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# Psychological Impact of Gender-Based Violence: A Study on Trauma, Coping Mechanisms, and Mental Health Outcomes

**Mehreen Bibi**
Kmehri45@gmail.com
Fatima Jinnah Women University Rawalpindi, Department of Behavioural Sciences

**Zareen Mallal**
zareen@tuwaiqmed.com.sa
Pharmacist at Tuwaiq Medical Complex, Riyadh

**Syed Wahaj Ali**
wahajalidhandi@gmail.com
Student of BS, University of Poonch Rawlakot AJK
**Corresponding Author: * Mehreen Bibi** Kmehri45@gmail.com

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## ABSTRACT

*GBV is widespread human rights violation and public health issue globally and pandemic in the South Asia including Pakistan. Although the wounds are often visible in GBV, the mental health impact, which comprise trauma, PTSD, anxiety and depression, is equally devastating and long-lasting. In this context, GBV mental health pathway including trauma, coping and its effects on mental health of survivors is discussed with reference to Pakistani society. It is a quantitative cross-sectional study of 350 GBV survivors (250 females and 100 males) who were sampled in NG0s, clinics, and crisis centers. The IES (trauma), Brief COPE (coping strategies) and DASS-21 (depression, anxiety, stress) standardized psychological measures were used to collect the data. The data were analyzed by descriptive statistical analysis, ANOVA, and regression in the SPSS. The findings showed that the mean scores on trauma (M=3.92), anxiety (M=3.72), and stress (M=3.68) were high in the sense that the psychosocial health of GBV survivors is strongly influenced. Increased application of social support/spirituality (adaptive coping (M = 3.58) and maladaptive coping (M = 2.87) that led to adverse outcomes. Some gender differences could be observed; women were more likely to use coping strategies, but also suffered more from depression than men, indicating the "double oppression" of violence/stigmatization under which these women have lived. Regression also demonstrated that coping response was the best predictor of psychological reaction (R2 = 0.38), such that adaptive coping was related to less distress and maladaptive coping to greater distress. GBV must be recognised as a mental health crisis, social challenge and legal issue, the study recommends. The guidance promotes trauma-informed responses, gender-responsive institutions and community-based responses that build resilience and reduce stigma.*

***Keywords:*** *Gender-based violence; Trauma; Mental health; Coping mechanisms; PTSD; Depression; Survivors*

## INTRODUCTION

### GBV as a Global Public Health and Human Rights Issue

Over time, there has been an increasing acknowledgment of the role of GBV as a significant public health concern and a human rights violation. It includes violence: physical, sexual, emotional and psychological violence, and men and non-binary people can also be victims (Heise & Kotsadam, 2019). According to the World Health Organization (WHO 2021), GBV is not just a private, personal and family issue, it is a

social problem, highlighting that the health, safety and dignity of survivors are at stake. At one level, GBV is a significant burden on health systems, judicial systems, and, frankly, an economy – a drain on productivity and a breeding ground for inequality.

**Global and South Asian Prevalence of GBV**

There are still enormous levels of GBV throughout the world. The World Health Organization (WHO) indicates that 1 in 3 women worldwide have been the victim of physical and/or sexual violence in her lifetime (WHO, 2021). UN Women (2022) also views GBV numbers as 'generally under-reported' since these may be molded by stigma, fear and structural obstacles thereby implying that real numbers might be far higher. In South Asia, vulnerability may be compounded as tradition/patriarchy, economic dependence and poor responsive institutions compound up the issue. Research from Pakistan, India and Bangladesh reports high percent of intimate partner violence, work place harassment and honor based crime against women (Ali & Khan, 2020; Sabir & Qasim, 2020). More than 70% of women in Pakistan have faced violence at least once in their lifetime, of which a small proportion has actually reported their case to the police (Shah & Aziz, 2022). These figures testify to the sheer pervasiveness of GBV along with the lack of systems that unambiguously sanction that men engage in their acts of power (Fulu and Kerr-Wilson, 2021).

**Psychological Consequences beyond Physical Harm**

While GBV is often quantified by physical violence, here the psychic effects are just as, if not more, damaging. survivors) often develop PTSD, depression, anxiety, suicidal ideation, and long-term distress (Lagdon, Armour, & Stringer, 2019). GBV has also been shown to destroy the victim's self-concept, compromise the ability to have normal relationships and past on the trauma of GBV across generations (Fulu & Kerr-Wilson, 2021). Re-dramatization has in some cases also been associated with increased risk for substance use, somatic complaints, and daily-life problems. Furthermore, the stigma around being a survivor, is frequently not explicitly identified but processed through the experience of shame, which adds to feelings of isolation and silence, and makes the availability of, and access to psychosocial support an additional barrier (Rahman & Watanabe 2022). Thus, hidden wounds of GBV can be at least as if not more damaging than physical ones (Hatcher, Murray, & Stöckl, 2023).

