family members or more and 41.5 percent of the families had more than four children (see Table 1).
Prevalence of different forms of violence.

Among the participants, 85.1 percent (n=646) had experienced some form of violence in the past year. Physical violence was experienced by 56.3 percent (n=427) of the women during the past year, while sexual violence was experienced by 53.0 percent (n=402). The corresponding figures for psychological violence was 81.8 percent (n=621).

Social support and occurrence of violence.

The results showed that informal social support was associated with fewer occurrences of all forms of IPV in the past year, whereas formal social support was shown to be associated with more occurrences of all forms of IPV in the past year.

Informal social support was at a five percent significance level, statistically significant as it was associated with fewer occurrences of past year physical violence, sexual violence, psychological violence as well as violence in general. This result shows that women who received informal social support were less than 90 percent likely to be exposed to physical violence (OR: 0.100, \(p<0.000\)), 99.80 percent less likely to be exposed to sexual violence (OR: 0.191, \(p<0.000\)), 85.2 percent less likely to be exposed to psychological violence (OR: 0.148, \(p<0.000\)) and 87.7 percent less likely to be subjected to violence in general (OR:0.123, \(p<0.000\)) than women who didn’t receive informal social support.

When investigating the role of formal social support with regards to the occurrence of violence, it was shown to be statistically significant as it was associated with more occurrences of past year physical violence, sexual violence, psychological violence and violence in general. Women who sought formal social support were 65.79 percent more likely to be exposed to physical violence (OR: 16.579, \(p<0.000\)), 39.97 percent more likely to be exposed to sexual violence (OR: 3.997, \(p<0.000\)) and 67.02 percent more likely to be exposed to psychological violence (OR: 6.702, \(p<0.000\)) and 90.91 percent more likely to be subjected to violence in general (OR: 19.091, \(p<0.000\)) than women who didn’t seek formal social support. Tables 2 and 3 show the relationship between different types of violence and social support as predictors.

Social support and mental health among women exposed to IPV.

The binary logistic regression analysis showed that informal social support was associated with less likelihood of adverse mental health when exposed to past year prevalence of psychological violence and past year prevalence of violence in general. Formal social support was shown to be associated with more likelihood of adverse mental health when subjected to psychological violence and violence in general.

Informal social support was shown to be statistically significant associated with less likelihood of adverse mental health when exposed to psychological violence (OR: 0.607, \(p<0.006\)) and violence in general (OR: 0.621, \(p<0.008\)). This shows that women who received informal social support when exposed to both psychological violence and violence in general were, respectively, 39.3 and 37.9 percent less likely to report adverse mental health than women who didn’t receive informal social support. Informal social support was statistically insignificant for mental health among women exposed to physical violence (OR: 0.727, \(p<0.082\)) and sexual violence (OR: 0.831, \(p<0.241\)).
Furthermore, formal social support was shown to be statistically significant associated with more likelihood of adverse mental health among women exposed to psychological violence (OR: 1.636, \( p<0.001 \)) and violence in general (OR: 1.518, \( p<0.005 \)). This shows that women who sought formal social support when exposed to both psychological violence and violence in general were, respectively, 63.6 and 51.8 percent more likely to report adverse mental health than women who didn’t seek formal social support. Formal social support was statistically insignificant for mental health among women exposed to physical violence (OR: 0.744, \( p<0.104 \)) and sexual violence (OR: 0.918, \( p<0.384 \)). Table 4 shows the relationship between informal social support and formal social support as predictors for mental health when exposed to different forms of IPV.

Table 1. Psychosocial factors and sociodemographics of respondents N=759

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age groups</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 – 35</td>
<td>447</td>
<td>58.9</td>
</tr>
<tr>
<td>36 – 45</td>
<td>228</td>
<td>30.0</td>
</tr>
<tr>
<td>46 – 60</td>
<td>84</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>361</td>
<td>47.6</td>
</tr>
<tr>
<td>Primary School (&lt; 6 years)</td>
<td>175</td>
<td>23.1</td>
</tr>
<tr>
<td>Secondary school (6 – 8 years)</td>
<td>110</td>
<td>14.5</td>
</tr>
<tr>
<td>Secondary school (9 – 10 years)</td>
<td>87</td>
<td>11.5</td>
</tr>
<tr>
<td>Intermediate (11-12)</td>
<td>17</td>
<td>2.2</td>
</tr>
<tr>
<td>Higher Education (&gt;= 13 years)</td>
<td>9</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Employed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>109</td>
<td>14.4</td>
</tr>
<tr>
<td>No</td>
<td>650</td>
<td>85.6</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>650</td>
<td>85.6</td>
</tr>
<tr>
<td>Skilled workers(trading, stitching, embroidery)</td>
<td>47</td>
<td>6.2</td>
</tr>
<tr>
<td>Un-skilled workers (Servant(^2) and shopkeeper)</td>
<td>21</td>
<td>2.8</td>
</tr>
<tr>
<td>Low and medium certified workers (office jobs- secretary, lady Health Visitor and school teacher)</td>
<td>41</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Socioeconomic status (SES)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low SES</td>
<td>242</td>
<td>31.9</td>
</tr>
<tr>
<td>Medium low SES</td>
<td>172</td>
<td>22.7</td>
</tr>
<tr>
<td>Medium high SES</td>
<td>202</td>
<td>26.6</td>
</tr>
<tr>
<td>High SES</td>
<td>143</td>
<td>18.8</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No children</td>
<td>33</td>
<td>4.3</td>
</tr>
<tr>
<td>1–2 children</td>
<td>203</td>
<td>26.7</td>
</tr>
<tr>
<td>3–4 children</td>
<td>208</td>
<td>27.4</td>
</tr>
<tr>
<td>5–6 children</td>
<td>195</td>
<td>25.7</td>
</tr>
<tr>
<td>7 and more</td>
<td>120</td>
<td>15.8</td>
</tr>
<tr>
<td><strong>Number of family members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 4 family members</td>
<td>266</td>
<td>35.0</td>
</tr>
<tr>
<td>5 – 17 family members</td>
<td>493</td>
<td>65.0</td>
</tr>
</tbody>
</table>

\(^2\) Work in others’ homes as cleaner or the cook
Table 2. Association between informal social support and past year prevalence of different forms of violence N=759

<table>
<thead>
<tr>
<th>Variables</th>
<th>Received no informal social support (N)</th>
<th>Received informal social support (N)</th>
<th>OR</th>
<th>CI at 95%</th>
<th>Chi-square p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>290</td>
<td>137</td>
<td>0.100</td>
<td>(0.057-0.175)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>317</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>278</td>
<td>124</td>
<td>0.191</td>
<td>(0.123-0.296)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>329</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>475</td>
<td>146</td>
<td>0.148</td>
<td>(0.064-0.342)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>132</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence in general</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>498</td>
<td>148</td>
<td>0.123</td>
<td>(0.045-0.341)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>109</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: * p < .05, ** p < .01, *** p < 0.001

