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Gender Based Violence, Social Support, and Impaired Mental Health in Afghan Refugee Women Residing in Pakistan

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Abstract
This study examines the association between Gender-Based Violence (GBV), particularly Intimate Partner Violence (IPV), social support, and mental health outcomes among Afghan refugee women. Employing a correlational research design, data were collected through purposive sampling from 142 married Afghan refugee women aged 18 to 59 residing in Dera Ismail Khan. Participants completed a self-constructed demographic questionnaire along with standardized measures assessing exposure to violence and symptoms of depression, anxiety, and stress. Statistical analyses, including reliability testing, correlation, hierarchical regression, and moderation analysis, were conducted to evaluate the relationships among variables. Findings revealed that psychological, physical, and sexual violence were significantly associated with elevated levels of depression, anxiety, and stress. Conversely, social support from family, friends, and significant others played a buffering role, mitigating the adverse effects of violence on mental health. Among the violence types, physical violence emerged as the strongest predictor of psychological distress. The study underscores the critical need for culturally sensitive mental health interventions and preventive strategies to address violence against Afghan refugee women.
Keywords: *Gender-Based Violence, Social Support, Stress, Depression, Anxiety, Afghan Refugees*

INTRODUCTION

Afghanistan is a landlocked nation situated at the intersection of the Middle East, Central Asia, and South Asia, with a population exceeding 30 million. The country is home to several major ethnic communities, including

Pashtuns, Tajiks, Hazaras, and Uzbeks. Its recent history has been shaped by decades of conflict, beginning with the Soviet invasion in 1979, followed by prolonged civil unrest. By the late 1990s, the Taliban regime assumed power, during which women endured extreme social restrictions, gender discrimination, and exclusion from education and public life (Kovess-Masfety et al., 2021).

Recent studies reveal that nearly half of Afghan women suffer from significant psychological distress, reflecting the cumulative impact of war, displacement, and gender-based violence. Political instability has further restricted access to healthcare services, especially in the domain of mental health. Deep-rooted patriarchal norms, trauma, and cultural practices such as early marriage, adolescent pregnancy, and Pashtunwali—a traditional tribal code of conduct—have constrained women's opportunities for education, inheritance rights, and skill development. Consequently, many women face challenges in achieving economic independence or starting their own enterprises. Moreover, the stigma surrounding mental illness discourages many from seeking professional psychological assistance.

Intimate Partner Violence (IPV) remains a widespread public health concern among Afghan women, particularly those living as refugees. Research consistently shows that refugee and immigrant women experience higher rates of domestic and gender-based violence compared to non-refugee populations. Following the collapse of Afghanistan's democratic government in 2021, ongoing violence, political turmoil, and poverty displaced nearly 1.6 million Afghans, forcing them to flee the country. Presently, approximately 8.2 million Afghan refugees are dispersed across over 100 countries, making them one of the largest refugee populations globally (UNHCR, 2025). Empirical findings underscore the gravity of this situation. A study in Iran reported that almost 80% of Afghan refugee women had experienced intimate partner violence within the previous year (Delkosh, 2018). These findings highlight the urgent need for mental health interventions, social protection mechanisms, and gender-sensitive policies to support these vulnerable populations.

Afghanistan's complex ethnolinguistic diversity and tribal social organization significantly influence its gender and cultural dynamics (Lamer, 2011). According to the World Health Organization (WHO, 2015), prolonged conflict and foreign intervention have deeply destabilized Afghan families, escalating the prevalence of gender-based and sexual violence. Their data reveal that approximately 17% of women have suffered sexual abuse, while 52% have endured physical assault. Moreover, mental health challenges remain pervasive. A national survey reported that around 47% of Afghans experience some form of psychological distress, including post-traumatic stress disorder (PTSD), major depressive disorder, generalized anxiety, and in severe cases, suicidal ideation or attempts. These disorders are intricately linked to Afghanistan's longstanding exposure to war-related trauma, economic deprivation, and social inequality. The same study found that nearly 39% of respondents identified serious mental health problems stemming from these adverse circumstances (Kovess-Masfety et al., 2021). The present study aimed to investigate the Gender Based Violence, Social Support, and Impaired Mental Health in Afghan Refugee Women Residing in Pakistan. Following are the objectives of the study.