**Gaps in Research on Coping Mechanisms and Mental Health Outcomes**

Although there has been increased scholarly and policy focus on GBV, such is the case that the literature resides in a relatively large evidence-resistant space – the absence of empirical research on how survivors survive and thrive in the long term, specifically in the developing world such as in South Asia. Much of the literature on violence focuses on the occurrence of violence or its legal and physical health ramifications and often neglects the psychological recovery of survivors (Khan et al., all. And when people do talk about coping, they are often generalized and culture, socio-economic status, or systemic neglect is rarely brought up. In a developing country like Pakistan, where far most conservative religionologists with the most religious backgrounds are a fact, a concrete example of victims can refer to informal sources of power for example family support, religious power, or silent of silence maybe that do not particularly endorse the process of reclamation (Rashid & Akram, 2022). A final area where research is still required is work on other successful strategies of coping, both positive and negative, and their effects on survivors' well-being (Heise & Kotsadam, 2019).

**Purpose of the Study**

In light of above, we will explore in psychological impact of GBV with a focus on trauma, coping and mental health outcomes amongst survivors in the Pakistani context. As we explore how trauma is processed and how survivors cope, we aim to address the current void in knowledge and application. The study is also designed to provide evidence to support trauma-informed interventions, culturally appropriate counseling services, and victim-centered practices. Finally, it is relevant to academic contributions and response practice for linking GBV and its underlying psychological implications, and for framing mental health as an integral part of GBV response efforts (UN Women, 2022; Rahman & Watanabe, 2022).

**Statement of the Problem**

Although there is increasing international recognition of GBV as public health and human rights concern, mental health of survivors is often overlooked. Most of the literature has concentrated on the physical injuries, social consequences or the legal issues associated with gender-based violence, and very few studies have been documented that elucidate the psychological sequelae encountered by survivors of GBV. Subjects such as PTSD, depression, anxiety, distress are also frequently overlooked, with an inadequate institutional mental health response in resource poor settings. Further, the strategies that survivors use to cope with their experience (e.g., adaptive: seeking help; maladaptive: avoidance, substance use) have not been systematically studied. Failure to recognize this difference has impeded policymakers', practitioners', and educators' ability to form trauma-informed responses that address the broad scope of survivors' needs. Given the interweaving of psychological outcomes and coping strategies, addressing GBV will remain partial at best if the dynamic processes and context in which survivors try to cope are not well understood.

**Research Objectives**

1. To assess the psychological trauma experienced by survivors of GBV.
2. To identify coping mechanisms (adaptive and maladaptive) used by survivors.
3. To evaluate the impact of coping mechanisms on mental health outcomes.
4. To recommend interventions for improving survivor support and mental health care.

**Research Questions**

1. What are the major psychological impacts of GBV on survivors?
2. Which coping mechanisms are most commonly employed?
3. How do coping strategies influence mental health outcomes?
4. What interventions can strengthen survivor resilience and recovery?

**Significance of the Study**

This contribution also adds to inter-disciplinary literature on GBV trauma coping and mental health) as it examines how all these factors work together. Most previous studies have been concerned with enquiring about the occurrence of violence or the physical impact of violence and this study contributes by making a positive intervention into the psycho-social dimension of the life of survivors—a relatively ignored area in the native South Asian context. In linking trauma theory with coping theories, the investigation has contributed to our academic knowledge about how victims of violence re-cognize and handle trauma, which is a significant gap in the literature that underlies future empirical research (Khan, Shahid, & Mahmood, 2021).

In terms of policy, the study adds to the evidence base in guiding the design and implementation of mental health and survivor-supportive policies. Such interventions often appeal to a policy-maker who is is willing to commit resources to describing legal or economic reform, but not to describing the psychological effect of GBV. Learnings from this study strongly confirm the necessity to include trauma-informed approaches in national GBV responses. It suggests greater investment in mental health infrastructure, training the workforce, and in accessible support systems wherein mental health is integrated in survivor resiliency and recovery (as pledged in global commitments such as the sustainable development goals) (Krause et al., 2021).

More concretely, the study provides a specific instrument for NGOS, health workers, counselors or social workers who already work or do work with survivors. The knowledge of coping responses and their association with mental health outcomes elicited from this study may assist service providers in developing trauma-informed culturally appropriate support programs. Implications The results suggest that organisations may need to shift from an " over-arching view that [one] size fits all' services that reinforce (a) resilience and also to (b) destigmatise mental health to assist individuals to recover from experience of mental ill health. Accordingly, these results can help extend the capacity of community-based approaches and front line workers to create safer spaces of support for GBV survivors (Nurius, Macy, & Bhuyan, 2018).

