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INVISIBLE WOUNDS: PSYCHOLOGICAL EFFECTS OF GENDER-BASED VIOLENCE ON RURAL WOMEN IN KHYBER PAKHTUNKHWA, PAKISTAN

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ABSTRACT

This study explored the psychological effects of gender-based violence (GBV) on rural women in Khyber Pakhtunkhwa, Pakistan, with a focus on how socio-cultural and structural dynamics shaped survivors' mental health experiences. Despite global commitments under Sustainable Development Goals (SDGs) 3 and 5 to ensure well-being and eliminate violence against women, GBV remained pervasive in rural Pakistan, with limited attention to its psychological consequences. A qualitative design was employed using purposive sampling to conduct 12 in-depth interviews (IDIs) with survivors, four focus group discussions (FGDs) with community women, and six key informant interviews (KIIs) with healthcare providers and social workers. Data were analyzed thematically using NVivo software. Findings revealed eight interrelated psychological effects of GBV: chronic fear and anxiety, internalized guilt and self-blame, depression and emotional numbness, social withdrawal, low self-esteem and loss of identity, intergenerational psychological impact, trauma and PTSD-like symptoms, and learned helplessness. Survivors reported persistent hypervigilance, emotional detachment, and diminished sense of self, while expressing concern over the transmission of fear and normalization of violence to their children. Key informants corroborated these patterns and highlighted the absence of trauma-informed mental health services in rural health systems. The findings underscored that GBV in rural Khyber Pakhtunkhwa functioned as both a mental health crisis and a public health challenge with intergenerational implications. This study concluded that addressing GBV required integrating culturally sensitive, trauma-informed psychosocial support into rural healthcare and GBV response frameworks, strengthening community-based referral pathways, and providing family-centered interventions to break cycles of violence. By documenting the psychological burden of GBV in a marginalized rural context, the study contributed evidence to inform Pakistan's progress toward SDG 3 (Good Health and Well-Being) and SDG 5 (Gender Equality).

Keywords: *Gender-based violence, psychological effects, rural women, Khyber Pakhtunkhwa, trauma, mental health, Sustainable Development Goals.*

INTRODUCTION

GBV is recognized globally as one of the most pressing public health challenges and a critical barrier to achieving gender equality and sustainable development. The United Nations identifies the elimination of GBV as central to the Sustainable Development Goals (SDGs),

particularly SDG 3, which aims to ensure healthy lives and well-being for all, and SDG 5, which calls for ending all forms of violence against women and girls (United Nations, 2023). Globally, approximately one in three women have experienced physical or sexual violence in their lifetime, making GBV a pervasive human rights violation and a leading driver of preventable morbidity and mortality among women (World Health Organization [WHO], 2021; Sardinha et al., 2022). The mental health consequences of GBV are equally severe, with survivors exhibiting higher prevalence of depression, anxiety, post-traumatic stress disorder (PTSD), and suicidal ideation compared to women without exposure to violence (Devries et al., 2013; Trevillion et al., 2012). These effects are amplified in low- and middle-income countries (LMICs), where social, cultural, and economic vulnerabilities intersect to limit women's autonomy and restrict access to protection and support services (Garcia-Moreno et al., 2015; Abramsky et al., 2018).

In Pakistan, GBV remains deeply embedded within patriarchal social structures and traditional gender hierarchies, with profound consequences for women's physical, reproductive, and psychological health. The Pakistan Demographic and Health Survey (PDHS 2017–18) reported that approximately 28% of ever-married women aged 15–49 had experienced physical spousal violence, and 6% had experienced sexual violence, with rural prevalence consistently higher than urban (National Institute of Population Studies [NIPS] & ICF, 2019). Emotional violence was reported by 26% of women, highlighting the widespread psychosocial dimensions of abuse (NIPS & ICF, 2019). These figures are underestimated due to underreporting driven by stigma, fear of retaliation, and cultural norms discouraging disclosure (Ali et al., 2021; Qureshi et al., 2020). Contributing factors include early marriage—affecting nearly 18% of girls before age 18—low female literacy, and economic dependency, all of which curtail women's decision-making power and exacerbate vulnerability to violence (Naz et al., 2022; Sarfraz et al., 2016).

Rural Khyber Pakhtunkhwa presents a particularly complex context. The province has one of the lowest female literacy rates in Pakistan—37.2% compared to 64.6% for males—with rural rates dropping below 35% in several districts, including Nowshera (Pakistan Bureau of Statistics [PBS], 2023). Strict adherence to purdah (female seclusion), restricted mobility, and male-dominated household decision-making structures reinforces women's socio-economic dependency and inhibit help-seeking behaviors (Naz et al., 2023; Mukhtar, 2023). Mental health infrastructure is extremely limited: KPK has fewer than 50 psychiatrists for a population of over 35 million, and rural districts lack integrated psychosocial services within primary healthcare (Khan et al., 2021; Riaz et al., 2024b). These structural gaps exacerbate the psychological impact of GBV, leaving survivors without formal avenues for trauma-informed care or support (Naz et al., 2022; Webb & Renzaho, 2023).

Evidence from PDHS and other national studies shows a strong association between exposure to intimate partner violence and poor maternal and reproductive health outcomes. Women who experience GBV are significantly less likely to receive antenatal care, deliver in health facilities, or access postnatal services, demonstrating the intersection between violence, maternal health, and systemic inequities (NIPS & ICF, 2019; Aftab et al., 2023). International research similarly underscores that the psychological sequelae of GBV—such as depression, anxiety, and PTSD—directly impact women's ability to seek timely healthcare and participate in social and economic life, perpetuating cycles of poverty and exclusion (Trevillion et al., 2012; Soggiu et al., 2022).

