



Intimate Partner Violence, Partner Substance Use, and Health Comorbidities Among Women in Pakistan: A Narrative Review

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ARTICLE INFO	ABSTRACT
Received: April 25, 2026 Revised: May 07, 2026 Accepted: May 22, 2026 Available Online: June 11, 2026 Keywords: intimate partner violence; partner substance use; alcohol; mental health; women's health; Pakistan; South Asia; narrative review Corresponding Author: Attia Rani Email: attia.rani@usa.edu.pk	Intimate partner violence (IPV) against women is widespread in Pakistan, and a growing but fragmented literature examines its relationship with substance use both a partner's alcohol or drug use as a risk factor for violence, and the survivor's own subsequent substance use as a hypothesized coping response alongside mental, reproductive, and physical health comorbidities. This narrative review synthesizes Pakistani and regional South Asian evidence on IPV epidemiology, its relationship with partner substance use, its health comorbidities, and the structural barriers keeping affected women from care, while distinguishing empirically supported pathways from theoretical assumptions. Nationally representative data indicate approximately one in three ever-married Pakistani women has experienced IPV, with a husband's alcohol or substance use consistently identified as a risk factor across national, community, and regional South Asian studies. IPV is consistently associated with depression, suicidal ideation, and postpartum depression, though evidence on physical and reproductive consequences remains limited. This review identified consistent, convergent observational evidence for one pathway (partner substance use → IPV) but found no Pakistani or South Asian evidence for the hypothesized reverse pathway (IPV → women's own subsequent substance use), supported only by theoretical reasoning and international data neither specific to IPV nor to Pakistan. This review's contribution is distinguishing these pathways clearly rather than conflating them, and identifying epidemiological, methodological, clinical, and policy gaps to guide future research, clinical practice, health-system development, and policy.

Introduction

Intimate partner violence (IPV) against women is recognized globally as a major public health and human rights concern, with the World Health Organization (WHO) estimating that approximately one in three women worldwide experience physical or sexual violence by an intimate partner in their lifetime. Within South Asia, IPV has been documented as a pervasive feature of marital relationships across multiple national contexts (Kanougiya & Shrivastava, 2025), shaped by shared patterns of patriarchal social structure, early marriage, and limited institutional response capacity, though the scale and character of the problem vary considerably

by country and by the specific populations studied. Pakistan reflects many of these regional patterns, although the prevalence and characteristics of IPV vary across provinces, study populations, and measurement approaches: nationally representative data indicate that roughly one in three ever-married women has experienced some form of physical, sexual, or emotional violence by a husband in her lifetime (Shaikh, 2024), with substantial variation across studies depending on region, sampling method, and measurement instrument (Ali et al., 2021).

A body of Pakistani and regional evidence has separately established two further points. First, a husband's or partner's use of alcohol or drugs is one of the more consistent risk factors for IPV perpetration identified in Pakistani samples (Shaikh, 2024; Ali et al., 2021), a pattern echoed in studies from South India examining alcohol-dependent men and their spouses (Satyanarayana et al., 2015; Indu et al., 2018; Periyasamy et al., 2024). Second, women exposed to IPV in Pakistan report significantly elevated rates of depression, suicidal ideation, and other adverse health outcomes (Ali, Mogren, & Krantz, 2013; Nowshad et al., 2022; Anwar et al., 2025). Existing reviews conducted in Pakistan have primarily summarized IPV prevalence and associated health outcomes but have not critically differentiated the evidence supporting partner substance use as a determinant of IPV from the largely untested hypothesis that IPV contributes to women's own substance use treating these as related but separately reported findings rather than as a set of pathways whose evidentiary strength differs markedly from one another.

A third pathway is frequently assumed in the international literature and in clinical discourse more broadly: that women exposed to IPV may themselves develop substance use problems, potentially as a means of coping with violence-related distress, a mechanism formalized in the self-medication hypothesis (Khantzian, 1985). This pathway is documented in global data that is not specific to intimate partner violence or to Pakistan (Stein et al., 2025), but an important finding emerging from the present review is that no Pakistani or South Asian regional study identified here measures IPV exposure and a woman's own substance use in the same sample using validated instruments. The existing Pakistani literature on women's substance use instead focuses on prevalence, stigma, and treatment-access barriers largely independent of any documented IPV history (Batool et al., 2017; Iqbal, 2026; Shahid & Asmat, 2023).