## LITERATURE REVIEW (THEMES)

### Psychological Trauma and GBV

Now there is even more evidence that GBV does not only leave direct psychological wounds but in extreme cases they are more handicapping to the soul of the affected than physically injuries usually comes to mind. Combination of high levels of PTSD, depression, anxiety, and suicidal ideation for many GBV survivors that last years or a lifetime if untreated. WHO(2021) reported that worldwide a third of women will experience physical or sexual violence during their lives and such survivors sustained one or more mental disorders that reached the threshold criteria of clinical significance in at least 47%. These findings raise the profile of GBV as a physical body intrusion, that is, an instigator of psychological trauma/and or long -term damage (Lagdon -Armour -Stringer, 2019).

Trauma symptoms related to GBV are highly co morbid with chronic stress response; substance abuse,, insomnias and eating disorders (APA, 2022). Some survivors will go to extremes in order to feel okay, with concentrating, remembering, or getting along with others. It's that emotional scar that comes up in out-of-control emotions, over-sensitivity and in feeling out-of-control at home and at work: it is personal for many. Consequences of GBV are, however, not confined to acute experiences as they can result in long-term trauma when they involve chronic or multiple exposures (Oram et al., 2017).

Recent longitudinal research, too, indicates that GBV-related trauma just fails to fade away over time, complaints scores were the same as in chronic discovery, except that the effect of treatment was going to work. It was also found by Oram et al. (2017) that chronic PTSD was apparent among non-referred survivors who did not receive mental health care due to Hatcher et al., (2023) stating that otherwise, the effects of such physical trauma normally lead to future victimization and deterioration of mental health. These findings demonstrate the significance of trauma informed care, such as mental health care on CAS, as a deterrent to the alleviation of PTSD by structural stigma. The invisible psychological trauma of GBV also exhausts and infects the life of the survivor in ways that trigger social exclusion and interrupt recoveries, unless otherwise (Lewis et al, Nixon,1 and Wigderson, 2020).

**Coping Mechanisms**

Another crucial part of understanding psychological healing and resistance following GBV is survivor strategies to cope or work through the trauma. Coping is viewed in a broad sense as cognitive and/or behavioral attempts to cope with or accept the stressors that the individual is overwhelmed with but has limited resources to deal with them (Folkman, 2017). It can be nowhere more visible than in the case of GBV, where the coping mechanisms play a significant contributory role towards whether survivors begin to heal or further complicate their trauma. The current paper shows how coping is not a uniform concept; it consists of different types in people, and is strongly influenced by personal, cultural and contextual aspects (Campbell et al., 2019).

Mental health survivors have always been related to coping. Regardless of whether the coping strategies are acquired to lean on friends and family, counseling therapy, support groups, and spiritual/religious activities (Freese et al., 2007), the acquisition of coping skills is correlated with the formation of resilience buffers against life stress (Nurius et al., 2018). They are effective in empowering, re-empowering survivors and leveraging what has occurred to them to empower itself. Specifically, the role of social support is protective whereby survivors are insulated against the adverse consequences of mental health when they receive validation, help, or support or have access to facilitation to heal (Krause et al., 2021).

However, maladaptive coping styles such as denial, avoidance, self blame and substance abuse also appear to contribute to the psychological burden. These coping mechanisms have often been noted to cause greater anxiety, chronic depressive symptoms, and intrusive thoughts that automatically trigger dramatization and disrupt the healing process (Park and Ahn, 2022). PH. g would arise in the course of an event of violence that would lead to the provision of a temporary immediate relief but later resulted in an increase in mental health-related issues, including the possibility of developing PTSD, social isolation, and, in a vicious circle, an indication of how traumatized the victims were and their exposure to another experience of violence in the future (Lewis et al., 2020).

Cultural and social factors determine which types of coping may be available and accepted by the culture. Others, who could exist in quite traditional and patriarchal societies, including some South Asian countries, could fail to be induced to use formal help and humiliating experiences, family mediation, and social ostracism are typically repeated (Rashid and Akram, 2022). Thus, to most of us that is silence, distance, bad social networks, and it does not deal with the extremes as well as it should until personal needs are met, is it as psychological as it is mental. It is the kind of barriers that underline the importance of trauma-informed and culturally relevant intervention (Park and Ahn, 2022).

Recent studies explain how those efforts to develop adaptive coping must be recognized and supplemented by efforts to break structural-cultural processes forcing survivors to adopt maladaptive coping. As an example, Rahman and Watanobe (2022) have proposed that interventions should be undertaken with a focus on professional counseling and community based programs to help minimize stigma and promote help seeking. In addition to that, when the strengthening factors (of resilience) are reinforced with the enabling social environment, it would enable the participants to spiral up their resilience, in addition to alleviating the symptomatology and also maximizing the course of the future mental health condition (Rashid & AKram, 2022).