Despite the growing body of evidence on GBV in Pakistan, most research has focused on prevalence and structural barriers to service access, with relatively little attention to the psychological consequences for rural women (Ali et al., 2021; Qureshi et al., 2020). Qualitative studies from rural Punjab and Sindh indicate high levels of emotional distress and social isolation among survivors, yet the mental health dimensions of GBV remain underrepresented in policy and programming, particularly in KPK (Mukhtar, 2023; Sadia et al., 2022). Moreover, there is limited localized evidence from districts such as Nowshera, where entrenched patriarchal norms, poverty, and lack of mental health infrastructure converge to shape women lived experiences of violence.

This study addresses these gaps by exploring the psychological effects of GBV on rural women in KPK through in-depth qualitative inquiry, focusing on Nowshera district as a representative

rural setting. By centering survivors' narratives and triangulating perspectives from healthcare providers and community stakeholders, the research provides context-specific insights into the mental health consequences of GBV within a setting characterized by intersecting socio-cultural and structural barriers. The findings aim to inform culturally sensitive, trauma-informed interventions that integrate mental health into GBV response mechanisms in rural Pakistan, contributing to national and global efforts to achieve SDG 3 and SDG 5.

Methodology

Study Design

This study adopted a qualitative exploratory design to examine the psychological effects of GBV on women in rural Khyber Pakhtunkhwa. Qualitative methods are widely recognized as effective for exploring complex social phenomena, capturing lived experiences, and understanding the socio-cultural context of GBV (Creswell & Poth, 2018; Braun & Clarke, 2022) and has been largely used in literature (Naz et al., 2024b, Naz et al., 204c; Riaz et al., 2024a; Naz et al., 2023a). The study focused on Nowshera district, a rural area in Khyber Pakhtunkhwa province characterized by entrenched patriarchal norms and limited access to mental health and GBV support services.

Study Setting

The study was conducted in Nowshera district, located in Khyber Pakhtunkhwa, Pakistan. Nowshera is predominantly rural, with an estimated population of 1.5 million, of which nearly 80% resides in agrarian and semi-urban settlements (Pakistan Bureau of Statistics [PBS], 2023). The district is characterized by deeply entrenched patriarchal norms, strict gender roles, and low female literacy rates. Recent census data report overall literacy in Nowshera at 52.3%, with female literacy at only 34.8% compared to 68.1% for males, reflecting significant gender disparities (PBS, 2023). Early marriage and purdah (female seclusion) are widely practiced, contributing to restricted mobility and limited autonomy for women in health-related decision-making.

Maternal and reproductive health indicators in Nowshera reflect broader provincial trends in KPK, where rural women face persistent barriers to accessing skilled care. Antenatal coverage and institutional delivery rates are lower than national averages, and reliance on Traditional Birth Attendants (TBAs) remains high (Naz et al., 2023; Sadia et al., 2022). Mental health services are scarce, with no dedicated psychiatric facilities in the district and limited integration of psychosocial support within primary healthcare (Naz et al., 2022). These structural and socio-cultural constraints create a challenging context for addressing the psychological effects of gender-based violence and make Nowshera a critical site for exploring the intersection of GBV, mental health, and rural healthcare access.

Study Population and Sampling

The target population comprised women survivors of GBV, healthcare providers, and community stakeholders. Purposive sampling was used to recruit participants who could provide rich, relevant insights into the psychological impact of GBV (Palinkas et al., 2015). Survivors were identified through local NGOs and women's community networks, ensuring inclusion of diverse experiences, including intimate partner violence and domestic abuse. Frontline healthcare workers and key informants were included to triangulate perspectives and capture systemic barriers.

A total of:

- **4 Focus Group Discussions (FGDs)** with women survivors of GBV,
- **12 In-Depth Interviews (IDIs)** with survivors, and
- **6 Key Informant Interviews (KIIs)** with healthcare providers, NGO representatives, and community leaders were conducted.

Sample size was guided by the principle of data saturation, achieved when no new themes emerged during analysis (Guest et al., 2020).

Data Collection

Data were collected using semi-structured guides developed from existing GBV and mental health frameworks (WHO, 2016; Garcia-Moreno et al., 2015). The tools explored experiences of violence, psychological effects, coping mechanisms, and barriers to accessing support. All interviews and FGDs were conducted in Pashto by trained female researchers in safe, confidential locations to ensure participant comfort and trust. Informed consent was obtained verbally and in writing prior to participation. Sessions were audio-recorded

with permission and supplemented with field notes.

Ethical Considerations

Given the sensitivity of GBV research, ethical protocols followed WHO guidelines on interviewing survivors (WHO, 2016). Confidentiality and anonymity were strictly maintained, with pseudonyms assigned to all participants. A referral mechanism for psychosocial support was established in collaboration with a local NGO to assist participants reporting distress. Ethical approval was obtained from the University of Agriculture, Peshawar Research Ethics Committee.

Data Analysis

All audio recordings were transcribed verbatim in Pashto and translated into English. Data were analyzed thematically using Braun and Clarke's (2022) six-phase framework, which involves familiarization, coding, theme development, and refinement. NVivo 12 software was used to organize and manage data systematically. An inductive approach was applied, allowing themes to emerge from the data while guided by theoretical sensitivity to GBV and mental health literature (Nowell et al., 2017).

To enhance rigor, multiple coders independently analyzed a subset of transcripts to ensure inter-coder reliability. Reflexive memos were maintained to document analytical decisions and minimize researcher bias. Triangulation across FGDs, IDIs, and KIIs strengthened the credibility and trustworthiness of findings (Lincoln & Guba, 1985).