Table 3. Association between formal social support and past year prevalence of different forms of violence N=759

<table>
<thead>
<tr>
<th>Variables</th>
<th>Sought no formal social support (N)</th>
<th>Sought formal social support (N)</th>
<th>OR</th>
<th>CI at 95%</th>
<th>Chi-square p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>299</td>
<td>128</td>
<td>16.579</td>
<td>(11.259-24.414)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>291</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>242</td>
<td>160</td>
<td>3.997</td>
<td>(2.942-5.431)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>98</td>
<td>259</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>321</td>
<td>300</td>
<td>6.702</td>
<td>(4.028-11.151)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>119</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence in general</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>334</td>
<td>312</td>
<td>19.091</td>
<td>(8.269-44.073)</td>
<td>0.000***</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>107</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: * p < .05, ** p < .01, *** p < 0.001
Table 4. Association between social support (informal and formal) and mental health among women exposed to intimate partner violence (IPV)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mental Health problem (N)</th>
<th>No mental health problem (N)</th>
<th>OR</th>
<th>CI at 95%</th>
<th>Chi-square p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among women exposed to physical violence (n=427)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received informal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>87</td>
<td>50</td>
<td>0.727</td>
<td>(0.479-1.105)</td>
<td>0.082</td>
</tr>
<tr>
<td>No</td>
<td>162</td>
<td>128</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sought formal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>81</td>
<td>47</td>
<td>0.744</td>
<td>(0.486-1.139)</td>
<td>0.104</td>
</tr>
<tr>
<td>No</td>
<td>168</td>
<td>131</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among women exposed to sexual violence (n=402)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received informal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42</td>
<td>82</td>
<td>0.831</td>
<td>(0.533-1.295)</td>
<td>0.241</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>172</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sought formal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>103</td>
<td>57</td>
<td>0.918</td>
<td>(0.606-1.391)</td>
<td>0.384</td>
</tr>
<tr>
<td>No</td>
<td>151</td>
<td>91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among women exposed to psychological violence (n=621)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received informal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>91</td>
<td>55</td>
<td>0.607</td>
<td>(0.415-0.888)</td>
<td>0.006**</td>
</tr>
<tr>
<td>No</td>
<td>237</td>
<td>238</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sought formal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>140</td>
<td>160</td>
<td>1.636</td>
<td>(1.191-2.248)</td>
<td>0.001**</td>
</tr>
<tr>
<td>No</td>
<td>189</td>
<td>132</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among women exposed to violence in general (n=646)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received informal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>91</td>
<td>57</td>
<td>0.621</td>
<td>(0.427-0.904)</td>
<td>0.008**</td>
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<tr>
<td>No</td>
<td>248</td>
<td>250</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sought formal social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>147</td>
<td>165</td>
<td>1.518</td>
<td>(1.112-2.070)</td>
<td>0.005**</td>
</tr>
<tr>
<td>No</td>
<td>192</td>
<td>142</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: * p < .05, ** p < .01, *** p < 0.001
Qualitative

When analyzing the interviews, the following categories were identified: factors associated with exposure to intimate partner violence; obstacles for seeking help; how the healthcare professionals receive and help; help options; and ideas for future change.

Factors associated with exposure to intimate partner violence

General factors deriving from a structural level (i.e., a woman’s position in society) and more specific aspects associated with relational dimensions (i.e., spousal conflicts) with regard to women being exposed to IPV were identified.

Relational factors.

All of the respondents perceived living in a joint family as a potential risk factor for being exposed to violence. This shared opinion correlates to women having a low status in the family sphere; i.e., not being respected by in-laws and because intimate partner violence is not only performed by the spouse but also by the extended family:

Women have always been exposed to violence, either with spouse, parents, brothers or other male members.

Arranged marriage, which is the most common form of marriage in Pakistan, was also described as a potential source of conflict. Prior to marriage, the partners are often not prepared for what is expected of them which may create friction in married life. Nevertheless, non-arranged marriages, where the husband has chosen his wife, can also become problematic as the in-laws are removed from choosing their son’s bride. It seems that gaining respect from the in-laws is crucial since parents have a great influence over their children even after they are married:

I know a lady with very big problem and she always come to us, saying: ‘please support me, please support me’ and then we went to see what her problem was. She had an in-laws problem, because her husband married according to his choice, not her in-laws choice.

Men and women in Pakistan experience very different life conditions. It is not uncommon that women are confined to the home and dependent on the husband for decision-making, while husbands are away for two to three months working. During the adjustment phase, when husbands return to the home, conflicts leading to violence were mentioned as arising often. Additionally, conflicts within the family sphere can occur if the woman is frustrated that the husband is not assuming his responsibility or if the woman behaves in a non-submissive way. These were mentioned as sources of disagreement and potential reasons for the occurrence of violence:

Sometimes, if there is problems and the husband is going away for earning a living. Mostly the woman is staying in the house, and the husband comes and she demands anything or complains about something, that kind of situation creates problems for the husband. If mother in-law and the wife are fighting with each other and husband comes, they are getting angry with their wives in our system.


**Life stressors.**

Some families have a seasonally based income which makes it difficult to predict the household budget and getting basic needs filled becomes a constant struggle. The majority of the respondents pointed out that life stressors, such as poverty and having numerous children, were contributing factors to the occurrence of violence:

*Partner relationship is mainly the crisis, poverty problem and joined family system and more children living in the house.*

**Women’s position in society.**

Pakistan is a male dominated society where women are considered subordinate. In the Pakistani culture, there is an implicit assumption that men have a higher position and thus authority over women. Subsequently, this leads to a situation where women have low autonomy and decision-making power. Women were described as assuming the role of follower rather than that of the decision maker, which forms a passive behaviour:

*And there is some cultural taboo like they say that women always remain lower then husbands. Yes, the following role, not the decision making role. That matters a lot.*

Low educational levels were described by the respondents as a contributing factor to the women being unaware of their rights. On the other hand, if a woman attained an education, she still might not be able to use it due to the controlling behaviour of her husband. The husband’s control extends from general to the specific aspects of wife’s ability to impact their own life. Even when it comes to their personal hygiene, women are not allowed to make decision for themselves; their efforts are hindered or controlled by the husband:

*In some sectors, I have noticed that the women want to make their hygienic conditions update, like daily bathing and so on, but the husbands does not allow them. “Ok, why are you dressed up like this, why you are changing clothes everyday, for whom?” These questions they usually ask which is very awkward.*

The wife is regarded as an extended part of the husband, not as an independent individual; this contributes to a low level of autonomy and comprehensive control of the woman’s behaviour. Religious misinterpretations of the Koran, leading to a lack of respect for women and justification for the use of violence, were also mentioned as potential causes leading to the occurrence of IPV.

**Obstacles for seeking help for women exposed to IPV**

Women’s low autonomy, leading to difficulties to reach healthcare facilities, together with the fear of negative social consequences and indirect help-seeking behaviour were identified as obstacles to seeking help when exposed to IPV.