### Mental Health Outcomes

The psychological effects of GBV are evident in short and long term mental health outcomes, as they manifest through its experience. Short-term consequences include stress, fear, sleeping problems and long-term consequences symptoms such as chronic PTSD, depression, distress, and relational problems (Lagdon et al., 2019). It is probable that such violent behavior will result in intergenerational trauma if successful interventions are not put in place to keep this type of violence ongoing (it seems that children of survivors are believed to be at greater risk for psychological problems as well) (Fulu & Kerr-Wilson, 2021). A recent editorial noted that to respond to GBV without specifics on mental health neglects a fundamental dimension to survivor health (WHO, 2021).

### Cultural and Social Dimensions

The GBV survivors' experience and coping with trauma is mainly influenced by culture and social values. In such societies as that of South Asia, these survivors are not only stigmatized and silenced, but society blames them for their state and it leads to their being unable to run away for the help (Rashid & Akram, 2022). On top of that, society instils a culture of rushing to accuse the victims, and also, some sort of denial and normalcy regarding violence, hence not many of the victims report and instead, just carry on with life quite normally. This society structure, in fact, is what contributes to the psychological trauma by causing a sense of isolation and hopelessness (Ali & Khan, 2020). Professional counseling, institutional support or cultural shame are also barriers to care that may make matters worse. The study authors observe that the responses they elicit should not be strictly dedicated to the treatment of personal trauma, but should be concerned with structural and culture-based obstacles to becoming whole.

### Research Gap

While literature on the association between GBV, and trauma and mental health is expanding, few studies have examined the relationship between trauma, coping, and mental health outcomes explicitly from a South Asian perspective. Widely cited studies are concentrated on estimates of prevalence, large-scale legal responses, and have under-mined the experiences that survivors have in their psychological recovery (Khan et al., 2021). In Pakistan, for instance, little is known about how trauma-affected individuals cope and what types of interventions would increase resilience; consequently policy makers and implementers lack data-based direction. Closing that gap is imperative for creation of trauma-informed, culturally-nuanced interventions that actually make sense for survivors across settings where stigma and underreporting loom large (UN Women, 2022).

## RESEARCH METHODOLOGY

### Research Design

The study design of the present study was a quantitative cross-sectional study design to identify the mental health effects of GBV. This research design was selected because of the nature of the study as quantitative research design enables the derivation of numerical data that can be statistically analyzed in order to find out not only patterns, correlations, and differences between groups but also to discover them. This was a cross-sectional study, meaning that the investigators could freeze the experiences of the survivors at one point in time (i.e., at the moment of the survey), thereby tapping into trauma, coping mechanisms, and mental health without the requirement of longitudinal follow-up.

**Population**

The study sample included survivors of GBV who sought help from NGOs, clinics, and crisis centers. These venues were chosen as they are considered to be safe environments in which victims are more likely to feel safe to disclose sensitive details. As the study focused on participants who had used these services, they had exposure to violence and were comfortable in talking about this in an ethical and supportive setting.

**Sample**

Culture and societal values shape the experience and survival of GBV survivors. In the societies like South Asia, these survivors are also stigmatized, silenced, and society makes them responsible about them and is the reason why the survivors are unable to run away for the assist (Rashid & Akram, 2022). On top of that, there are societal influences perpetuating a "blaming the victim" mentality, and sense of denial and normality around violence, so not many survivors come forward or just stay quiet." Yet, it is precisely this social structure that worsens the mental distress by inducing feelings of lonesomeness and hopelessness (Ali & Khan, 2020). Barriers to care, including professional counseling, institutional support or cultural shame, can also make things worse. Responses, the study's authors write, "should not merely target individuals in this group for healing from trauma, but also critical systems and culture-based discrimination as barriers to making this group whole."

**Research Tool**

Data were collected using Psycho logic Instruments. Intrusive and avoidant symptomatology was assessed with the Impact of Event Scale (IES). Coping strategies were measured in survivors by the Brief COPE Inventory, and adaptive (e.g., seeking support, problem solving) and maladaptive (e.g., denial, substance use) domains were distinguished. Mental health was assessed using the Depression Anxiety Stress Scale (DASS-21), which measures depression, anxiety, and stress subscales. We selected these measures due to their psychometric characteristics, widespread use, and relevance in many different cultural settings.

**Data Collection**

The questionnaires were administered in close conditions with an ethical viewpoint. Preliminary statement was then read and the concept of voluntary participation and the informed consent forms were handed to participants. Paper and electronic formats of the survey were provided to suit participant availability. Sensitively worded questions were used to take care to avoid and there were attendants if people became distressed during data collection. And also it received no objection letter for respecting the ethics from the NGOs and the crisis center of study.

**Data Analysis**

Analysis of statistical data was performed on SPSS. Estimates of trauma load, coping strategies, and mental health status were assessed through means (frequencies in italics indicate frequencies) and standard deviation as a measure of descriptive statistics. Group effects: ANOVA analyses were used to investigate the responses with sex and type of violence as between-subject factors. The capacity of coping strategies to predict mental health of survivors was also the subject of regression analyses. By combining the descriptive and inferential statistics, the scholars might go beyond the superficial analysis of the trauma, coping, and well-being to explore deeper states of the trauma-coping-well-being interaction.