Beyond summarizing the available evidence, this review critically differentiates empirically supported pathways from theoretical assumptions and identifies important epidemiological, methodological, clinical, and policy gaps that should guide future research and service development. The remainder of this review first summarizes the burden of IPV among women in Pakistan, then synthesizes evidence relating partner substance use to IPV, examines the mental and physical health consequences of IPV, evaluates the limited evidence regarding survivor substance use, reviews barriers to help-seeking and health-system response, critically appraises the existing literature, and concludes with recommendations for future research, clinical practice, health-system development, and policy.

Methodology

Literature was identified through a general-purpose web search tool returning results indexed from PubMed, Google Scholar, PLOS, ResearchGate, publisher platforms, and institutional repositories. The literature search and verification process was conducted during July 2026.

Search Strategy

Combinations of the following terms were used: "intimate partner violence," "domestic violence," "substance use," "alcohol," "drug abuse," "mental health," "comorbidity," and "Pakistan," together with targeted author/title-specific queries used to verify bibliographic details for individual sources. For the regional South Asian search, terms included "intimate partner violence," "women's substance use," "alcohol," and the names India, Bangladesh, Nepal, and Sri Lanka in combination. Searches were conducted through July 2026; no additional searches were performed after this period, so eligible publications appearing after this date are not reflected in this review.

Eligibility Criteria

Language and Publication Period

English-language sources only. Primary empirical and review studies were drawn from 2013–2026; foundational theoretical works cited for conceptual framing (Khantzian, 1985; Bronfenbrenner, 1977; Bandura, 1977) were exempted from this range, as they are cited for theory rather than as evidence of prevalence or outcomes.

Inclusion Criteria

Peer-reviewed studies or major institutional reports and reports from United Nations agencies addressing IPV, partner or survivor substance use, or health comorbidities among women in Pakistan; South Asian regional studies directly relevant to the same

conceptual pathways; international systematic reviews or meta-analyses used explicitly, and only, to characterize pathways for which no Pakistani or regional data were located.

Exclusion Criteria

Non-English sources; secondary news or blog coverage not reporting original data; sources for which author identity, journal, and publication year could not be confirmed through at least one authoritative page (publisher site, PubMed, or the journal's own site).

Duplicate Handling

The search tool frequently returned the same underlying study via multiple indexed pages (for example, a single study appearing via a publisher page, an institutional repository, and an aggregator). Duplicates were identified manually by matching title, author list, and DOI; each underlying study is counted once in the reference list regardless of how many indexed copies were returned.

Full-Text Retrieval

Where available, full texts were retrieved from publisher websites or PubMed Central to verify study characteristics, methodological details, and bibliographic information. For studies where full texts were unavailable, data were extracted from abstracts and authoritative indexing records, and these limitations were acknowledged during evidence synthesis.

Relevance Determination

Relevance was judged from title, abstract, and, where retrieved, full text. No dual independent screening was conducted, no PRISMA flow diagram was generated, and no formal count of total records identified, screened, or excluded is available. Because findings were synthesized narratively rather than quantitatively (e.g., via meta-analysis), interpretation necessarily involved reviewer judgment regarding the relative weight given to individual studies of differing design and sample size; this judgment is made explicit throughout the review rather than presented as a neutral aggregation. Accordingly, the findings should be interpreted as a structured narrative synthesis of the available evidence rather than as the results of a formal systematic review.

Summary of Included Studies

Table 1 summarizes the design, sample, key findings, and limitations of the empirical studies and reviews included in this synthesis, drawn directly from the verified evidence base described in the Methodology. Foundational theoretical works (Khantzian, 1985; Bronfenbrenner, 1977; Bandura, 1977) are not included in this table, as they are cited for conceptual framing rather than as empirical studies with their own design, sample, and findings.