1. To examine the relationship between intimate partner violence (IPV) and impaired mental health in Afghan refugee women residing in Pakistan.

2. To find out how social support affect the relationship between intimate partner violence (IPV) and mental health, in Afghan refugee women.

LITERATURE REVIEW

Gender-Based Violence

Gender-based violence (GBV) refers to any act that causes physical, sexual, or psychological harm to women due to their gender or socially assigned roles (Carpenter, 2006). It encompasses behaviors that inflict pain, distress, or restriction of personal freedom in both private and public spaces (Shenon et al., 2009). Such acts often arise from unequal power relations and social expectations that subordinate women.

Intimate Partner Violence

One of the most prevalent manifestations of GBV is intimate partner violence (IPV), which involves the use of physical force, emotional manipulation, sexual coercion, or controlling behavior by one partner toward another. Globally, IPV remains among the most widespread forms of abuse faced by women (UN, 2025). Physical abuse includes acts such as hitting, burning, kicking, or assaulting with weapons, sometimes leading to severe injury or death. More extreme cases include human trafficking and modern slavery, where control and coercion are maintained over long periods.

Domestic violence affects not only partners but also children who may witness or experience such abuse, leading to emotional and psychological harm. In many cases, young people are also subjected to physical violence within their relationships, often intensified by cultural and social pressures (WHO, 2012).

Verbal violence, another damaging form of abuse, includes insults, threats, and demeaning comments often targeting personal beliefs, identity, or family. Women frequently face sexually explicit verbal abuse or hate speech, which can be spread through conversations or online platforms. According to the World Health Organization, hate speech aims to dehumanize, humiliate, and instill fear, causing profound emotional distress that can, in some cases, lead to self-harm or suicide (WHO, 2012).

Psychological violence is designed to undermine an individual's self-esteem and emotional stability. It involves threats, manipulation, deception, withholding essential information, or deliberate isolation. In domestic settings, this form of abuse may include ignoring a partner, constant criticism, or emotional neglect. When directed toward women, these behaviors constitute psychological gender-based violence—an attempt to erode independence, confidence, and mental health (UN Women, 2011).

Sexual violence within intimate relationships occurs when a woman is coerced or forced to engage in sexual acts without her consent. This may involve marital rape, humiliation, or denial of the right to refuse sex or use contraception. Such acts are commonly used as tools of dominance and control (Heise et al., 1999). The United Nations Population Fund (UNPF, 2021) defines sexual violence in domestic relationships as any unwanted sexual act, attempt, or trafficking for sexual purposes by an intimate partner or family member.

Economic or socioeconomic violence occurs when a perpetrator limits a woman's access to financial resources, education, or employment opportunities. Such control restricts autonomy and increases dependence. In domestic relationships, economic abuse may involve withholding money, preventing work or study, or exploiting a woman's financial assets. According to the Council of Europe, economic violence includes denial of

financial rights, restricting access to employment, and failing to fulfill monetary obligations such as child support (UNPF, 2021). Intimate partner violence, often referred to as domestic violence, remains the most pervasive form of gender-based abuse. Historically regarded as a private issue, it was long overlooked as a human rights violation. International conventions now require governments to safeguard victims and ensure justice. The United Nations defines domestic violence as physical, psychological, sexual, or financial abuse between partners or family members, regardless of cohabitation. Women are disproportionately affected, and survivors often endure long-term physical and emotional harm, with limited access to legal protection due to weak enforcement mechanisms (UN, 2025).