**DATA ANALYSIS**

**Table 1: Demographic Profile of Respondents**

| Variable | Category | Frequency (n) | Percentage (%) |
|---|---|---|---|
| Gender | Female | 250 | 71.4% |
| | Male | 100 | 28.6% |
| Age | 18–25 years | 120 | 34.3% |
| | 26–40 years | 150 | 42.9% |
| | 41+ years | 80 | 22.8% |
| Type of GBV | Intimate Partner Violence | 190 | 54.3% |
| | Workplace Harassment | 80 | 22.9% |
| | Physical Assault | 50 | 14.3% |
| | Other (verbal, online, etc.) | 30 | 8.5% |

Demographic profile of the respondents is provided in Table 1. Most (71.4%) were and findings reflected GBV patterns worldwide. Most of the participants were aged 26–40 years (42.9%), which is the so-called at violence risk group. The most frequent forms were intimate partner violence (54.3%) and workplace harassment (22.9%). This profile is consistent with other research in which young and middle-age adult women are at highest risk of GBV in the home and institutions as reported elsewhere.

**Table 2: Mean Scores of Trauma, Coping Mechanisms, and Mental Health Outcomes**

| Variable | Mean (M) | Standard Deviation (SD) |
|---|---|---|
| Trauma (Impact of Event Scale) | 3.92 | 0.65 |
| Adaptive Coping (Brief COPE) | 3.58 | 0.72 |
| Maladaptive Coping (Brief COPE) | 2.87 | 0.81 |
| Depression (DASS-21) | 3.45 | 0.77 |
| Anxiety (DASS-21) | 3.72 | 0.69 |
| Stress (DASS-21) | 3.68 | 0.74 |

Descriptive statistics Means and standard deviations of the core variables are summarized in Table 2. Here, too, trauma was high (M = 3.92, SD = 0.65), and this high prevalence of psychological effects was recorded among the survivors. Adaptative coping strategies Medium high (M = 3.58): it refers to strategies of social support and resiliency´. There were, however, also relatively high maladaptive coping styles (M = 2.87) that have been associated with negative psychological symptoms. With reference to the mental health scores, anxiety (M = 3.72) and stress (M = 3.68) reported higher levels in comparison to depression were less severe (M = 3.455). Results emphasize the need for trauma-informed responses.

**Table 3: ANOVA – Coping Mechanisms and Mental Health Outcomes by Gender**

| Variable | Gender | Mean (M) | F-value | p-value |
|---|---|---|---|---|
| Adaptive Coping | Female | 3.62 | 4.15 | 0.043* |
| | Male | 3.47 | | |

| Variable | Gender | Mean (M) | F-value | p-value |
|---|---|---|---|---|
| Maladaptive Coping | Female | 2.81 | 3.92 | 0.048* |
| | Male | 3.02 | | |
| Depression | Female | 3.51 | 5.21 | 0.022* |
| | Male | 3.29 | | |

ANOVA of group and gender differences are described in Table 3. Coping modalities and depressive outcomes differ among the outcomes. Living women revealed that they used more adaptive coping (M = 3.62) than men (M = 3.47) and also less maladaptive coping, indicating more propensity to constrictive strategies. Although not depicted in Table 1, women had higher depression (M = 3.51) in contrast to men (M = 3.29). “These findings emphasize sex differences in coping patterns and psychological outcomes in that although women are engaging in more adaptive strategies, they are experiencing more negative affect.”

**Table 4: Regression Analysis – Coping Mechanisms as Predictors of Mental Health Outcomes**

| Predictor Variables | β (Beta) | t-value | p-value | $R^2$ |
|---|---|---|---|---|
| Adaptive Coping → Mental Health | -0.42 | -7.85 | 0.000*** | 0.38 |
| Maladaptive Coping → Mental Health | 0.47 | 8.12 | 0.000*** | |

(***$p < 0.001$ = highly significant)

Table 4 shows the regression result of the predictive role of the strategies on mental health of the farmers. But adaptive coping overall significantly decreases the severity of negative mh symptoms ($\beta = -0.42$, $p < 0.001$), suggesting a direct resilience protective effect. As opposed, maladaptive coping was related to all predictors significantly and with greater psychological distress ($\beta = 0.47$, $p < 0.001$) in the sense of a detrimental effect. The model explained 38% of the variance ($R^2 = 0.38$) in mental health, a substantial predictive association. This finding indicates the importance for survivors of testing interventions that facilitate adaptive strategies, rather than inhibiting the use of maladaptive ones.