**Low autonomy.**

The reduced autonomy Pakistani women faced were described by the respondents as one of the major reasons for not seeking help. Furthermore, they described how few women actually believe that they could survive without their husband, primarily because they are financially dependent on them and have few options to survive
economically on their own. Lack of financial means was also described as an obstacle to obtaining medical care. Being financially dependent also makes it difficult for the woman to seek help without the husband’s knowledge since he controls family expenses:

They may not talk about it because if the husband beats her or does anything against her will, you know he is providing her with everything, therefore she may not even complain about it.

Family and community members’ attitudes impact the possibility for the woman to receive help; she is dependent on their good will to take her to a health facility. If they perceive the violence as her fault, she will not get the help she needs. The women were also described as being hindered from seeking help because of their limited ability to move freely and the family’s fear that the matter will be exposed. Access to medical care is not always possible; she might be stopped by the family in order to avoid the cause of the violence being revealed. Another factor that might stop women from getting the help required is that some women are not allowed to leave their homes:

In healthcare, if the violence occurs it is important to reach to facility but most of the time it is not possible. Why, because if woman is injured at home due to violence and no one allow her to go to the hospital. Because that also gives picture of the violence and that expose the family conditions and family is not allowing that woman to go outside the house boundaries, especially in the community and even in the city.

Even when it comes to taking their children to the healthcare facility, their limited mobility and decision making powers decrease the possibility of them getting help:

Even their kids become sick they don’t have the authority to take them to facility, health facility. So, decision making power is very poor. The woman doesn’t get that power.

Fear of consequences.

Disclosing violence makes the woman vulnerable as she may be accused of besmirching the family’s honour. The woman’s personal condition and behaviour is intertwined with the family’s honour and disclosing an occurrence of violence is regarded as putting both the family’s and the husband’s honour at risk. If the family has a well respected reputation, the position creates help-seeking obstacles which make it significantly difficult for the woman to seek help. The importance of protecting the family’s honour and maintaining a good façade in the community makes it impossible to seek help and forces the woman to submit to the violence:

And sometimes it is a bug system, bug means to get honour, honour in community. If the fathers or the family have big name or honour in community and this, the daughter of that family is suffering, and having violence from the partner. So because of the family boundaries they will not disclose the problem.

Violence within the family sphere was also described as perceived as a very private matter. Subsequently, what goes on with a married couple is supposed to be kept private so it doesn’t risk negatively affecting the family and the husband’s honour; everything
is supposed to be handled within the family. This principal, together with the notion that violence is a private matter, can be applied even within the family sphere. For example, senior family members may have knowledge of the violence but choose not to interfere. This makes the women vulnerable as support and protection are lacking from people outside the family as well as from those within it. The woman may also choose not to talk about the violence in order to protect her parents from feeling the pain and shame of their daughter’s situation. Violating the existing social norm that family matters are not to be exposed might be interpreted as showing disrespect to the family and the husband:

Obviously first of all it is seen as a very private matter. They don’t want to talk about it to another person, to a stranger; also many women out here will be still very protective of their husbands’ honour and their family honour so they don’t want to disgrace the husband.

The respondents characterized the women exposed to violence as generally having nominal trust in available help options or possible avenues out of the violence. Divorce is not seen as a solution since it is not socially accepted. Another reason why the women stay in violent relationships is because of the fear of being a bad mother or even losing their children:

Also you see in this culture, women will stay in the marriage because of children. They may fear that, children might be taken away from them or the husband would claim the custody.

As previously mentioned, negative social consequences are anticipated by the women if the violence is disclosed. They fear social stigma; that other people will look at them differently or even blame them for the occurrence of violence. Shame and guilt probably hinder women exposed to IPV from seeking help:

They think that she is not good and it’s her problem and it’s her mistake that’s why the husband is angry and so they are thinking negative.

Indirect help-seeking behaviour.

The respondents stated that it was rare for women to seek direct help for IPV; rather, they tended to seek help by showing other symptoms. The women sought help for both the mental and physical consequences of violence without disclosing the cause of their health conditions:

Most of the time the women don’t verbalize the condition and what happened. They just cry or they convey the actual message in some other body part.

During home visits, the woman might stress that she has some problem without revealing the cause of the condition. One respondent expressed that if the immediate social support was deficient, they may then choose to seek help from a healthcare professional. To avoid disclosing the occurrence of violence, the woman seeking help might attempt to give alternative explanations for her health conditions:

They exhibit those problems in different aches and sometimes in bad evil conditions they say, ‘Ok, we are not feeling better because some bad evil came in side of us’. So they exhibit in different conditions. They don’t give actual reason.
Even so, the woman may often disclose the occurrence of violence if she is directly asked about it. This may indicate that validating the woman’s condition through asking about it reduces her feeling of guilt and fear of stigma and helps her to come forward.

Another important obstacle for women seeking help was that the occurrence of violence is regarded as an integrated part of married life. Often, the woman has normalized the violent behaviour and therefore has difficulties conceptualizing it as a problem for which there is a solution. One of the respondents put it thusly:

*As I said it may not be their primary complaint that they are bringing, also some will take it as normal in this culture. They may not talk about it if the husband beats or does anything that is against her will.*

**The healthcare professionals receiving and helping women exposed to IPV**

The respondents expressed that it is a complicated task to discover ongoing IPV in Pakistan since family matters are often regarded as private. Uncovering IPV must be done with an abundance of caution, otherwise healthcare professionals risk angering the husband—which may have negative ramifications for the woman—or even being reported to the police.

**Perception and Attitudes.**

To directly address IPV in a clinical encounter was described as a cultural taboo both for the respondents and the women exposed to violence. The women seeking help at the healthcare facility perceived a risk to be disparaged by others if the occurrence of violence was revealed. The respondents also expressed that, in general, the women didn’t want to be asked about it; by not addressing it, they felt they protected the woman from the fear of the perceived negative consequences. Furthermore, they experienced the overall issue as being too complex for them to be able to suitably help. For example, it was described as difficult to understand the dynamics of the marriages. In their opinion, IPV is an extant problem and attitudes are well established and difficult to change. A lack of trust in the possibility to change the situation combined with a dearth of available help options contributed to a perception that there is little they can do:

*Sometimes, they really need psychological or psychiatric help or some other help like financial or social or team help. But we don’t have those active teams. So we’re helpless sometimes.*

The respondents also reported that they perceived a lack of support when they encounter obstacles or negative consequences while attempting to help a woman exposed to IPV. The sensitive nature of the issue, along with fear of standing alone, might stop them during the help process:

*If we are getting problem, we will be alone, sometimes staff won’t help, and the team won’t help. It’s difficult, it is a sensitive issue.*

**Discovering IPV.**

A common method used to discover IPV in a family is to ask neighbours. Sensitivity about the issue seems to be lessened when it does not concern the woman being questioned and there is a willingness to help other women get professional help when
their own family honour is not at risk. Other ways to identify ongoing violence included contacting non-governmental organizations (NGOs) or community leaders, informing them about the situation and letting them handle the matter.