Table 1. Coding Framework Development Process

Categories (Condensed Meaning)	Themes (Overarching Patterns)
Persistent fear, hypervigilance, anxiety triggers	**Chronic Fear and Anxiety**
Self-blame, internalized guilt, social reinforcement	**Internalized Guilt and Self-Blame**
Hopelessness, emotional numbness, depressive symptoms	**Depression and Emotional Numbness**
Stigma, shame, withdrawal from social networks	**Isolation and Social Withdrawal**
Loss of agency, diminished self-worth, verbal abuse impact	**Low Self-Esteem and Loss of Identity**
Children's fear, transmission of trauma, parenting stress	**Intergenerational Psychological Impact**
Flashbacks, nightmares, PTSD-like symptoms	**Trauma and PTSD-like Symptoms**
Repeated failed help-seeking, resignation, helplessness	**Hopelessness and Learned Helplessness**

Results

A total of eight themes emerged from the thematic analysis, derived inductively from FGDs, IDIs, and KIIs using NVivo. The coding process followed Braun and Clarke's (2022) six-phase framework, with iterative comparison across transcripts to ensure thematic saturation. Themes were validated through triangulation of perspectives from survivors, healthcare providers, and community stakeholders. The final thematic map illustrates the multifaceted psychological effects of GBV on rural women in Khyber Pakhtunkhwa.

Table 2. Thematic Coding Framework on Psychological Effects of GBV

Codes (Participant Quotes)	Categories (Condensed Meaning)	Themes (Overarching Patterns)
"Even when he is not here, I feel fear." / "Always scared he will beat me again."	Persistent fear, hypervigilance, anxiety triggers	**Chronic Fear and Anxiety**
"Everyone says it's my fault." / "I should stay quiet to save family honor."	Self-blame, internalized guilt, social reinforcement	**Internalized Guilt and Self-Blame**
"I cry all night." / "I feel empty inside, like nothing matters."	Hopelessness, emotional numbness, depressive symptoms	**Depression and Emotional Numbness**

"I don't meet neighbors anymore." / "I stopped going to my mother's house."	Stigma, shame, withdrawal from social networks	**Isolation and Social Withdrawal**
"He says I am useless." / "I have no value, no identity."	Loss of agency, diminished self-worth, verbal abuse impact	**Low Self-Esteem and Loss of Identity**
"My children hide when they hear his voice." / "I fear my daughter will think this is normal."	Children's fear, transmission of trauma, parenting stress	**Intergenerational Psychological Impact**
"I see those moments again at night." / "I wake up sweating and shaking."	Flashbacks, nightmares, PTSD-like symptoms	**Trauma and PTSD-like Symptoms**
"I went everywhere for help, no one listened." / "Now I just bear it silently."	Repeated failed help-seeking, resignation, helplessness	**Hopelessness and Learned Helplessness**

Chronic Fear and Anxiety

A pervasive theme emerging across all FGDs, 11 of 12 IDIs, and multiple KIIs was the experience of persistent fear and heightened anxiety among survivors of gender-based violence. Women described living in what one participant called a "state of alertness," anticipating violence even during moments of calm.

As one survivor stated, *"Even when he is not here, I feel fear. My heart beats fast when I hear footsteps outside... I always think he will come and hit me again."* Another woman shared, *"I cannot sleep peacefully. Even in his absence, I imagine the sound of him shouting. I wake up sweating at night."*

This constant hypervigilance reflects trauma-related psychological distress commonly associated with intimate partner violence. In qualitative studies of rural Pakistan, women have described similar experiences of "continuous fear," often compounded by economic dependence and lack of safe spaces to escape abuse (Naz et al., 2022; Ali et al., 2021). The findings align with global evidence showing that prolonged exposure to violence creates chronic anxiety disorders, hyperarousal, and somatic symptoms such as palpitations and insomnia (Devries et al., 2013; Soggiu et al., 2022).

In the rural Khyber Pakhtunkhwa context, these psychological effects are intensified by structural and cultural factors. Several participants highlighted the absence of protective mechanisms, stating that returning to their natal homes was "not an option" due to societal pressure to "adjust" and maintain family honor.

One woman explained, *"There is no safe place. If I leave, they will say I have brought shame. If I stay, I live in fear."* This intersection of fear and social control underscores the compounded vulnerability rural women face when both the household and community reinforce silence and endurance.

Healthcare providers interviewed as key informants observed the manifestation of this fear in clinical encounters.

A midwife stated, *"When women come for antenatal checkups, I see the anxiety in their eyes. They tremble when I ask about their home life. Many develop blood pressure problems because of this constant fear."*

These accounts reflect how chronic anxiety due to GBV transcends psychological distress and begins to manifest as physical and obstetric complications, a pattern well documented in South Asian maternal health research (Qureshi et al., 2020; Webb & Renzaho, 2023).

The theme also revealed an important link between fear and help-seeking behaviors. Many women described avoiding disclosure or delaying medical care out of fear of retaliation.

One participant explained, *"If I speak to anyone, he will find out and beat me worse. So, I stay quiet, even when I am hurt inside."*

Such narratives reflect the first "delay" in the Thaddeus and Maine (1994) framework—delay in deciding to seek care—where fear of violence inhibits women's access to both physical and mental health services.

This chronic fear also extended to public spaces. Some participants described anxiety when interacting with neighbors or visiting healthcare facilities, anticipating judgment or community gossip. This "social hypervigilance" illustrates how GBV-induced trauma transcends the home and becomes embedded in women's broader social existence, creating a cycle of isolation and mental exhaustion (Naz et al., 2023b).

Overall, the findings demonstrate that fear in rural GBV survivors is not a temporary emotional response, but an enduring psychological state shaped by repeated exposure to violence, cultural norms enforcing silence, and lack of protective

structures. Addressing this chronic anxiety requires trauma-informed interventions that combine individual psychosocial support with community-level efforts to create safe spaces and dismantle honor-based narratives that perpetuate fear.