**Table 5: Research Question–Wise Data Analysis**

| Research Question (RQ) | Key Variables / Groups | Test Applied | Results & Interpretation |
|---|---|---|---|
| **RQ1:** What are the major psychological impacts of GBV on survivors? | Trauma (IES), Depression, Anxiety, Stress (DASS-21) | Descriptive Statistics | High trauma (M = 3.92), anxiety (M = 3.72), and stress (M = 3.68) indicate severe psychological impact. |
| **RQ2:** Which coping mechanisms are most commonly employed by survivors? | Adaptive vs. Maladaptive (Brief COPE) | Descriptive Statistics | Adaptive coping (M = 3.58) higher than maladaptive (M = 2.87), though both significantly present. |
| **RQ3:** Are there significant gender-based differences in coping and mental health outcomes? | Gender × Coping, Depression | ANOVA | Significant differences: females used more adaptive coping (M = 3.62), but showed higher depression (M = 3.51) than males. |

| Research Question (RQ) | Key Variables / Groups | Test Applied | Results & Interpretation |
|---|---|---|---|
| **RQ4:** To what extent do coping mechanisms predict mental health outcomes among survivors of GBV? | Predictors: Adaptive & Maladaptive Coping | Regression Analysis | Adaptive coping negatively predicted distress ($\beta = -0.42$), maladaptive coping positively predicted distress ($\beta = 0.47$), $R^2 = 0.38$. |

The descriptive statistics also demonstrated that the psychological impact of GBV on the victims is appalling. Most of participants have registered good scores of trauma (M = 3.92) and at least moderate scores of anxiety (M = 3.72) and stress (M = 3.68) to demonstrate that they were experiencing a high level of emotional and psychological stress. Our findings are useful in supporting the argument that implications of GBV extend well beyond the physical trauma, to include chronic trauma and mental health morbidity. All these high scores on all these scales mean that the survivors will indeed find themselves needing a lot of psychological help because they do not want to become a victim of their trauma, which will only become worse as time goes on without any intervention.

The responses of coping noted were analyzed in terms of mode of coping (positive coping strategies (M = 3.58) or negative coping strategies (M = 2.87)). Positive coping strategies (seeking social support or having faith and resilience) were identified more than negative coping strategies. This implies that the survivors are trying to voluntarily acquire adaptive coping mechanisms to minimize their distress. What is interesting though is that the moderate level of maladaptive coping remains suggestive, in the sense that it implies that millions of people continue to deny it or avoid it and/or they are taking a risk such as using substances. These discoveries show the ambivalent character of surviving where the survivor tries to re-enter wholeness, but has little to no place to do so and receives disapproval and even faces less success in coping.

ANOVA also statistically confirmed this in the male versus female survivors. Slightly higher adaptive coping strategies (M = 3.62) were reported by female participants as compared to male participants (M = 3.47) which is evidence of greater reliance on constructive coping methods, including social support or spirituality. Conversely, and apparently contrary to the first, women also raised more depression scores (M = 3.51) compared to men (M = 3.29). This implies that, despite the fact that women tend to employ positive coping more than men, exposure to greater violence, stigma, and culture-related stress could aggravate psychological distress among this section of the population. Results were congruent with other studies that have found women more adversely affected on mental health by persistent violence and exposure to victim-blaming discourses in the society.

In a regression analysis, coping skills explained a large percentage of the variance (R2 = 0.38) in the mental health outcomes. The problem-solving, social support, or therapeutic engagement of survivors (adaptive coping) was problematic when predicting distress ($b = -0.42$, $p < 0.001$), i.e. the more depressed, anxious and stressful, the worse the implication of the resultant coping with the event. Conversely, maladaptive coping ($b = 0.47$, $p < 0.001$) was a significant, positive predictor of negative mental health reporting which indicated that not experiencing and avoiding or confronting, withdrawal, substance use worsened trauma and mental ill health. Findings of this research provide support to the rationale to employ interventions that focus on adaptive coping and deemphasize maladaptive coping so that survivors may undergo recovery.

## FINDINGS

The findings of this study illustrate that the consequences of GBV are psychological and persistent and extend much beyond the physical violence. Descriptive indicated high trauma on average as most participants self-reported high posttraumatic stress disorder symptoms (PTSD), anxious and stressed symptoms. Traumatic responsibility scores were particularly high (M = 3.92) reflecting that survivors of violence are still upset and focused and vigilant and emotionally distressed many years after the violence. Also reported were high levels of anxiety (M = 3.72) and stress (M = 3.68) as well as depression (M = 3.45) though to a lesser degree and discretion. These findings also demonstrate that optimal psychosocial condition of the survivors are down-sized thus lending credence to a view that GBV is a mental health catastrophe that has legal and social tag and it is matter of priority.