Healthcare professionals often offer their services through home visits. During these times, it can be a great obstacle to have other people around when talking about violence in the home, especially if the husband, mother or sister is present. Sometimes healthcare professionals have to be discrete about what they know and cannot confront husbands or in-laws directly. In those situations, they talk about the woman’s relationship and give advice without directly referring to the ongoing violence.

The unwillingness to ask directly about violence in the home is often so extensive that a woman can repeatedly seek help for conditions suspected to be linked to violence without the healthcare professionals asking about the nature of those conditions. Nevertheless, one of the respondents did say that only if a woman has been seeking help repeatedly, or her condition was acute, will they start to explore the reasons behind it:

Our medical officer was suspecting pneumonia conditions, but the doctor advised her to just bring an x-ray report. She brought the x-ray report and the first rib was very bad cracked. So then that medical officer asked; did something happen to you? Did somebody expose you to violence, or did somebody hit you?

Different stages of helping.

When asked about how they receive women who have been exposed to IPV, three of the respondents referred to different stages. Commonly, they all expressed that in the first phase they listen, explore and give emotional support to let the woman communicate her feelings. In the next phase, they try to find solutions, giving advice and counseling. One of the respondents described how she normally feels very bad receiving these women. Her method was to first listen so that the woman can relieve her anger and anxiety and thereafter try to find some immediate solution; for example finding out if there are parents or friends that can help the woman. Another respondent described that as much emotional support possible is offered at first, moving on to more practical aspects, such as what can be done, what the woman herself can do, what she has already done as well as trying to identify the woman’s fears and what she has tried until that point that has and has not worked. She also expressed it was important to ask if other people around the woman knew about what was going on:

And well obviously when they are received, first level is you offer as much of emotional psychological support as you can and then work on other things, what can be done and what can she do, what other things has she done up until now what has worked what has not worked, what are her fears, does people know about it, that way.

Activating the woman’s own coping strategies.

One respondent found it important to help the women figure out what they want, to get to know themselves better and try to understand what is going on, in order to make their own decisions. Another example of advice was for the woman to share her problems with people around her that she could trust and another suggested simply praying more. All four respondents had the opinion that it was important to empower the help-seeking woman in any way; for example, through encouraging assertive behaviour:
Encouraging assertive behaviours, bring forth herself as more strong, share it and let other people know about it.

Teaching the woman how to avoid violence by identifying the cause of the violence and showing them how to read the signs for when an attack is imminent was stressed. Their suggestions could include advising the woman when it is appropriate to talk about things with the husband and when it is not. This advice encourages the woman to adapt to the violent behaviour rather than identifying it as unacceptable and finding strategies to end it. The nature of their advice reflects the actual situation for women in Pakistan, where they have few options to end abuse:

...if there is often beating, helping her to read through the signs, like if the husband is alcoholic, he would come home and beat her, you know, every women will have some signs where she would know that this will be followed by aggression or violence.

Help options
Social support was described by the respondents as an extremely important aspect for women exposed to violence. When fulfilling its purpose, it has the function of validating the woman’s situation and encouraging her to seek help. Sharing the issue was seen as positive, giving the woman the courage to change the situation. Even though lack in the formal social support was identified, it was stressed as an important factor. Formal social support from NGOs and healthcare professionals could help to relieve external life stressors.

Informal social support.
One respondent described that women sometimes take initiatives to start up informal, small-scale female support groups to help each other without the involvement of the community. She described how there is not always a large family community to lean on for women in these positions, but that internally, the women help each other:

I think that some of females are internally are helping to each other. I also met one woman she said they made their like female support group. She said we are helping each other if violence occurs, it is not a large huge family community help, but in small scale they are helping each other.

The role of the family in Pakistani society has also been shown to be valuable in these matters and is regarded as the foremost source of support even when it is dysfunctional. One reason might be the lack of trust in authorities, which might be based in a belief that there isn’t much help forthcoming from them. Acquiring help from parents was believed to be another possible help option. Support from within the family, specifically from the mother—who, the respondents felt, should speak about the issue with their daughters instead of remaining silent—was mentioned as something that could create openness around the issue and prevent IPV from being repeated over generations:

Another thing is the mothers, who need to talk about this. Because the same mothers, have faced the same problems in their lives and they remain quiet. Therefore the tradition goes on and on, which is not good.
Other forms of providing social support described by the respondents included lending money or helping the woman with transportation to a healthcare facility. Another suggestion was that relatives and friends should validate the woman’s experience and stand up for her so that she could gain the strength needed to take action and change her situation:

* Might be lending her money, might be to take her to any area or to a governmental organizational or to a counselor. If the social support is helping then it is easier, otherwise it is difficult.

Formal social support.

The respondents emphasized the need to tackle IPV through helping on a structural level and providing assistance in a way that includes the whole family system. Giving emotional support on its own is not enough; it should be combined together with family planning, financial support and help with providing educational options. The need for expanded help was described by one of the respondents thusly:

* Husband needs counseling, wife needs counseling, all family member needs counseling and with counseling they also need some extra support and financial resources. Like educational things, like other things. So, only social support will not work according to me.

It was also stressed that if the government had a good support system, which is lacking today, women would benefit more. Another suggestion of formal social support included female support groups, where the women’s life situation could be validated and shared:

* Sometimes we arrange some programs for the women and get together and sharing her ideas. This is the social support and the socialization, to sit together and let everyone share their problem, maybe someone will understand. And she might think: I’m not the only one with this problem, there is a solution.

Yet another way in which healthcare professionals are assisting women who seek help is through guiding them to different legal resources or help organizations whenever needed; for example, when a woman wants to initiate divorce proceedings. Community leaders often play a very important role; whenever there is a problem in the community that healthcare professionals hear about, they discuss it with the community leaders who, in turn, have the authority to take action. Aside from the community leaders, NGOs and different women’s associations play important roles as resources where women can seek help. Those resources are community based, which is also an important aspect of the help-seeking situation since working close to the inhabitants of the community increases trust and the ability to help:

* NGO-teams, who is working around who is our partner organizations; we must talk with them and convey the message to them. So these people are local people and those people can convey this message to the family.

Religious leaders are other authorities to whom women turn in times of difficulty. Still, one respondent pointed out the difficulty with those people providing support as they are not always educated. Often, they merely follow traditional rules or succumb to the
pressure from their community resulting in the woman not receiving the support needed:

So in these conditions usually the Imam are the best people who can decide but if they don’t have clear knowledge, then if they don’t have clear interpretation, they don’t understand that Koranic knowledge. This is because few Imams are educated.

Ideas for future change

The ideas for change that our respondents suggested can be sorted into three categories: striving for women’s autonomy; improving formal support information; and structural changes. Each of the three examples shows that action has to be taken on different levels in order for change to occur.

Striving for women’s autonomy.