Table 1: Summary of Included Studies

Author(s), Year	Design	Sample	Key Findings	Limitations
Ali, Karmaliani, Farhan, Hussain, & Jawad (2021)	Narrative/PRISMA-informed review	25 studies (21 peer-reviewed + 4 grey literature), 2008–2018	Lifetime prevalence: psychological violence 31.3–83.6%; physical 10.0–98.5%; sexual 2.5–77.0%; combined 1.0–68.0%	No standardized IPV definition or Pakistan-validated instrument across included studies
Ali, Mogren, & Krantz (2013)	Cross-sectional	759 married women, aged 25–60, Karachi	Suicidal thoughts: physical violence OR 4.41; sexual OR 4.39; psychological OR 5.17. Only 27% had disclosed IPV to anyone	Single urban site; self-report of stigmatized experience; cross-sectional
Anwar, Sadia, Khan, & Aslam (2025)	Cross-sectional	300 mothers, 6 weeks–12 months postpartum	Miscarriage moderated the IPV–postpartum depression relationship	Purposive sampling; effect sizes not verifiable beyond abstract level
Batool, Manzoor, Hassnain, Bajwa, Abbas, Mahmood, & Sohail (2017)	Cross-sectional survey	119 male drug users, Lahore	No dedicated female rehabilitation centres identified; severe stigma toward female drug users documented	Sample is male-only by necessity; not evidence about women's substance use patterns

Indu, Jinu, Pallikkal, Sampathkumar, & Joy (2018)	Not fully verified beyond abstract	Spouses of alcohol-dependent men, India	Domestic violence associated with psychological morbidity in spouses	Design details not retrieved beyond abstract level
Iqbal (2026)	Qualitative (interpretative phenomenological analysis)	12 women with substance use disorder, snowball sampling	Three themes obstructing help-seeking: cultural/religious, institutional/structural, interpersonal	Small, non-probability sample; not generalizable
Kanougiya & Shrivastava (2025)	Regional narrative review	31 studies across South Asia, 2013–2024	Significant IPV–mental health associations across all included South Asian countries	Review-level synthesis; Pakistan-specific study count within it not separately verified
Khan, Kakar, Muhibullah, & Kakar (2026)	Mixed-methods field study	97 total: 55 women survivors + 42 professionals, Quetta	Fear of stigma (76.36%), family influence (63.64%), police inefficiency (69.09%), court delays (60.00%) as dominant barriers	Geographically bounded to Quetta; not generalizable to other provinces
Nowshad, Jahan, Shah, Ali, Ali, Alam, Khan, Mahmood, Saba, Arnone, & Shah (2022)	Cross-sectional	789 married women, aged 18–49, Gilgit-Baltistan	Past-year IPV prevalence 22.8%; depression AOR 1.97; poor quality of life AOR 3.54	Single remote region; not generalizable nationally
Periyasamy, Narayanan, Kandasamy, Ezhumalai, & Shanmugam (2024)	Cross-sectional	Female spouses of men with alcohol dependence syndrome, India	IPV documented among spouses of alcohol-dependent men	Verified only at abstract level in this review
Satyanarayana, Hebbani, Hegde, Krishnan, & Srinivasan (2015)	Qualitative dyadic study	14 couples (heavy-drinking men who perpetrated IPV + their wives), South India	Alcohol, gender roles, and IPV closely interconnected; anger dyscontrol identified by both partners as a trigger	Small qualitative sample; not generalizable
Shahid & Asmat (2023)	Systematic review	8 of 52 identified studies met inclusion criteria	Stigma reduces SUD treatment engagement; family reaction is a major relapse driver	Very narrow final study pool limits generalizability
Shaheed & Warraich (2023)	Mixed-methods field study	256 total: 146 women survivors + 110 service providers/facilitators, 3 Punjab districts	Cultural imperative to preserve marriage, service coordination gaps, and stigma identified as key barriers	Bounded to Multan, Lahore, and Vehari districts; not representative of Punjab or Pakistan nationally
Shaikh (2024)	Secondary cross-sectional analysis (PDHS 2012–13 & 2017–18)	Nationally representative, ever-married women 15–49	Lifetime IPV prevalence 33.48% (95% CI 30.76–36.32); husband's alcohol use a significant correlate	Self-reported, sensitive disclosure likely underestimates true prevalence

Stein, Flor, Gil, Khalil, Herbert, et al. (2025)	Systematic review + meta-analysis (Burden of Proof)	40 studies, global (not Pakistan-specific)	Sexual violence associated with STIs, maternal abortion/miscarriage, and MDD; physical GBV weakly associated with drug use disorders	International evidence only; not generalizable to Pakistan without confirmation
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Section 1: Burden of Intimate Partner Violence in Pakistan

Understanding the burden of IPV is essential for interpreting its relationship with partner substance use, health outcomes, and help-seeking among women in Pakistan.