Internalized Guilt and Self-Blame

A dominant psychological pattern emerging across 9 IDIs, 5 KIIs and all FGDs was the deep internalization of guilt among women survivors, often reinforced by family and community narratives. Many participants described believing they were personally responsible for the abuse.

One survivor shared, *"Everyone says it's my fault; they told me to adjust and keep the family together."*

Another woman echoed, *"When he beats me, I think maybe I have failed as a wife. Maybe I deserve it because I spoke back."*

This theme captures how GBV survivors in rural Khyber Pakhtunkhwa internalize societal blame, converting external violence into self-directed guilt. These accounts reflect a well-documented psychological consequence of GBV: the development of self-blame as a coping mechanism in patriarchal contexts. Research from Pakistan indicates that cultural and religious narratives emphasizing women's duty to "preserve family honor" make survivors particularly vulnerable to internalizing blame (Ali eta al., 2021; Mukhtar, 2023). In KPK, where community surveillance is strong and honor-based norms are entrenched, this guilt becomes a tool of social control, reinforcing silence and endurance over help-seeking (Naz et al., 2022).

Healthcare providers interviewed corroborated this pattern. A Lady Health Worker stated, *"When I talk to women about violence, they often say, 'Apa, it must be my mistake. If I was patient, he would not hit me.' They carry the blame inside themselves even when they are the victim."*

Such narratives highlight the intersection between GBV and women's psychological construction of self in rural societies where subservience is idealized. International literature similarly identifies internalized blame as a predictor of depressive and PTSD symptoms in GBV survivors, particularly in honor-based cultures (Trevillion et al., 2012; Soggiu et al., 2022).

The theme also intersected with social stigma. Several women described being explicitly told by relatives to endure violence quietly to avoid "bringing shame" to the family.

One participant recalled, *"When I told my mother about the beatings, she said, 'Stay quiet; a good woman hides her pain.' After that, I stopped speaking."*

This silence, reinforced by guilt, mirrors findings from rural Punjab where community narratives perpetuate the idea that women are responsible for family cohesion, even at the cost of their well-being (Sarfraz et al., 2016).

In the rural KP context, internalized guilt carries unique psychological consequences. The combination of economic dependence limited female mobility, and lack of psychosocial services creates conditions where women not only endure violence but come to see it as a reflection of their own inadequacy.

As one FGD participant put it, *"I have no education, no job, no voice. If he beats me, maybe it is because I am nothing."*

This illustrates how GBV and structural inequality converge to erode self-worth and entrench learned helplessness.

Linking these findings to existing literature, studies in South Asia emphasize that internalized guilt is not merely an emotional response but a socio-culturally mediated psychological adaptation. It serves to maintain family structures under patriarchal norms while simultaneously deepening women's mental health burden (Mumtaz & Salway, 2007; Naz et al., 2023b). Addressing this requires interventions that challenge cultural narratives and incorporate trauma-informed counseling to help survivors externalize blame and rebuild self-agency.

Depression and Emotional Numbness

Depressive symptoms and emotional detachment emerged as a profound psychological effect of GBV, reported in 10 of 12 IDIs, all FGDs, and 5 of 6 KIIs. Women consistently described persistent sadness, hopelessness, crying spells, and a sense of emptiness.

One survivor stated, *"I just sit and cry at night... sometimes I feel nothing at all, like I am empty inside."*

Another IDI participant shared, *"I feel like there is no reason to live. Even if I smile in front of others, inside I am broken."* Several participants described a loss of interest in daily activities and difficulty caring for children, reflecting classic symptoms of depression.

Healthcare providers in KIIs observed similar patterns. A psychologist (KII-6) noted, *"Most women I see are clinically depressed. They come saying they feel*

tired of life, unable to find joy. Many meet the criteria for major depressive disorder, but they have never been diagnosed."

A Lady Health Worker (KII-3) added, *"When I visit homes, I see women sitting silently, eyes blank. They say, 'Apa, nothing matters anymore.' It is emotional numbness from years of abuse."*

A gynecologist (KII-1) connected these symptoms to maternal outcomes: *"Depression affects their pregnancy care. Some women stop eating properly or miss checkups because they feel hopeless."*

The emotional numbness described by participants reflects what trauma literature identifies as a dissociative coping mechanism. Survivors reported "shutting down" emotionally to endure repeated violence.

One FGD participant explained, *"I have stopped feeling. If I feel, I will die inside. So, I become like stone."* Another shared, *"When he beats me, I go somewhere else in my mind. I can't feel the pain anymore."*

Such detachment, while protective in the short term, has long-term consequences for mental health, parenting, and social functioning (Trevillion et al., 2012; Soggiu et al., 2022).

In rural Khyber Pakhtunkhwa, structural factors amplify this depressive burden. Limited access to psychosocial services, social stigma surrounding mental illness, and cultural expectations of endurance create conditions where women's depression remains untreated and invisible.

One IDI participant stated, *"There is no one to tell. If I say I am sad, they laugh and say, 'All women go through this.'"*

This aligns with evidence that normalization of suffering in patriarchal societies exacerbates untreated depression among GBV survivors (Naz et al., 2022; Mukhtar, 2023).

Key informants highlighted the systemic neglect of mental health in GBV response. A social worker (KII-4) explained, *"When women report violence, the focus is on physical injury. No one asks about the mind. We are losing women to silent suffering."*

This gap reflects findings from Pakistan's health system, where mental health integration into primary care remains extremely limited, particularly in rural districts (Khan, Ahmad, & Jenkins, 2021).

The intergenerational impact of this depressive state also surfaced in narratives. Several women described emotional withdrawal affecting their children.