An important step towards decreased violence against women in the home is education. The respondents believed that education could encourage women to disclose the violence through awareness of their legal rights. Education also gives some level of autonomy through participation in the community and the potential to earn money. Participating in activities outside the home and getting influence and support from a social network were also mentioned as ideas that could positively contribute to women’s overall situation:

I feel that if women get good education, it will help a lot. Because while getting an education or in the education process you will meet friends, colleagues and other diversified people. So that gives you an idea, if you have that problem, how to talk, and bring up that problem.

Nevertheless, having an education or a job was not believed to be enough to mitigate the situation when exposed to violence. The respondents expressed their belief that the woman’s personal assets—i.e., internal strength and confidence along with having faith and a good understanding of the religion—were of importance. The respondents also expressed it was important to empower girls at an early age and help them to be more vigilant about protecting themselves and their rights:

Maybe helping young girls in school colleges, making them more aware of how should they be more vigilant on their own rights and how they can help themselves and protect their own rights.

Improving formal support.

One of the critiques of formal support by the respondents was directed towards general physicians in that they lack the training to receive women exposed to IPV or discover ongoing violence in the home:

Places that have qualified people, obviously they will be more attending, but at the primary level, general physicians lack a lot of that training. Those things are actually not dealt with.

Critique was also directed towards policy makers for not creating laws necessary for the protection of women:
In our government they don’t make any legislation. If someone go for the support or seeking help from policy makers and all they don’t.

Information.

It was emphasized that information that creates an increased awareness about IPV is important. Ideas about how this could happen included the following: writing and talking about it in the media; having articles published in the local language; having professionals talk about it in the electronic media; and shedding more light on IPV in general. The disadvantages with the media were also brought up: in the past, for example, some women have tried to seek help from the media only to become publicly exposed without getting any real help. It was therefore advised that women should seek help from organizations. Another suggestion was that women who had a positive experience solving a difficult incident of family violence could share their experiences with others:

If someone gets a positive response then she can go easily and she can take help and the previous one will quote, discuss or share the positive response.

Better knowledge of religious doctrine was also described as a potential way to protect and increase the respect for women:

In Pakistan, like we follow the holy book Koran and in the Koran, God is giving a lot of respect to women and God has described all the rule and responsibilities of women as well as men.

Structural changes.

Health problems and poverty were pointed out as two important factors that need to be addressed in order to decrease the incidence of IPV. Enforcing legal protection was also mentioned as an important structural action:

If the government has strong system then violence wouldn’t occur, because there are laws but they are not obeyed, that’s why. So if there is a good system from government and non governmental organization, then I think she can seek help.

Another idea that was raised by the respondents was to offer premarital counseling to couples. In Pakistan, most couples do not get a courting period for the man and woman to get to know each other and are often immediately exposed to an intimate relationship.

It was also mentioned that policy level adjustments are important and that strong politicians can make a change. Benazir Bhutto (prime minister of Pakistan, 1988–1990 and 1993–1996) was taken as one example of a strong female politician working to improve conditions for Pakistani women. One respondent pointed to the possibility of historical change in that these issues were not even discussed openly ten years ago:

Maybe ten years back or fifteen years back, we were not even talking about these issues so openly as we may be doing now so it is not like it is going to be a drastic change in one or two years time, but I mean we do see hope.
Discussion

Quantitative

The purpose of this study was to examine if informal and/or formal social support is associated with fewer occurrences of intimate partner violence (IPV) in a group of Pakistani women. Additionally, a second aim was to investigate if informal and/or formal social support is associated with less adverse mental health in those already exposed to IPV.

The quantitative result showed that women who received informal social support were less likely to be subjected to physical violence, psychological violence, sexual violence and violence in general. The reverse was detected for formal social support. It was not shown to be associated with fewer occurrences of violence but was rather associated with a higher likelihood to be subjected to IPV. Women who sought formal social support were more likely to report occurrences of physical violence, sexual violence, psychological violence and violence in general. When assessing social support in relation to mental health status, the result showed that informal social support was associated with less adverse mental health when being subjected to psychological violence and violence in general. In contrast, formal social support was shown to be associated with more adverse mental health when subjected to psychological violence and violence in general. No significance was found for physical violence and sexual violence with regards to both informal and formal social support.

The result of the first question showed that informal social support is associated with fewer occurrences of IPV. This finding is consistent with previous research by Goodman, Dutton, Weinfurt and Vankos (2005) who, in their longitudinal study investigating women’s resources and ability to stay safe, found that informal social support was a protective factor for re-abuse. One possible explanation is that informal social support may trigger coping strategies and expand the behavioural repertoire of the abused women through increased feelings of well-being. Previous research has shown that social support may enhance psychological well-being and personal competence (Langford, Bowsher, Maloney & Lillis, 1997) which could enhance the possibility of finding constructive alternatives and solutions. One other suggestion is that informal social support also can function as an alternative to the abusive relationship in terms of creating practical solutions for the woman. According to Goodman, Bennet and Dutton (1999), instrumental social support from family and friends (e.g. offering a place to stay) has been shown to be strongly associated with the woman’s ability to take the actions required to put an end to ongoing violence. Another explanation of the obtained result may be that positive social support from family and friends has been shown to buffer stress factors creating spousal conflicts and prevent the occurrence of IPV as was shown in a study by Lee (2005). It is also possible that validation and support from an informal social support network can encourage the woman to conceptualize the violence as unacceptable and thus trigger her help-seeking behaviour.

When investigating the role of formal social support in the first question, it was shown that seeking help from formal sources was associated with more occurrences of IPV. Contrary to the result of this current study, Sullivan and Bybee (1999) showed in their study from the USA that women who received help from formal sources were at a reduced risk for being exposed to violence. The study was conducted in a different social context than the present study, which could explain the contrasting result. No
literature has been found describing women’s perception of formal support in Pakistan; however, the qualitative result of this study shows that formal social support has limited resources, which could further highlight the contrasting result.

There are many possible interpretations to the result and without a longitudinal study it is not possible to draw any causal conclusions. The result could imply that the women sought formal social support when exposed to IPV but the support was not sufficient to help the woman overcome abuse. In line with the qualitative findings of this study, another interpretation of the result is that the act of exposing family matters by taking the problem outside the family may be perceived as a lack of respect and a disgrace to the family and possibly lead to more violence. According to Shaikh (2000), IPV in Pakistan is traditionally regarded as a private matter and the intervention of outsiders, including formal support sources, is not welcome. Breaking this cultural norm through seeking help from formal sources could possibly lead to negative consequences in the form of more violence. This finding is supported by a study from Israel, showing that seeking help from formal sources was perceived by the extended family as a revolt against society; one that brought shame to the family, and lead to rage, hostility, and e-communication from both the woman’s family of origin and husband (Haj-Yahia, 2002).