Leaving an abusive relationship can be highly challenging. Emotional dependency, financial control, social stigma, and threats against oneself or family members frequently prevent victims from leaving. Many survivors develop what is known as battered woman syndrome, where prolonged abuse leads to feelings of helplessness and fear. Isolation, lack of resources, and rigid cultural expectations surrounding family life further compound the danger and difficulty of escaping abusive environments (UN, 2025).

Mental Health

According to the World Health Organization, mental health is a condition of overall well-being in which individuals can manage life's challenges, realize their abilities, work effectively, and contribute to their communities. It plays a vital role in leading a balanced and fulfilling life. However, individuals exposed to poverty, inequality, disability, or violence are more vulnerable to mental health problems. Social support—defined as meaningful relationships that enhance self-worth and belonging—is a critical protective factor (Gottlieb, 2000). People with strong social connections are better equipped to cope with stress, whereas those with limited support systems are more prone to anxiety, depression, and post-traumatic stress disorder (PTSD), and even face an increased risk of early mortality (Southwick et al., 2005).

Effects of Intimate Partner Violence on Mental Health

Exposure to intimate partner violence often results in severe mental health issues, with depression, anxiety, and PTSD being the most common outcomes. Prolonged abuse erodes a survivor's sense of safety and self-worth, frequently leading to major depressive episodes (Campbell et al., 2000). Anxiety disorders may manifest as panic attacks, hypervigilance, and chronic worry due to ongoing fear of further violence (Shwartz, 2025). PTSD is also prevalent, marked by intrusive memories, nightmares, and emotional numbness following traumatic experiences (Merton & Mohr, 2001). To cope with the psychological distress, some survivors resort to substance use, which can worsen emotional and physical health (WHO, 2021). Sleep disturbances, muscle tension, and somatic complaints are also common symptoms associated with IPV-related trauma (Coten et al., 2006).

Intimate partner violence significantly diminishes life satisfaction and overall well-being, particularly when various forms of abuse—physical, emotional, and financial—occur simultaneously (Shwartz, 2025). Survivors often experience isolation, losing support from friends, family, and community networks. This situation worsened during the COVID-19 pandemic when lockdowns restricted mobility and access to help (Stark et al., 2020).

Beyond psychological harm, IPV can cause serious physical health problems, including reproductive issues, unintended pregnancies, and pregnancy complications (WHO, 2002). The resulting trauma often leads to reduced productivity, absenteeism, and increased dependency on others. Economic control by abusive partners further deepens financial insecurity and emotional vulnerability (Minh et al., 2013).

Theoretical Framework

Theoretical frameworks provide essential lenses to understand how intimate partner violence (IPV) and mental health issues intersect, especially in conflict-affected and patriarchal societies. Feminist theory explains IPV as a product of gender inequality, emphasizing that patriarchal norms grant men authority and control over women, leading to abusive behaviors. Scholars like Dobash and Dobash (1977) and Walker (1984) suggest that these socially constructed roles make women more vulnerable to violence, as they internalize subservience from an early age. Similarly, research shows that IPV is more frequent in households where men strongly adhere to traditional gender roles and patriarchal values (Leonard & Senchak, 1996; Smith, 1990). The Trauma Theory further explains that exposure to violence or abuse can cause lasting psychological damage, such as post-traumatic stress disorder (PTSD), depression, and anxiety, as individuals relive traumatic experiences and feel constant fear or helplessness. Heise's Ecological Model (1998) expands on this by viewing IPV as an outcome of multiple interacting layers—individual, relational, community, and societal. Factors like substance abuse, poor mental health, relationship conflicts, lack of community support, and weak institutional frameworks contribute collectively to violence. The Learned Helplessness Theory (Seligman, 1975) explains how repeated abuse can cause victims to feel powerless, leading to emotional withdrawal and resignation. Complementing this, the Stress, Social Support, and Buffering Hypothesis highlights that strong social connections can protect individuals from the harmful mental health impacts of stress and violence. Finally, the Diathesis-Stress Model emphasizes that mental health problems emerge when stress interacts with personal vulnerabilities, such as a history of trauma or genetic predisposition, explaining why not all IPV survivors experience the same psychological outcomes. Together, these theories provide a comprehensive understanding of how structural, social, and psychological factors interact to shape the experiences and mental health of IPV survivors.