One FGD participant shared, *"I cannot hug my children. I feel so empty that I have nothing to give."*

International evidence underscores that maternal depression in the context of GBV significantly affects child emotional development and perpetuates cycles of trauma (Evans et al., 2020; Sardinha et al., 2022).

Isolation and Social Withdrawal

Isolation and withdrawal from social networks emerged as a significant psychological effect of GBV, reported in 8 of 12 IDIs, all FGDs, and 4 of 6 KIIs. Women consistently described distancing themselves from relatives, neighbors, and community spaces due to fear, shame, and stigma.

One survivor shared, *"I stopped going to my mother's house because they said I bring shame by talking about my husband."*

Another IDI participant echoed, *"I don't meet neighbors anymore. People ask questions, and I feel their eyes judge me."*

This pattern demonstrates how violence extends beyond the home, disrupting women's social connections and reinforcing emotional isolation.

FGD participants repeatedly linked isolation to internalized stigma. One woman said, *"When you are beaten, everyone knows. They don't ask for help; they talk behind your back. It's easier to stay inside."*

Another explained, *"If I go out, they say I am a bad wife. So, I hide inside my home."*

These statements illustrate the intersection between psychological distress and social control mechanisms in rural Khyber Pakhtunkhwa, where purdah and honor-based norms regulate women's mobility and reinforce silence (Naz et al., 2023a; Mukhtar, 2023).

Key informants confirmed the impact of social withdrawal on mental health. A Lady Health Worker (KII-2) observed, *"Many women stop attending community health sessions after violence starts. They are afraid of gossip, so they isolate themselves."*

A healthcare provider (KII-1) added, *"We see women coming for checkups only when absolutely necessary. They avoid public spaces because they feel ashamed."*

A social worker (KII-4) explained the systemic effect: *"Isolation makes it harder to reach survivors. When women withdraw, they are cut off from any information or help."*

This theme aligns with global research indicating that GBV-induced social isolation exacerbates depression, anxiety, and PTSD symptoms by

removing critical protective factors such as social support and community validation (Trevillion et al., 2012; Soggiu et al., 2022). In rural Pakistan, where informal social networks often substitute for formal support systems, withdrawal carries a double burden: emotional loneliness and reduced access to assistance (Qureshi et al., 2020; Ali et al., 2021).

Several women described how isolation became both a coping mechanism and a source of psychological harm.

One IDI participant stated, *"When I stay away from people, there are no questions, no shame. But then I feel alone, like I am disappearing."* Another said, *"I used to visit neighbors to feel alive. Now I am staying inside these walls. It feels like a prison."* These narratives highlight how withdrawal provides temporary safety from stigma while deepening feelings of emptiness and detachment.

In rural KPK, the consequences of social withdrawal are compounded by gendered mobility restrictions. With purdah limiting women's movement, isolation due to GBV often becomes near-total confinement, intensifying psychological harm. Key informants linked this to service delivery gaps.

A community midwife (KII-5) explained, *"When women cut ties, they stop coming for maternal checkups. We lose them in the system until a complication brings them back."* This illustrates the critical link between isolation, mental health, and maternal outcomes.

Low Self-Esteem and Loss of Identity

Low self-esteem and erosion of personal identity emerged as a critical psychological effect of GBV, identified in 9 of 12 IDIs, all FGDs, and 5 of 6 KIIs. Women described how constant verbal, emotional, and physical abuse stripped them of self-worth and agency.

One IDI participant stated, *"He says I am useless, and now I feel it is true... I have no value."* Another shared, *"I used to think I was a person. Now I feel like a servant with no name, no voice."* These narratives illustrate how GBV not only inflicts physical harm but dismantles women's sense of self, leaving a lasting psychological scar.

FGD participants echoed with similar experiences. One woman explained, *"Every day he calls me names–dog, worthless woman. After years, I started believing it. I feel like nothing."*

Another said, *"When you are beaten and insulted in front of children, you lose respect for yourself. I don't recognize who I am anymore."*

Such statements highlight how abuse erodes identity through repeated humiliation and powerlessness, a pattern widely documented in IPV literature (Mumtaz & Salway, 2007; Soggiu et al., 2022).

Key informants confirmed this pattern. A Lady Health Worker (KII-2) observed, *"Many women say, 'Apa, I am not important. My life is for others.' They have no sense of self left."*

A psychologist (KII-6) explained the clinical impact: *"Years of abuse break their self-image. They come saying, 'I am worthless,' which is a sign of severe low self-esteem and depression."*

A social worker (KII-3) added, *"Loss of identity makes it harder for women to leave abusive situations because they don't believe they deserve better."*

In rural Khyber Pakhtunkhwa, structural and cultural dynamics intensify this loss of identity. Purdah norms, economic dependence, and the prioritization of male authority create an environment where women's value is tied almost exclusively to obedience and family honor.

One IDI participant said, *"Here, a woman is only good if she keeps quiet and serves. If I speak, I am bad. So, I stopped being myself."* This reflects how GBV intersects with gendered socialization to produce psychological disempowerment (Naz, et al., 2022; Naz et al., 2023b).

The theme also revealed the interconnection between self-esteem and help-seeking. Several women expressed that their diminished sense of worth prevented them from pursuing support.

One FGD participant shared, *"I thought, who will listen to a woman like me? I am nothing. So, I stayed silent."* Another stated, *"When you believe you are worthless, you stop dreaming of a better life."* This aligns with evidence that low self-esteem and identity erosion reduce resilience and perpetuate cycles of abuse (Trevillion et al., 2012; Webb & Renzaho, 2023).

Key informants emphasized the need for psychosocial interventions to rebuild agency. A midwife (KII-5) explained, *"When women start believing they are human, they come for care. That's why counseling is as important as medicine."*

These insights underscore that addressing GBV's psychological toll requires interventions that restore self-worth and identity alongside physical safety.