The most robust nationally representative estimate comes from a secondary analysis of the Pakistan Demographic and Health Surveys (PDHS) 2012–13 and 2017–18, which found that 33.48% (95% CI: 30.76–36.32) of ever-married women aged 15–49 had experienced emotional, physical, and/or sexual IPV in their lifetime (Shaikh, 2024). In the final multivariable model, the number of living children, a woman's own knowledge of parental physical IPV, her husband's alcohol use, and marital control behaviors were all significantly associated with IPV. Trend analysis across the two survey rounds indicated a modest decline in reported emotional and physical IPV, and rural areas consistently reported higher prevalence than urban areas.

Regional and facility-based studies report a substantially wider range than this national estimate, reflecting differences in sampling frame, setting, and measurement instrument rather than a single underlying “rate” of IPV in the country. A narrative synthesis of Pakistani literature published between 2008 and 2018, screened from an initial pool of 2,479 records down to 25 included studies (21 peer-reviewed plus 4 grey-literature sources) using PRISMA-informed methodology, reported lifetime prevalence estimates of 31.3–83.6% for psychological violence, 10.0–98.5% for physical violence, 2.5–77.0% for sexual violence, and 1.0–68.0% for combined physical and sexual violence (Ali et al., 2021). This variability highlights the limited comparability of prevalence estimates across Pakistani studies and underscores the need for standardized, culturally validated measurement instruments.

At the level of individual populations, a population-based study of 759 married women aged 25–60 in urban Karachi, using a multi-stage random sampling technique and structured interviews conducted by trained community midwives, found that women subjected to any form of IPV reported markedly poorer mental health than unexposed women, with the strongest associations observed for suicidal thoughts in relation to physical violence (OR 4.41, 95% CI 3.18–6.12), sexual abuse (OR 4.39, 95% CI 3.17–6.07), and psychological abuse (OR 5.17, 95% CI 3.28–8.15) (Ali, Mogren, & Krantz, 2013). Notably, only 27% of women exposed to violence had disclosed this to anyone, and disclosure was almost always to parents rather than to any formal service a finding that recurs, in different forms, across nearly every source reviewed here and that bears directly on why help-seeking is addressed as its own section later in this review.

In a more remote setting, a cross-sectional study of 789 married women aged 18–49 in the Himalayan villages of Gilgit-Baltistan, using a WHO screening instrument for past-12-month IPV and a locally validated depression symptom measure, found a past-year IPV prevalence of 22.8% (95% CI 20.0–25.9), rising to 18.5% among pregnant women (95% CI 11.7–27.9) (Nowshad et al., 2022). In this sample, a poor relationship with a mother-in-law was associated with substantially increased risk of IPV (AOR 2.85, 95% CI 1.90–4.28), while husband's college-level education (AOR 0.40, 95% CI 0.22–0.70) and higher household income (AOR 0.44, 95% CI 0.29–0.68) were protective.

Taken together, these four sources spanning a nationally representative survey, a systematic narrative synthesis, an urban population-based study, and a remote rural cohort converge on a consistent qualitative picture despite their divergent quantitative estimates: IPV is common among Pakistani women, is shaped strongly by household-level relational factors and by broader socioeconomic conditions, and is associated with substantial under-disclosure to any formal source of support. Among these risk factors, partner alcohol and substance use emerge repeatedly across study designs and settings, providing the basis for the next section's focused examination of this pathway.

Section 2: Partner Substance Use as a Risk Factor for IPV (Pathway A Established Evidence)

Across the Pakistani evidence reviewed in Section 1, a husband's or partner's use of alcohol or drugs recurs as one of the more consistent risk factors for IPV, despite comparatively low rates of alcohol consumption in the Pakistani population overall. In the nationally representative PDHS-based analysis, husband's alcohol use remained a statistically significant risk factor for IPV in the final multivariable model, alongside marital control and knowledge of parental violence (Shaikh, 2024). The narrative synthesis of Pakistani literature similarly identified husband's drug addiction, alongside unemployment and a “lazy work attitude,” as a recurring risk factor for battering across the studies it reviewed (Ali et al., 2021). Facility-based accounts of women seeking rehabilitative or shelter services

echo this pattern qualitatively, describing a recurring dynamic in which a husband's addiction drives demands for money that, when refused, precede violence though this qualitative pattern comes from case-level accounts rather than a quantified Pakistani study designed specifically to test it, and should be read at that level of evidence.