Conceptual Model

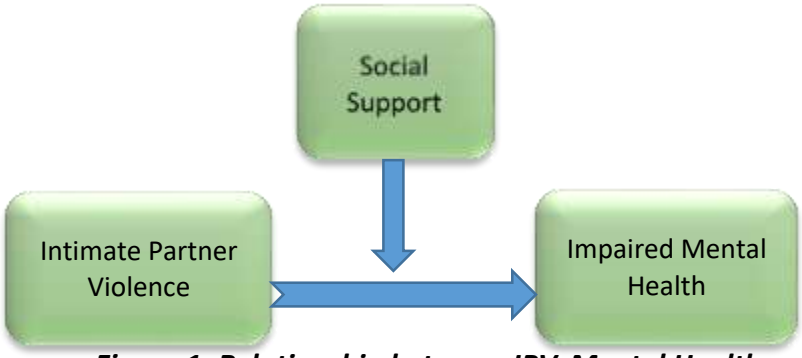

Figure 1: Relationship between IPV, Mental Health, and Social Support

RESEARCH METHODOLOGY

This study employed a quantitative correlational research design using purposive sampling to investigate the relationship between intimate partner violence (IPV), mental health, and social support among 142 Afghan refugee women aged 18–59 living in Pakistan. Participants met specific inclusion criteria—they were married Afghan refugee women fluent in Pashto—while those outside the age range, unmarried, non-Pashto speakers, or recent migrants were excluded. Data were collected using three validated tools: the WHO Violence Against Women (VAW) scale to assess IPV, the Depression Anxiety Stress Scales (DASS-21) to evaluate mental health, and the Multidimensional Scale of Perceived Social Support (MSPSS) to measure social support. All instruments were translated into Pashto following MAPI guidelines through forward and backward translation, pilot testing, and expert review to ensure cultural and linguistic accuracy. A pilot study with 10 participants tested feasibility and clarity, after which the main study was conducted in Dera Ismail Khan. Ethical principles such as voluntary participation, informed consent, confidentiality, and participant safety were strictly observed, with interviews conducted in private, safe environments. Data analysis provided moderate support for the study's hypotheses and offered insights into the cultural dynamics influencing IPV and mental health among refugee women.

RESULTS

Table 1

Psychometric Properties of Scales and Their Subscales (N = 142)

Scale	Mean	SD	Range	Cronbach's α
Intimate Partner Violence (Total)	5.30	4.31	13–26	0.90
Psychological Violence	1.84	1.57	0–4	0.81
Physical Violence	2.32	2.19	0–6	0.85
Sexual Violence	1.14	1.25	0–3	0.83
Social Support (Total)	54.04	19.37	16–88	0.93
Significant Others	18.45	6.30	4–28	0.89
Family	18.26	6.90	4–28	0.91
Friends	17.33	7.84	4–28	0.76
Mental Health (Total)	47.47	13.47	23–78	0.88
Stress	16.78	5.11	14–28	0.67
Anxiety	15.83	4.74	14–28	0.73
Depression	14.85	5.16	14–28	0.78

All scales demonstrated acceptable to excellent reliability, with Cronbach's alpha values ranging from 0.67 to 0.93. The IPV and Social Support scales showed strong internal consistency, while the DASS-21 exhibited good reliability overall. Only the stress subscale showed slightly lower consistency, suggesting minor measurement variation.