Intergenerational Psychological Impact

The effect of GBV on children and its transmission across generations emerged as a significant theme, identified in 7 of 12 IDIs, all FGDs, and 5 of 6 KIIs. Survivors frequently expressed concern over how violence was shaping their children's emotional and behavioral development.

One IDI participant stated, *"My children hide when they hear his voice. Even when he is calm, they stay quiet, afraid it will start again."* Another shared, *"I fear my daughter will grow up thinking this is normal. She tells me, 'Amma, when I marry, will my husband also hit me?'"*

FGD participants vividly described the emotional toll on their children. One woman said, *"My son holds my hand and cries when he sees me hurt. He says, 'Amma, please don't make him angry.' A child should not carry that fear."* Another explained, *"When my daughter hears shouting, she wets herself. She is only five, but she lives in fear like me."*

These accounts reflect the intergenerational nature of trauma, where children's exposure to domestic violence creates cycles of anxiety, emotional dysregulation, and normalization of abuse (Evans et al., 2020; Sardinha et al., 2022).

Key informants emphasized the long-term implications. A psychologist (KII-6) observed, *"Children who grow up in violent homes often show signs of PTSD—nightmares, hypervigilance, aggression. Without intervention, they carry these scars into adulthood."*

A Lady Health Worker (KII-2) added, *"Mothers tell me their children refuse to go to school because they are scared to leave them alone. Violence destroys not only the woman but the whole family."*

A social worker (KII-4) stressed the cultural dimension: *"In our society, when girls see their mothers endure, they learn silence. When boys see their fathers beat, they learn control. This is how violence passes to the next generation."*

In rural Khyber Pakhtunkhwa, where access to child mental health services is almost nonexistent, these effects are intensified. Survivors repeatedly expressed helplessness in protecting their children emotionally.

One IDI participant stated, *"I can cover their bodies, give them food, but I cannot cover their minds. The fear has entered their hearts."* Another FGD participant echoed, *"Sometimes I think leaving would save them, but where will I go? So, they grow up seeing this pain."*

This highlights how structural barriers, cultural expectations, and economic dependence trap women and children in cycles of trauma.

Global evidence supports these findings, with studies showing that children exposed to intimate partner violence face increased risks of depression, anxiety, substance abuse, and future perpetration or victimization (Evans et al., 2020; Trevillion et al., 2012). In Pakistan, limited research has explored this intergenerational dimension in rural contexts, making these findings particularly relevant for policy and intervention design (Naz et al., 2023a).

Key informants highlighted the need for family-centered interventions. A community midwife (KII-5) stated, *"When we help the mother, we must help the child. Otherwise, we are only healing half the wound."* A healthcare provider (KII-1) emphasized integrating psychosocial support into maternal and child health programs: *"We see the link between violence and children's health every day. Mental health counseling must become part of rural healthcare."*

Trauma and PTSD-like Symptoms

Symptoms consistent with post-traumatic stress disorder (PTSD) emerged as a recurrent pattern in women's narratives, reported in 8 of 12 IDIs, all FGDs, and 6 of 6 KIIs. Survivors described experiencing flashbacks, nightmares, intrusive memories, and intense physiological reactions to reminders of violence.

One IDI participant stated, *"At night I wake up sweating... I see those moments again when he hit me."* Another shared, *"Even when I hear a loud noise outside, my heart jumps like he is coming. My body freezes."* These accounts highlight how GBV-induced trauma persists long after physical incidents end.

FGD participants described similar distress. One woman said, *"Sometimes I hear his voice in my dreams and I scream. My children wake me up crying."* Another explained, *"When I see his clothes or smell his perfume, I start shaking. It feels like the beating is happening again."* These narratives are consistent with trauma research showing that survivors of intimate partner violence frequently develop PTSD-like symptoms due to sustained, repeated exposure to threat in an environment perceived as inescapable (Devries et al., 2013; Trevillion et al., 2012).

Key informants confirmed the prevalence of trauma responses.

A psychologist (KII-6) observed, *"Most women I see meet clinical criteria for PTSD, but they don't have the language for it. They describe 'heart racing,' nightmares, panic. It is trauma in every sense."*

A healthcare provider (KII-1) noted, *"We see many women faint or develop palpitations during consultations when violence is mentioned. The body remembers."*

A Lady Health Worker (KII-3) explained, *"Women say their chest feels heavy, their hands sweat when they hear arguments nearby. It is fear living inside the body."*

In rural Khyber Pakhtunkhwa, structural barriers intensify the impact of trauma. With no specialized mental health services in most districts, women reported bearing these symptoms in silence.

One IDI participant stated, *"People think I am mad because I jump at every sound. I don't tell them why. They won't understand."* Another FGD participant echoed, *"Here, they say, 'All women face this, be strong.' They don't know the pain that stays in the mind."*

This normalization of violence and lack of psychosocial support perpetuate untreated trauma and chronic psychological suffering (Naz et al., 2022; Khan et al., 2021).

Several participants linked trauma symptoms to maternal health.

A midwife (KII-5) explained, *"Women with this kind of fear often have difficult labors. Their bodies are tense, blood pressure rises. The mind and body are connected."*

This finding aligns with South Asian studies demonstrating the adverse obstetric outcomes associated with IPV-related PTSD (Qureshi et al., 2020; Webb & Renzaho, 2023).

Importantly, the narratives underscore that trauma in these rural contexts is not only psychological but deeply embodied. Survivors described headaches, chest tightness, gastrointestinal issues, and chronic fatigue, reflecting somatic manifestations of prolonged stress. These patterns resonate with evidence that untreated PTSD in GBV survivors often presents as physical illness in settings where mental health literacy is low (Soggiu et al., 2022).