This pathway is not unique to Pakistan within the region. Three India-based studies converge on a closely related finding. A qualitative dyadic study interviewing 14 heavy-drinking men who had perpetrated IPV together with their 14 wives, analyzed separately using thematic and narrative methods, found that alcohol consumption, gender roles, and IPV were deeply interconnected, with anger dyscontrol and poor conflict-resolution skills identified by both partners as triggers for heavy drinking and violence alike (Satyanarayana et al., 2015). A related study examined domestic violence and psychological morbidity specifically among spouses of alcohol-dependent men (Indu et al., 2018), and a subsequent cross-sectional study extended this to a broader sample of female spouses of men with alcohol dependence syndrome (Periyasamy et al., 2024). While methodological details of these two studies were verified only at the abstract level in the present review, their convergence with both the Pakistani findings and the qualitative dyadic study strengthens confidence that this is a regionally consistent pattern rather than an artifact of any single study design or sampling approach.

It is important to be precise about what this evidence does and does not establish. The Pakistani and regional sources above document an association between a partner's alcohol or substance use and IPV, observed via cross-sectional and qualitative designs; none employ a longitudinal or experimental design capable of establishing that partner substance use causes IPV in a strict sense, and reverse or bidirectional pathways (for example, relationship conflict driving both drinking and violence, as suggested by the dyadic accounts in Satyanarayana et al., 2015) cannot be ruled out. Throughout this review, the term "risk factor" is used in the epidemiological sense of a variable statistically associated with increased likelihood of IPV in the cross-sectional data available, without implying established temporal precedence or a demonstrated causal mechanism; where a study's design permits no stronger claim, this should be understood as the intended, deliberately limited meaning. Read within a social-ecological framework (Bronfenbrenner, 1977), partner substance use operates most plausibly as a relationship-level risk factor that interacts with individual-level factors (a husband's employment status, a woman's own education) and broader societal norms around marital control and family honor documented in Section 1, rather than as an isolated determinant. This framework is used only to organize and interpret the available evidence and should not be interpreted as empirical confirmation of a specific causal sequence.

Although the consistency of findings across Pakistani and regional studies strengthens confidence in this association, the predominance of cross-sectional and qualitative designs means that the certainty of causal inference remains limited.

Taken together, Pathway A partner substance use as a risk factor for IPV is the most consistently supported relationship between substance use and IPV identified in this review, supported by convergent findings across national, urban, and regional South Asian sources. This stands in direct contrast to the pathway examined in Section 4, where no comparable body of evidence exists.

Section 3: Mental and Physical Health Consequences of IPV

Mental Health Outcomes

Depression and psychological distress. In the Gilgit-Baltistan cohort of 789 married women, IPV exposure in the past 12 months was significantly associated with depressive symptoms (AOR 1.97, 95% CI 1.39–2.77), with depression present in 55.1% of women who had experienced IPV (Nowshad et al., 2022). The same study found IPV associated with more than three times the odds of poor perceived quality of life (AOR 3.54, 95% CI 1.90–6.58), indicating that the psychological burden of IPV extends beyond diagnosable depression into broader self-rated wellbeing.

Suicidal ideation. In the Karachi population-based study of 759 married women, suicidal thoughts showed the strongest associations of any outcome measured with physical violence (OR 4.41, 95% CI 3.18–6.12), sexual abuse (OR 4.39, 95% CI 3.17–6.07), and psychological abuse (OR 5.17, 95% CI 3.28–8.15) (Ali, Mogren, & Krantz, 2013). These effect sizes are considerably larger than those observed for depression in the Gilgit-Baltistan sample, though the two studies used different populations, instruments, and outcome definitions, so the two sets of estimates should not be directly compared as though measuring the same construct.

Postpartum depression. A cross-sectional study of 300 Pakistani mothers 6 weeks to 12 months postpartum, using purposive sampling, found that miscarriage moderated the relationship between IPV and postpartum depressive symptoms (Anwar, Sadia, Khan, & Aslam, 2025). Specific effect sizes and the precise form of this moderation are not reported here because only abstract-level information was available for verification in the present review. This finding is notable both as an independent mental health data point and as the closest thing in the currently verified Pakistani literature to a study connecting a reproductive event (miscarriage) with an IPV-related mental health outcome a connection returned to in Section Physical and Reproductive Health Outcomes.

Collectively, these findings indicate that the mental health consequences of IPV are more consistently documented in Pakistan than its physical or reproductive health consequences, which are examined next.