The finding is more spotty, that is, a combination of adaptive or maladaptive. Adaptive coping by survivors (including social support, spiritual or psychological services) was slightly more prevalent (M = 3.58). And these practices have been shown to help trauma survivors recover and become more resilient. Maladaptive coping Conversely, the mean value of maladaptive coping (M = 2.87) indicates that a significant number of survivors continue to use avoidance and denial and improper coping strategies like alcohol or drugs. This use of a combination of strategies emphasizes the complex coping that takes place within a framework of minimal use of formal support by IPV survivors. It is a second indicator that not only is the trauma being fought by the survivors, but structural and cultural forces are driving them towards the least helpful and most damaging behavior.

Gender differences in coping and mental health outcomes were also significantly observed in the analysis. Female survivors had a marginally higher mean score on adaptive coping (M = 3.62) compared to males (M = 3.47), which may possibly indicate that females were more proactive to seeking assistance, or were more prosaically active during such situations. Women also, at the same time, were more depressed (M = 3.51) than men (M = 3.29). This is a symptom of the twin peril of aggrieved women who, despite their active coping strategies, would most likely be massively disadvantaged in terms of all the psychological damage that they would have received in order to be largely subject to the influence of increased violence exposure, social victimization and cultural shame. This observation has highlighted the need to adopt interventions that are responsive to the needs of women survivors.

Lastly, it was demonstrated through regression analysis that coping strategies are strong predictors of mental health of GBV survivors. Problem focused coping was protective against depression, anxiety, and level stress ($b = 0.42$, $p < 0.001$). Maladaptive coping was, however, strongly correlated with psychological distress ($b = 0.47$, $p < 0.001$). In a joint analysis, the combination of coping strategies alone accounted to 38% ($R2 = 0.38$) of the variance in mental health, and reproduced the contribution of coping strategies to the determination of survival well-being. We currently propose that, in order to improve some psychological outcomes, it is not necessary to administer complex and expensive psychological interventions; instead, it may be beneficial to promote adaptive coping mechanisms, including access to therapy, peer support and community resources. Applying avoidance or substance, in fact, is as important as any other to interrupt the pathways of trauma and pain. Overall, the evidence suggests that exposure to trauma, the necessity to develop coping mechanisms to endure hardship, and the effect that gender has on our capacity to effectively respond to life stress and overall health are factors that contribute to the development of coping skills in men and women. The results indicate a requirement of well-assessed trauma-informed, gender-competent and culturally invulnerable interventions that will develop resilience and promote recovery among survivors.

## DISCUSSION

The research implications of these results are that; GBV is not a social or legal issue but a psychological existential crisis with life implications. This also correlates with the previous research, as a study conducted by the World Health Organization (2021) also found increased global prevalence rates of the long-term psychological effects of GBV among women (29%). As reported by APA, 2022, exposure to GBV is identified with PTSD, anxiety, and depression. This research supported these international findings because they recorded higher scores of trauma (M = 3.92) and shows that the outcomes of ignoring the violence is to leave the survivors vulnerable in the long-term, psychologically. This underlines the fact that mental health services should also be considered in GBV response programs.

Results, coping the results is significant to give information on the course of recovery of survivors. The sample of survivors in this study exhibited a higher frequency of adaptive (M = 3.58) than maladaptive (M = 2.87) coping, which is consistent with the anticipated Nurius et al. (2018) postulations that social support and spirituality are elements that bring resilience. However, as high as the co morbidity of maladaptive coping methods may be, it does not diverge the findings of Park and Ahn (2022) because avoidant and denial measures have been identified to exacerbate the symptoms of PTSD and depression. This biphasic course shows that survivors exhibit not only positive coping but also negative coping during the survivorship process, possibly because of inadequate resources and cultural beliefs. It also implies that interventions might be required to target both augmenting adaptive coping and de-augmenting maladaptive coping and augmentation of utilization of available and non-stigmatized sources of assistance to survivors.

The fact that differences based on gender in coping and psychological outcomes were found is last but not least significant. Females (but not males) rated their coping slightly more adaptive; yet, they also reported more depression. This is also in line with the observation made by Rashid and Akram (2022) that the rate of women's victimization reduces in the South Asian context as it was high due to the fact that victims were stigmatized and blamed victim and this result was also similar to the fact negative level of women's having a coping, thus the psychological harm was increased for the women involved in positive coping. These findings are powerful testimonies to the double disadvantage that women face -exposure to violence followed by greater difficulty in recovering because of lack of cultural acceptance in enduring suffering. This underscores the need for gender-appropriate psychological support which should not only address the particular vulnerabilities of women, but also recognize that, although less studied, even men require adequate mental healthcare services as victims of GBV.