Research made on this particular matter emphasizes that South Asian women are unwilling to seek help from the outside and rather turn to their informal social network for help (Yoshioka, Gilbert, El-Bassel & Baig-Amin, 2003). One explanatory factor to the result of this study may be that the women who sought formal social support were the ones who lacked an informal social support network to turn to. Literature suggests that women seek help from formal sources when they have depleted their own resources or when informal social support is not enough (Lempert, 1997). It can be assumed that women lacking informal social support are exposed to both more severe abuse and the risk of the abuse continuing unnoticed. According to Levendosky et al. (2004), violence has been shown to have a negative impact on a woman’s social network through social isolation by the partner, where the chance of someone from the outside intervening decreases. This result suggests that the women in the present study who sought formal social support were not only lacking informal social support but were also exposed to a more severe form of violence; two components that lead to help-seeking. Research indicates that severity and frequency of abuse are predictors for help-seeking (Ellsberg, Winkvist, Pena & Stenlund, 2001; Rhodes & McKenzie, 1998; Vatanar & Bjorkly, 2009). The result may indicate that these women were the ones seeking help as a consequence of severe violence. Social support has also been shown to be less efficient in cases of severe IPV (Beeble, Bybee, Sullivan & Adams, 2009; Carlson et al., 2002), which, in turn, may have impacted the result of formal social support being associated with more violence.

The second question examined if social support is associated with less adverse mental health for women who already are exposed to IPV. When investigating the role of informal social support, the results showed that this type of social support was associated with less adverse mental health of women exposed to psychological violence and violence in general. This finding is consistent with previous research demonstrating that social support has a protective effect on the mental health of women exposed to IPV (Beeble, Bybee, Sullivan & Adams, 2009; Carlson, Mennett, Choi & Rose, 2002; Coker et al., 2002; Thompson et al., 2000). One suggestion to the result is that verbal
assault, as a component in psychological violence, may reinforce self-blaming patterns and that social support, through validation and through providing a different perspective, can alter the self-blaming thoughts and dysfunctional assumptions and limit their negative impact on the psychological well-being of the abused. Previous research has shown an association between women who repeatedly and over a longer period of time blame themselves for ongoing violence and the emergence of depressive symptoms (Cascardi & O’Leary, 1992). The dimension of instrumental aid in social support may have a positive effect on the mental health of the abused in terms of relieving life stressors together with perception of not being alone; knowing that there are supporters available in times of difficulties may decrease anxiety and feelings of helplessness.

While informal social support was associated with less adverse mental health for women exposed to psychological violence, it did not show any association with less adverse mental health for physical or sexual violence. One suggestion is that psychological violence is a less obvious form of violence and perceived by others as less severe; this might lead to the woman’s network and perceived social support to be less negatively impacted by the abuse. According to research, severe violence is related to lower levels of perceived support and a negative impact on the social network (Thompson et al., 2000).

Seeking formal support when exposed to psychological violence was shown to be associated with more adverse mental health. The negative impact of psychological violence on mental health may be an underlying factor for the obtained result. According to previous research, psychological violence has been shown to be the form of violence that has the most severe negative impact on psychological well-being (Beeble, Bybee, Sullivan & Adams, 2009). Additionally, the different result obtained for informal and formal social support (respectively, being associated with fewer occurrences of IPV versus associated with more occurrences of IPV) may indicate a difference in help-seeking behaviour. One suggestion is that women exposed to a less severe form of psychological violence turned to their informal social network and women who were exposed to a more severe form of psychological violence turned to formal help sources, which is in line with the assumption that severe abuse is a predictor for help-seeking from formal sources (Ellsberg, Winkvist, Pena & Stenlund, 2001; Rhodes & McKenzie, 1998; Vatanar & Bjorkly, 2009). Severity of abuse is not only linked with seeking help from formal sources but also to severity of mental health symptoms (Golding, 1999) which could explain the association with more adverse mental health when seeking help from formal sources.

Making the violence public and seeking help from formal sources could nevertheless fall in line with results from the qualitative data, leading to negative social consequences and increased psychological stress. According to these findings, seeking formal support was associated with more adverse mental health through negative social consequences. Since psychological violence does not cause any obvious physical harm/health conditions, it is probable that women exposed to this form of violence might be perceived as less legitimate cases seeking help from the social network and help-provider. Due to these reasons, social stigma from the social network, when seeking outside help, may also be more pronounced than for other forms of violence. The qualitative data of the current study showed that healthcare professionals affirmed the women’s help-seeking behaviour when the health condition was acute. It is possible that women who seek formal support when exposed to psychological violence do not
receive the support or validation needed or are met with disbelief, which along with the aforementioned components, could negatively impact their mental health. Due to data limitations, an investigation of perception or quality of support when disclosing violence was not possible. Still another aspect is the stigma associated with mental health problems which can also be a contributing barrier to seeking and receiving the help needed. This is supported by Budman, Lipson and Meleis (1992) who showed that women exposed to IPV often don’t seek help for mental health problems but rather await a physical health condition to legitimize help-seeking.

**Qualitative**

A second purpose of this study was to explore Pakistani healthcare professionals’ perception of help-seeking behaviour of women exposed to IPV, as well as their methods for receiving and helping victims of abuse.

The qualitative result showed that most women are confined to the home and restricted from the decision-making process. These same conditions that leave women with limited opportunities to participate in the community may also hinder them from gaining autonomy and a better position in society. Additionally, lacking financial independence and being unable to contribute financially to the family, together with not having attained a formal education, may be interconnected with maintaining a low status; all components that were shown to be risk factors for the occurrence of IPV. According to Heise’s (1998) ecological model, rigid gender roles and women’s subordination to men have been acknowledged as contributors to IPV.

Education and information increasing women’s awareness of their rights was, according to the results, an important component in the prevention of IPV. It can be supposed that this occurs as accessing education allows them the opportunity to interact with people outside the family, which may strengthen their informal social network and increase the possibility to access help and valuable information in times of difficulty. Previous research has shown that low levels of education limit women’s awareness of available resources and restricts them from seeking help (Krishnan, Baid-Amin, Gilbert, El-Bassel & Waters, 1998). This finding further highlights the importance of education and gaining information on how to access possible help-options in order to increase help-seeking.

Nevertheless, contradictory findings regarding the effect that women’s empowerment has on IPV have been presented in literature. Paradoxical tendencies have been observed with education: lacking a formal education has been associated with a higher risk of being subjected to IPV (Koenig et. al, 2003; Ali, Asad, Mogren & Krantz, 2009); while a higher level of educational attainment also has been shown to increase the risk for IPV (Moore, 2008). The wife’s earnings have been similarly shown to serve both as a risk and a protective factor (Naved & Persson, 2005). It appears that risk and protective factors are linked with the women’s position and autonomy and these, in turn, might influence her behaviour. It has been proposed that a woman with increased autonomy behaves more assertively, which may challenge the traditional power relationship with her husband and consequently increase the probability of him using violence (Moore, 2008). Furthermore, conflict between spouses, particularly when the woman showed non-submissive behaviour, was described by the respondents as a risk factor for more controlling behaviour from the husband and for exposure to IPV. In line
with this result, research has shown that disobeying or arguing with the husband has been linked with IPV (Heise & Garcia-Moreno, 2002; Naved & Persson, 2005). Challenging the power structure and striving for increased autonomy appears to be a complex matter; a change that—in the long-term—could serve as protective factor may at the onset involve both punishment and increased risk for IPV, discouraging women’s attempts from being an active agent in decision making while striving for autonomy.