Hopelessness and Learned Helplessness

Hopelessness and a profound sense of powerlessness were among the most recurring patterns in the narratives, identified in 10 of 12 IDIs, all FGDs, and 6 of 6 KIIs. Women described a loss of belief in their ability to change their circumstances after repeated exposure to violence and failed attempts to seek help.

One IDI participant said, *"I went to the elders, to the police... no one helped. Now I just bear it silently."* Another shared, *"At first, I fought back, I cried for help. But every time they told me to be patient. Now I don't feel anything. I just wait for it to end."*

FGD participants echoed this emotional resignation. One woman explained, *"When you try again and no one listens, you stop hoping. You accept this life."* Another said, *"I have no energy left to fight. Even if I run away, where will I go? My parents will send me it back. It is better to stay quiet."* These accounts reflect the psychological state described as "learned helplessness," where prolonged, uncontrollable violence erodes a survivor's perception of agency and reinforces endurance over resistance (Walker, 2017; Trevillion et al., 2012).

Key informants corroborated this theme.

A social worker (KII-4) stated, *"Women come to us once, twice, and when they see nothing changes, they stop coming. They accept violence as fate."*

A Lady Health Worker (KII-3) observed, *"I see women saying, 'Apa, this is my qismat (destiny).' They stop asking for help because they believe nothing can change."*

A psychologist (KII-6) emphasized the clinical consequences: *"Hopelessness is dangerous. It leads to deep depression and, in some cases, suicidal thoughts. We see this more in rural women with no support system."*

In rural Khyber Pakhtunkhwa, structural and cultural barriers intensify this learned helplessness. Survivors frequently cited fear of social stigma, economic dependence, and lack of shelter as reasons for giving up help-seeking.

One IDI participant said, *"If I leave, they will say I destroyed my home. If I stay, I suffer. Either way, there is no respect, no safety."* Another explained, *"There are no places for women like us here. No one protects us. So, we learn to keep quiet."*

These narratives align with research showing that institutional neglect and absence of survivor-centered services reinforce helplessness in patriarchal rural contexts (Naz, Ayub, & Afridi, 2023; Webb & Renzaho, 2023).

FGD participants also connected this hopelessness to their children's future. One woman shared, *"I pray my daughters don't live this life, but what hope can I give them when I cannot save myself?"* This highlights how learned helplessness extends beyond individual survivors, shaping family dynamics and perpetuating cycles of trauma.

Key informants stressed the need for systemic change to counteract this psychological state. A healthcare provider (KII-1) said, *"We cannot expect women to speak if every door they knock on stays closed.*

Services must work together to show women that help exists." A community midwife (KII-5) added, *"Even small successes matter. When one woman sees another get justice, hope returns to the whole community."*

Discussion

This study revealed the profound psychological toll of gender-based violence (GBV) on rural women in Khyber Pakhtunkhwa, demonstrating patterns of chronic fear, depression, self-blame, trauma, and social withdrawal. These findings were consistent with global evidence that GBV was not only a physical violation but also a prolonged mental health crisis with intergenerational consequences. Survivors in this study described living in a constant state of hypervigilance, anticipating violence even during periods of calm. Such accounts aligned with previous research that linked intimate partner violence to anxiety disorders and post-traumatic stress in low-resource settings (Devries et al., 2013; Trevillion et al., 2012). Within the rural KPK context, fear was intensified by cultural constraints, purdah-related isolation, and the absence of safe spaces, which reinforced women's perception that violence was inescapable and socially sanctioned (Naz et al., 2023b).

Depression and emotional numbness also emerged as pervasive effects. Many women reported persistent sadness, hopelessness, and emotional detachment, often as survival mechanisms to endure sustained abuse. These findings were in line with evidence that prolonged GBV exposure increased the risk of major depressive disorder and somatic symptoms, particularly in settings where psychosocial services were scarce (Soggiu et al., 2022; Khan et al., 2021). In rural Pakistan, where mental health integration into primary healthcare remained limited, untreated depression not only worsened psychological well-being but also undermined maternal and child health outcomes.

A notable finding was the internalization of guilt and self-blame. Survivors frequently described believing they were responsible for the abuse, a perception reinforced by family members, community elders, and cultural norms that framed endurance as a woman's duty. This pattern reflected the powerful influence of honor-based social structures in shaping psychological responses to violence (Ali et al., 2021; Mumtaz & Salway, 2007). In rural KPK, where extended family and jirga systems prioritized "saving the home" over women's safety, self-blame functioned as a mechanism of social control that perpetuated silence and emotional harm (Naz et al., 2023a). Social withdrawal further compounded these dynamics, as survivors described retreating from neighbors and relatives to avoid judgment. This mirrored global evidence that GBV-induced isolation exacerbated depression and reduced access to informal support networks that are critical in rural settings (Qureshi et al., 2020; Webb & Renzaho, 2023).

Women also reported that prolonged abuse eroded their sense of identity and self-worth. Survivors spoke of feeling "worthless" and "voiceless," illustrating how GBV dismantled personal agency. This finding was consistent with research documenting the psychological disempowerment caused by intimate partner violence and its impact on help-seeking behaviors (Trevillion et al., 2012; Soggiu et al., 2022). In rural KPK, where women's social value was closely tied to obedience and family honor, the loss of identity was amplified, reinforcing cycles of dependency and silence (Naz et al., 2023a).

The study also demonstrated the intergenerational transmission of trauma. Survivors voiced concern for their children's fear and behavioral changes, describing anxiety, withdrawal, and the normalization of violence among them. These narratives aligned with international research showing that exposure to domestic violence in childhood increased the risk of depression, anxiety, and future perpetration or victimization (Evans et al., 2020; Sardinha et al., 2022). In rural Pakistan, where child mental health services were virtually absent, these findings underscored the long-term public health and social implications of GBV.