Table 2

Relationship of Covariates, Intimate Partner Violence (IPV), Social Support, and Impaired Mental Health (N = 142)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Years of Marriage	—													
2. Husband Age	.77**	—												
3. Dissatisfied Relationship	.16	.08	—											
4. Children	.61**	.43**	.12	—										
5. Family System	-.01	-.09	.02	.04	—									
6. Psychological Violence	.23**	.22**	.16*	.16*	-.07	—								
7. Physical Violence	.31**	.16*	.22**	.18*	-.05	.77**	—							
8. Sexual Violence	.30**	.26**	.14	.12	-.16	.44**	.49**	—						
9. Significant Others	-.23**	-.16	-.16	-.16	.03	-.48**	-.50**	-.27**	—					
10. Friends	-.18*	-.15	-.20*	-.13	.01	-.42**	-.46**	-.15	.71**	—				
11. Family	-.30**	-.35**	-.26**	-.15	-.03	-.52**	-.51**	-.26**	.87**	.73**	—			
12. Stress	.23**	.15	.16*	.22**	-.04	.43**	.47**	.23**	-.40**	-.38**	-.43**	—		
13. Anxiety	.22**	.21**	.19*	.31**	-.02	.31**	.44**	.13	-.46**	-.33**	-.45**	.71**	—	
14. Depression	.31**	.23**	.16*	.25**	-.04	.48**	.54**	.24*	-.51**	-.39**	-.53**	.69**	.71**	—

Psychological, physical, and sexual violence were positively correlated with stress, anxiety, and depression, indicating a strong link between IPV and poor mental health. Conversely, social support from family, friends, and significant others showed negative correlations with these mental health outcomes. This demonstrates that social support plays a protective role in reducing the adverse effects of intimate partner violence.

Table 3

Hierarchical Regression Representing IPV and Social Support as Predictors of Stress (N = 142)

Variables	B	95% CI LL	95% CI UL	SE B	β	R^2	ΔR^2
Model 1						.08	.08
Constant	.56	19.51	33.61	3.56	—		
Marriage Years	.09	-.21	.40	.15	.10		
Relationship with Husband	.72	-.14	1.59	.44	.13		
Husband's Age	.11	-.19	.42	.15	.12		
Model 2						.30	.22
Constant	35.31	25.56	45.06	4.92	—		
Marriage Years	.13	-.22	.38	.15	.07		
Relationship with Husband	.16	-.67	.96	.14	.02		
Husband's Age	-.01	-.30	.27	.14	-.01		
Psychological Violence	2.98	-3.37	9.34	3.21	.11		
Physical Violence	**7.13**	**.08**	**14.18**	**3.56**	**.25***		
Sexual Violence	-.52	-4.83	3.79	2.18	-.02		
Significant Others	-.16	-2.26	1.92	1.05	-.02		
Family	-.96	-2.99	1.07	1.02	-.16		
Friends	-.36	-1.53	.79	.58	-.07		

Model 1, containing demographic factors, explained only 8% of stress variance and was not significant. Model 2, which included IPV and social support, explained 30% of variance and was statistically significant ($p < .001$). Physical violence emerged as the only significant predictor, indicating that higher levels of physical abuse were associated with greater stress among Afghan refugee women.

Table 4

Hierarchical Regression Analysis Representing IPV as a Predictor of Anxiety

Variables	B	95% CI (LL–UL)	SE B	β	R^2	ΔR^2
Model 1					**.14**	**.14**
Constant	22.40	16.07 – 28.74	3.20	—		
Marriage years	.09	-.18 – .37	.14	.11		
Relationship with husband	.73	-.04 – 1.51	.39	.14		
Age	.17	-.09 – .45	.14	.21		