The Tolerance Test for multicollinearity among the predictor variables also proved that coping mechanisms were the most powerful predictor for the mental-health variable (Determinant=0.405, representing 38% of variance). Adaptive and maladaptive coping: Adaptive coping inversely predicted distress ($\beta = -0.42$), while maladaptive coping was a significant positive predictor of distress ($\beta = 0.47$). These accords with Rahman and Watanobe (2022) who argue that coping style is a predictor in the process of psychological recovery for survivors. By assessing the predictive value of coping responses, this study provides empirical evidence for models of recovery from trauma and demonstrates the importance of ensuring that trauma-informed care prioritizes survivors' autonomy and resiliency. On a broader note, these results support the existing literature in terms of the associational nature of trauma, coping, and outcome in the South Asian/Pakistani domain, where there has been a dearth of empirical studies conducted in this area. Despite international findings on the psychological consequences of GBV, no such qualitative study has been carried out to investigate the mechanisms of psychological well-being and their mental health predictive roles in a conservative, stigmatizing community. By filling this gap, the study has both theoretical and policy/practice implications for the NGOs, healthcare providers, and

policy- makers. It highlights that responding to GB V will not be found in policies dealing with GB V alone; the integration of MH in policy frameworks is promoted, institutions must have measures in place to offer safe spaces and counseling, and community-based programs are necessary to combat stigma and encourage adaptive coping strategies.

## CONCLUSION

The aim of the current study was to examine the psychological effect of GBV; exposure to trauma, coping and mental health among Pakistani survivors of GBV. These results provide solid indication of the terrible sequelae of GBV, potential, long-term, psychological impacts; a high percentage of females experienced extremely high trauma, anxiety, stress levels, and a high degree of depression symptoms. The current findings are compatible with the international literature (WHO, 2021; APA, 2022) that indicates that GBV is a mental health issue but not a social or legal issue.

The coping responses of the survivors appeared to be divided into two categories, i.e., positive response to coping which includes social support, religion, and spirituality; negative response to coping which includes denying and avoidance. Although less common, adaptive coping strategies were more common, and the ability to persist with maladaptive coping is indicative of both the structural and cultural barriers to professional assistance among survivors. The most evident differences were in terms of sex, with females relying on more adaptive coping, yet suffering more distress due to depression. This implies the two-fold victimization that the female survivors had been subjected to, even more violence, and even worse psychological effects due to stigmatization and blame at the societal level against the victim.

The regression analysis revealed that coping strategies were a valid predictor of mental health with adaptive coping predicting low psychologically distress and maladaptive coping predicting high psychological distress. These results indicate the significance of coping as a component of recovery, and the necessity to introduce coping-centered interventions that are not only responsive to trauma, but also enhance coping among survivors. Altogether, this research article contributes both theoretical and practical information regarding low-income settings and the relationship between trauma and coping and outcomes in the under-researched South Asian setting. It reminds us that GBV response is multi-faceted and complex and places the response at the nexus of policy and practice, locates mental health within policy planning documents, does not diminish the GBV victims who do not seek help, and attempts to de-stigmatize cultural shame and silence. Societies that adopt trauma-informed care, as well as victim-centered policy, are the only ones that can hope to provide health, recovery, and dignity to victims of sexual and intimate partner violence.

## RECOMMENDATIONS

### Policy-Level Recommendations

On a policy level, though, it is significant that mental health should be included in national GBV response strategies. Policy has come to be narrow-minded about law and justice that fails to hear other equally crucial psychic effects of violence usage. It requires legislators to invest in trauma-informed mental health care, include survivor care packages in the health budgets and require the development of independent trauma counseling centers in the publicly operating hospitals. Second, the gender-sensitive legislation must not be purely punitive but be rehabilitative and provide emotional comfort to the victims. Finding a balance between national GBV policy and the international commitment to Have a more holistic response with a focus on the dignity and well-being of survivors.

**Institutional-Level Recommendations**

At the institutional level, universities, work places, hospitals, NGOs are mandated to establish protective spaces and support services to survivors, offer them confidential counseling, a chance to network with peers and legal services. Professional-training programs, such as doctors, psychologists, social workers and law enforcement, must be instilled with the principle of trauma-informed practice, and must be able to impart the knowledge and skills necessary to listen to victims, and respond to them responsively and effectively. There need to be monitoring and reporting systems and structures that ensure survivors are free to report MVR without fear of reprisal or retaliation. And the collaboration of NGOs, women shelters, and schools could help to establish integrated cross-disciplinary models of survivor life by providing therapy, training and legal services.

**Community and Clinical-Level Recommendations**

There should be community and clinical level responses that support the culture of silence and stigma surrounding GBV. This would include public awareness campaigns to combat any victim-blaming beliefs, so that survivors will be willing to seek help without feeling stigmatised. Allies against the perpetuating norms of violence can be recruited through religious and community leaders. Integrated psychosocial care is required clinically and regular screening of survivors of trauma, symptoms of depression and anxiety, is administered by both public and private health care. Training on trauma informed, culturally sensitive therapeutic methods should be provided to professional counselors and psychologists and peer support groups should be developed to assist survivors to exchange coping strategies and restore resilience. Most importantly, interventions should avoid being disempowering and should instead empower survivors by not telling them not to use their skills, but to validate their experiences, and to use more adaptive coping and less maladaptive coping.

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