Hopelessness and learned helplessness were recurring undercurrents in participants' narratives. Repeated failed help-seeking and the absence of accessible survivor-centered services led many women to accept violence as an unchangeable part of life. Survivors often described abuse as "fate" or "qismat," reflecting the psychological resignation described in battered woman syndrome literature (Walker, 2017). These findings highlighted how structural barriers—including the lack of safe shelters, weak justice mechanisms, and cultural pressure to endure—reinforced cycles of abuse and silence (Naz et al., 2023a; Webb & Renzaho, 2023).

These results carried significant policy and program implications. Integrating trauma-

informed mental health services into primary care and Lady Health Worker programs was essential to address the psychological burden of GBV in rural settings. Community-based initiatives needed to challenge honor-based narratives that normalized violence and reinforced guilt. Establishing confidential reporting pathways, survivor-centered referral systems, and safe shelters was critical to counteract learned helplessness and restore women's agency. Furthermore, family-centered interventions that provided psychosocial support for children were necessary to disrupt intergenerational cycles of trauma. By documenting the mental health dimensions of GBV in rural Khyber Pakhtunkhwa, this study underscored the importance of framing violence not only as a legal or social problem but also as a public health priority.

Conclusion and Recommendations

This study concluded that gender-based violence (GBV) had severe and enduring psychological effects on rural women in Khyber Pakhtunkhwa, including chronic fear, depression, emotional numbness, self-blame, social withdrawal, and trauma symptoms resembling post-traumatic stress disorder (PTSD). The findings demonstrated that beyond immediate physical harm, GBV disrupted women's sense of identity, undermined their agency, and perpetuated cycles of silence reinforced by socio-cultural norms. The results further revealed significant intergenerational consequences, as children exposed to domestic violence exhibited fear, anxiety, and normalization of abuse. These patterns underscored that GBV in rural KPK functioned as both a mental health crisis and a public health challenge with long-term societal implications.

The study emphasized that the absence of trauma-informed, survivor-centered services in rural Pakistan compounded the psychological burden of GBV. Structural barriers—including weak legal mechanisms, lack of safe shelters, inadequate mental health infrastructure, and cultural stigmatization—contributed to survivors' learned helplessness and reduced help-seeking behaviors. These findings highlighted the urgent need to integrate psychosocial care into GBV response frameworks and to adopt culturally grounded strategies that address both individual healing and systemic change.

Based on the evidence generated, several recommendations are proposed:

1. **Integration of Mental Health into Primary Care:** Incorporating trauma-informed psychological support into rural primary healthcare and Lady Health Worker programs was critical. Training frontline health providers to identify and refer survivors with depression, anxiety, and PTSD symptoms could bridge existing service gaps.

2. **Community-Level Interventions:** Addressing honor-based norms and victim-blaming through community education campaigns and engaging local leaders was essential to reduce stigma and encourage disclosure. Creating safe communal spaces could help survivors rebuild social networks and resilience.

3. **Strengthening Referral Pathways and Safe Shelters:** Developing confidential reporting mechanisms, strengthening referral systems, and establishing survivor-centered shelters in rural districts would counteract learned helplessness and offer tangible options for safety.

4. **Family-Centered Psychosocial Support:** Providing counseling and emotional support for children exposed to GBV was necessary to mitigate intergenerational trauma and promote healthy psychological development.

5. **Policy Alignment with SDGs:** Ensuring that GBV response strategies aligned with Sustainable Development Goal 3 (Good Health and Well-Being) and SDG 5 (Gender Equality) would reinforce Pakistan's commitment to reducing violence against women and integrating mental health into public health policy.

6. **Further Research:**

Conducting longitudinal studies on the psychological and intergenerational effects of GBV in rural Pakistan would provide deeper insights for evidence-based policy and program design.

In conclusion, the study underscored that addressing the psychological dimensions of GBV was indispensable for breaking cycles of violence and promoting women's health and well-being in rural Khyber Pakhtunkhwa. Culturally sensitive, multi-sectoral interventions that integrate mental health services into GBV response frameworks

were essential to ensure both immediate protection and long-term healing for survivors and their families.

Limitations and Future Research

This study had certain limitations that should be acknowledged when interpreting the findings. First, the research was conducted in selected rural areas of Khyber Pakhtunkhwa, specifically focusing on women in Nowshera district, which may limit the generalizability of the results to other regions of Pakistan with different socio-cultural contexts. While qualitative methods allowed for rich, in-depth exploration of survivors' experiences, the findings reflected the perspectives of a purposive sample and could not be extrapolated to the entire rural population.

Second, the sensitive nature of GBV and the prevailing stigma surrounding disclosure may have influenced participants' willingness to fully share their experiences, resulting in potential underreporting of certain psychological effects. Although triangulation through in-depth interviews (IDIs), focus group discussions (FGDs), and key informant interviews (KIIs) enhanced credibility, the absence of longitudinal follow-up limited the ability to capture changes in survivors' mental health over time.

Third, the study did not include quantitative assessment tools to measure the severity of depression, PTSD, or anxiety symptoms, which might have provided additional diagnostic insights. Resource constraints also prevented the inclusion of male perspectives, community leaders, and extended family members who play critical roles in shaping cultural norms and responses to GBV.

Future research should address these limitations by conducting longitudinal, mixed-methods studies that combine qualitative narratives with validated psychological scales to better understand the severity and progression of GBV-related mental health outcomes. Expanding the geographic scope to include multiple provinces and diverse rural contexts would enhance representativeness. Additionally, exploring interventions that integrate mental health support within community-based GBV response systems would provide evidence for scalable, culturally sensitive models. Investigating children's psychological experiences and long-term outcomes in households affected by GBV would also contribute to understanding intergenerational trauma and inform family-centered approaches.

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