Variables	B	95% CI (LL–UL)	SE B	β	R^2	ΔR^2
Model 2					**.34**	**.20**
Constant	34.25	25.48 – 43.02	4.43	—		
Marriage years	.09	-.17 – .35	.13	.10		
Relationship with husband	.36	-.37 – 1.09	.37	.07		
Age	.07	-.18 – .33	.13	.09		
Psychological violence	-2.91	-8.64 – 2.80	2.80	-.12		
Physical violence	9.74	3.40 – 16.08	3.20	.37*		
Sexual violence	-3.22	-7.10 – .65	1.96	-.14		
Significant others	-1.96	-3.84 – -.07	.95	-.32		
Family	-.45	-2.28 – 1.38	.92	-.08		
Friends	-.53	-.52 – 1.57	.53	.11		

Model 1 explained 14% of anxiety variance but was not statistically significant. Model 2, including IPV variables, explained 34% of the variance and was significant ($p < .001$). Among all predictors, only **physical violence** emerged as a significant contributor to higher anxiety levels.

Table 5

Hierarchical Regression Analysis Representing IPV as a Predictor of Depression

Variables	B	95% CI (LL–UL)	SE B	β	R^2	ΔR^2
Model 1					**.12**	**.12**
Constant	21.86	14.91 – 28.82	3.52	—		
Marriage years	.17	-.13 – .48	.15	.19		
Relationship with husband	.63	-.22 – 1.49	.43	.11		
Husband's age	.10	-.19 – .41	.15	.11		
Model 2					**.41**	**.29**
Constant	34.34	25.31 – 43.36	4.56	—		
Marriage years	.16	-.11 – .43	.13	.17		
Relationship with husband	.02	-.73 – .77	.38	.00		
Husband's age	-.04	-.31 – .22	.13	-.05		
Psychological violence	1.97	-3.91 – 7.85	2.97	.07		

Variables	B	95% CI (LL–UL)	SE B	β	R^2	ΔR^2
Physical violence	9.22	2.70 – 15.75	3.29	.32**		
Sexual violence	-1.99	-5.99 – 1.99	2.01	-.08		
Significant others	-1.16	-3.10 – .77	.98	-.17		
Family	-1.28	-3.16 – .60	.95	-.21		
Friends	.41	-.65 – 1.49	.54	.07		

Model 1 explained 12% of the variance in depression but was not statistically significant. Model 2, which included IPV variables, significantly predicted depression ($p < .001$) and explained 41% of the variance. Among all predictors, **physical violence** was the only significant contributor, indicating higher abuse increased depression levels.

DISCUSSION

This study explored how intimate partner violence (IPV) affects the mental health of Afghan refugee women and how social support influences this relationship. The results showed that physical, psychological, and sexual violence were positively associated with stress, anxiety, and depression, with physical violence emerging as the strongest predictor of poor mental health. Women who experienced physical abuse often reported severe emotional distress and fear, while psychological and sexual violence were less predictive, likely due to cultural stigma that discourages Afghan women from discussing domestic abuse. In Afghan society, patriarchal beliefs and the concept of family honor often silence victims and normalize such behavior. Social support from family, friends, and significant others showed a protective role, helping reduce the negative mental health effects of IPV. Women with stronger support networks experienced less stress, anxiety, and depression. These findings highlight the need for culturally sensitive interventions, community-based counseling, and awareness programs to address IPV among Afghan refugees. Empowering women and challenging traditional norms that justify violence are essential steps toward improving their mental health and well-being.

CONCLUSIONS AND RECOMMENDATIONS

This study found that physical, sexual, and psychological violence were all linked to higher levels of stress, anxiety, and depression among Afghan refugee women. Physical violence emerged as the strongest predictor of poor mental health. Although social support played a positive role, it did not significantly reduce the effects of IPV. These results highlight the need for stronger protection and mental health interventions for survivors. Overall, the findings stress the urgent importance of addressing IPV to improve refugee women's psychological well-being. It is recommended to develop targeted interventions focusing on reducing physical violence and improving mental health support for Afghan refugee women. Policies should also strengthen community-based support systems and address cultural norms that perpetuate gender-based violence.

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