Conflicts with in-laws, in combination with the woman’s overall low status in the new family, were also shown to create incidents of violence. To be accepted by the in-laws seems to be crucial for the woman’s life conditions. This is specific to Pakistani culture, where a woman is married into a new extended family and her relationships are based on marital ties that she has to build and maintain (Mumtaz & Salway, 2009). This may create a situation where the woman is expected to be subordinate to an already existing family structure and tradition; violating this expectation may lead to conflicts resulting in IPV.

Having numerous children was pointed out as another risk factor for IPV incidence, primarily because of the financial constraints associated with large families. In contrast to this finding, having numerous children has been shown to be a protective factor for IPV (Moore, 2008). Nevertheless, the result of the present study may be a reflection of the limited amount of control that women have over their own sexuality and subsequent family planning, which is supported by existing evidence showing a correlation between sexual violence and unwanted pregnancies (Kapadia, Saleem & Karim, 2009).

According to the result, it was acknowledged that formal help structures have limited resources and that women have very little trust that there is a way out of the violence. It is difficult for a woman in Pakistan to survive on her own outside the family system and this lessens her options with regards to ending violence. It seems that instead of defining IPV as a problem, violent cultural models are instead internalized and destructive behaviour normalized. Previous research has shown that, with limited possibilities for ending violence and sparse help options, women may be less prone to recognizing IPV as a problem and conceptualizing it as intolerable. The first stage in the cognitive process of deciding to seek help—where the woman defines the situation as a problem (Liang, Goodman, Tummala-Narra & Weintraub, 2005)—may be inhibited by these aforementioned components and stop the woman from taking action and further help-seeking.

The results also showed that the help given by healthcare professionals often encouraged the women to be passive rather than take action; providing advice on how to adapt to the husband in order to avoid violence. While the advice may create the perception of control for the woman over her situation, it also stressed her role as being the catalyst for violence without addressing the root causes. This finding is consistent with previous research showing that the lack of resources and options to end the violence has also been linked to conforming to the husband’s demands as a strategy to avoid violence (Schuler, Bates & Islam, 2008).

Another factor identified as an obstacle to seeking formal help, connected to the notion that IPV should be kept private within the family, was the protection of family honour. The results showed that feelings of shame hindered women exposed to IPV from seeking help from their family of origin. Protecting family honour was consequently
shown to function as an obstacle to seeking both formal and informal social support. As previously mentioned, IPV is traditionally regarded as a private matter and outsiders, including formal support sources, should not intervene (Shaikh, 2000). These factors were shown to create not only psychological barriers (i.e., fear of social stigma when seeking help) but also practical obstructions, such as the family restricting the woman from leaving the home to seek formal help. Previous research has shown that controlling behaviour from the partner, along with being financially dependent, have been described as factors hindering women from seeking medical care (Lempert, 1997).

According to the results, instrumental social support (e.g., lending money or helping with transportation) was shown to be an important component to helping a woman access formal help resources. When the woman reaches out to a healthcare facility and has decided to seek help, fear of negative social consequences was also identified as an impediment to help-seeking behaviour. To seek help indirectly, without exposing family matters, implies conforming to the existing norm and may function as a coping strategy to avoid the feared consequences. It may also reflect that feelings of shame and self-blame for causing the violence hinders women from disclosing the true reason for the help-seeking. Subsequently, indirect help-seeking behaviour functions as a buffer for being exposed to social stigma but also, at the same time, as a barrier from receiving adequate help and support. Previous studies have shown that indirect help-seeking behaviour has been linked to fear of stigma and rejection from supporters, leading to low perceived quality of support (Williams & Mickelson, 2008). A way to circumvent or break this pattern may be through strengthening informal social support. Informal social support was, according to the result, shown to encourage women to seek help from formal sources. It is plausible that a supportive social network, validating the need for outside help, reduces the fear of social stigma and rejection and therefore increases help-seeking and the disclosure of IPV.

The apprehension of mentioning violence was shown to be shared by healthcare professionals. This can create an invalidating experience of help-seeking and further reinforce the taboo and non-disclosure of violence. This can create a negative cycle where IPV continues to exist unnoticed and the woman loses trust in formal social support. Women who are ignored or put down when they seek help tend to blame themselves and return to the abusive relationship (Lempert, 1997). The healthcare professionals were prone to ask the woman about IPV only when the health condition of the woman was acute or the woman had sought help repeatedly, which may reinforce the behaviour of seeking help, particularly when exposed to severe and frequent abuse. Nevertheless, it has been shown that social support may be less efficient when given in cases of more severe violence (Goodman, Dutton, Wienfurt & Vankos 2005). Furthermore, it has also been demonstrated that the severity of abuse is correlated with the severity of mental health symptoms (Golding, 1999). This shows the importance of identifying IPV and helping the woman at an early stage in order to prevent adverse mental health consequences. According to the results, women did disclose the violence when asked, which indicates that the healthcare professional’s response, through validation of the woman’s condition, can help the IPV victim to overcome the fear of social stigma and be receptive to help.

Female support groups, both formal and informal, were pointed out as important forums for validation and sharing of life conditions. Sharing a difficult situation with others that have similar experiences may reduce feelings of guilt and shame and help women to
come forward. It also could be perceived as a more acceptable form of support, less associated with stigma; it could be regarded as a combination of informal and formal social support and an intervention based on sharing rather than external help from authorities. In order to overcome barriers for help-seeking and make the support more accessible, developing this form of support could be beneficial. Previous research has demonstrated that participating in groups in the community can be beneficial for the psychological well-being of women through a sense of purpose and providing social roles (Berkman, Glass, Brisette & Seeman, 2000). It can also function as a platform for promoting healthy behaviours and addressing social and health inequalities (Campbell & Mclean, 2002).

Method discussion

One of the strengths of the original study—from which the quantitative portion of this study data was based—was that it was a population-based resource where the participants were selected by random sampling. It also included a comparatively large sample, which generated satisfactory statistical power and reliability. Furthermore, the data collection was made with a well known instrument by community midwives who were trusted by the community members. This could have impacted the number of participants that disclosed IPV. One reservation, however, is that some interviews were conducted in the home which may constitute a risk of underreporting violence but also over-reporting social support. A limitation of a cross-sectional study is that the causal relationship cannot be established and temporal sequence cannot be assured; that the women were first abused and then received social support, which reduced the risk, for example, of the occurrence of violence and in some cases adverse mental health. The results of informal social support as being associated with fewer occurrences of IPV and formal social support associated with more occurrences of IPV are therefore suggestive rather than conclusive. Another limitation of this study is the separate analysis of the different types of violence. The conclusions drawn may be problematic since different forms of violence often overlap. The outcome of informal social support as being associated with fewer occurrences of IPV and less adverse mental health may have been confounded with other underlying variables. It is possible that the women who sought help have a more resourceful coping style and were more likely to find social support and less likely to be subjected to IPV.

Since the quantitative data was already collected, the variables chosen had to be adjusted to already existing data which implied some limitations. Due to data limitations when measuring formal social support, no conclusions on whether the women actually had received help or what their perception was of the received help were possible. Regarding informal social support, the quality of the received support was not controlled for nor was what type of informal social support (i.e., emotional, practical, informational etc.) that had been given. The type of social support, and the perception of it, has been found to be critical regarding its effectiveness; this, together with the importance of specifying contextual factors, has been highlighted in literature (Uchino, 2009). A data collection of the perceived quality of social support and to whom the participants primarily turned should be considered for future research. A standardized questionnaire measuring the quality and perception of the social network could be used favorably. It would have been interesting to investigate whether the abuser could have
received informal social support and how it would affect the relational dimension and occurrence of IPV; however, due to data limitation this was not possible.

Due to limitations in the original questionnaire, the adverse mental health variable measured symptoms of depression rather than the diagnostic definition of depression. For future research, it would be interesting to have access to the complete diagnostic criteria for depression in order to be able to draw conclusions on it as an effect of IPV. Underlying factors contributing to adverse mental health—such as life circumstances and other health conditions, or mental health issues such as PTSD—that could have impacted the reported mental health symptoms were restricted because of data limitations and not controlled for.

One obvious limitation of the qualitative data collection was the small sample used. Three out of four respondents were representative for the larger quantitative sample since they were directly working in the field with women from lower and middle income socioeconomic strata. Furthermore, the respondents represented a second source of information; for example, regarding the question, “What could prevent a woman from seeking help”, the answers were often based on clinical examples but may in some cases have derived from hypothetical assumptions. The interviews were conducted in English and, not being the native language of the respondents, created a language barrier that may have limited the answers and comprehension of the interview questions. It is also possible that some culturally specific information was misinterpreted. As interviews have an interpersonal dimension, respondents may be affected by the interviewers and adjust their answers to what they consider is appropriate for the person asking the question. Ethnicity, gender and age may be factors influencing the respondent’s answers (Hayes, 2004). Notably, the question regarding the women’s perception of the interviewers as incompatibly oriented, culturally speaking was also raised and the possibility of censure cannot be ruled out. Nevertheless, it could be equally likely that the different cultural backgrounds of the interviewers had a positive impact on the barriers to talk about such a sensitive issue.

The quantitative data and the majority of the qualitative data represented women from lower and middle socioeconomic strata and the results can only be generalized for women facing similar life conditions in Pakistan.

**Conclusion**

The quantitative results of the present study showed that informal social support was associated with fewer occurrences of IPV and adverse mental health when exposed to psychological violence. These results suggest that strengthening informal social support could be a beneficial intervention to stop violence against women and limit milder adverse mental health consequences. Further research is needed to investigate the active components and the functions of informal social support; moreover, the type of support that had a beneficial effect and started courses of action that prevented further abuse needs to be indentified. This knowledge is of use for people meeting victims of abuse in their profession; they could use the information to activate the woman’s informal social network by encouraging her to talk to family members and friends and also include them in help interventions, for example.
There is also a need to develop formal social support; seeking help from formal sources was shown to be associated with more occurrences of IPV and also more adverse mental health when exposed to psychological violence. To follow-up and give continuous support after women sought formal social support (for example, through home visits to show their presence and involvement) would be important, for example to intervene in case of increased violence. Moreover, in order to improve the capacity to adequately help women, more training—with regards to structured counseling and knowledge about psychological conditions—is a competency that would be beneficial, if developed further. Additionally, in order to identify IPV at an early stage and reduce the taboo around the issue, it is essential to ask about the woman’s family situation as a routine part of the diagnostic interview. In order to empower the healthcare staff working with IPV victims, it is also valuable to emphasize their importance and potential to have a positive impact on the patient’s health outcome through the way they receive the patient. Furthermore, through integrated supportive services (e.g. shelters), women could get help to create an independent life, serving as protection for future abuse and an option to the abusive relationship and subsequently facilitate the help-seeking process.

Working with IPV requires taking multiple aspects into account. Research has found that in order to prevent abuse, many different resources need to cooperate such as family and friends, professional counselors, shelters, religious leaders, lawyers and police (Horton & Johnson, 1993). There are undoubtedly structural challenges in Pakistan requiring long-term work; for example enforcing legal protection, developing formal support, creating educational opportunities for women and empowering women’s position in the society. Nevertheless, creating awareness through information is an equally important step to create a dialogue and openness around the issue in order to change cultural norms that stop the identification of IPV, help-seeking and further interventions. Taking into account the cultural context, the information is preferably implemented at the community level where community leaders, religious leaders and healthcare professionals play an essential role in the work against IPV.

References:


BBC Pakistan Country profile. Visited on 21/12/09: [http://news.bbc.co.uk/2/hi/americas/country_profiles/1157960.stm](http://news.bbc.co.uk/2/hi/americas/country_profiles/1157960.stm)


World health organization (2003). Multicountry study on women's health and life experiences questionnaire (version 10)


Appendix 1

**Interview guide**

- The purpose of this interview is to know more about your experiences when encountering women exposed to Intimate Partner Violence (IPV). We would also like to gauge your thoughts on the women’s help seeking behaviour. The information we gather from you will be used in our research and be a part of our thesis.
- Your participation is voluntary and you are free to withdraw at any time, without giving a reason.
- The interview will take approximately 45min—1 hour. It will also be recorded and later transcribed. Your answers will be anonymous and your identity will not be revealed. We ensure that your confidentiality is maintained throughout.
- We are committed to handling both your information and responses with the highest standards of privacy, anonymity and confidentiality in mind.

Age:
Gender:
Profession:
Professional experience:

**Theme: Coping of the healthcare professional**

1. What is your opinion on IPV?

2. In your profession do you meet women that have been exposed to IPV?

3. If you meet a woman that has been exposed to IPV, how do you receive her? If you suspect IPV, even though the woman for some reason does not tell you, do you ask her about it or is there any other ways of going about to reveal this sort of information?

4. Do you give any advice to the woman who has been exposed to IPV? If yes, what kind of advice?

**Theme: help-seeking and social support**

5. What do you think might hinder women from seeking help when being exposed to IPV?

6. What do you think could encourage these women to seek help?

7. What methods do you believe could be used to help a woman who is, or has been exposed to IPV?

8. Do you think social support is important for a woman who is exposed to IPV? If so, how? What kind of social support?

**Theme: Future and interventions**

9. Do you have any thoughts on whether or not the situation for women, exposed to IPV, will change in the future?