Physical and Reproductive Health Outcomes

General physical health. The narrative synthesis of Pakistani IPV literature reported that physical injuries were documented in 16.5% of IPV-exposed women over a 12-month period, with pain lasting at least one day in 13.9% of cases, sprains, bruises, or cuts in 7.3%, and broken bones in 4.1% (Ali et al., 2021). This represents the only quantified estimate of physical injury identified in the verified Pakistani evidence base and should be treated as illustrative of the scale of physical harm rather than as a precise national estimate, given the review's own acknowledged measurement heterogeneity across its included studies (see Section 1).

Reproductive health outcomes. No study in the currently verified Pakistani evidence base reports a quantified association between IPV and reproductive health outcomes such as miscarriage, abortion, or sexually transmitted infection. The Anwar et al. (2025) study discussed above touches reproductive experience only insofar as miscarriage functions as a moderator of a mental health outcome (postpartum depression), not as a study of IPV's effect on reproductive morbidity itself. This represents a genuine gap in the Pakistani literature as currently verified in this review, not merely an oversight of search strategy.

Maternal outcomes. Similarly, no Pakistani source in the verified evidence base reports maternal health outcomes (pregnancy complications, low birth weight, preterm delivery) in relation to IPV. This gap is noted here and returned to in Section 7.

International Context

The international "Burden of Proof" meta-analysis by Stein and colleagues, drawing on 40 studies of gender-based violence (not specific to intimate partner violence, and not specific to Pakistan), found that sexual violence was associated with a minimum 100% increased risk of maternal abortion and miscarriage (BPRF = 2.00) and a minimum 50% increased risk of major depressive disorder (BPRF = 1.50), both rated as moderate-strength (three-star) associations (Stein et al., 2025). Physical GBV showed a weaker association with drug use disorders (minimum 20% increased risk, two-star) and showed no credible association with alcohol use disorders after conservative adjustment for between-study heterogeneity.

These figures are presented here explicitly as international context, not as Pakistani findings. They indicate that the mental health associations documented in Pakistani sources are broadly consistent with a broader global evidence base, but they cannot substitute for the Pakistan-specific reproductive health data identified as absent in Section Physical and Reproductive Health Outcomes.

Critical Synthesis

The Pakistani evidence on mental health consequences of IPV is reasonably consistent in direction depression, suicidal ideation, and postpartum depression are each documented as associated with IPV exposure though the specific magnitude of association varies considerably across studies using different populations and instruments, and none of the designs support causal inference. The evidence on physical health consequences is thin, resting on a single quantified data point (Ali et al., 2021), and the evidence on reproductive and maternal health consequences specifically is currently absent from the verified Pakistani literature, a gap that international data (Stein et al., 2025) can contextualize but not fill.

Despite the growing Pakistani literature linking partner substance use with IPV (Section 2) and IPV with adverse mental health outcomes (Section 3), evidence addressing women's own substance use following IPV remains notably absent. Thus, while Pathway A (partner substance use → IPV) is supported by Pakistani and regional evidence, Pathway B (IPV → survivor substance use) remains largely theoretical within the Pakistani and South Asian literature. This unresolved pathway forms the focus of the following section.

Section 4: Women's Own Substance Use Following IPV (Pathway B Evidence Gap)

Where Sections 2 and 3 documented consistent, if methodologically limited, Pakistani and regional evidence for two distinct pathways, this section addresses a third pathway that is frequently assumed in adjacent literature but is not, on the evidence gathered in this review, empirically established within Pakistan or South Asia: that IPV exposure contributes to a woman's own subsequent substance use.

What the Pakistani literature on women's substance use actually shows. The available Pakistani sources on women's substance use are not organized around IPV exposure at all, but around prevalence, stigma, and access to treatment as freestanding problems. A facility-based study of habitual drug users in Lahore, conducted between April and December 2016 using non-probability purposive sampling, documented severe social stigma toward female drug users and the absence of any dedicated female rehabilitation centers in the study's setting but the study's own sample (n=119) was male-only, precisely because the researchers were unable to recruit

female participants due to the stigma they were documenting (Batool et al., 2017). This is informative about the environment women with substance use problems face, but it cannot be read as evidence about the prevalence, patterns, or antecedents of women's substance use itself.

A qualitative study using interpretative phenomenological analysis with 12 women already identified as having a substance use disorder, recruited via snowball sampling, found three master themes obstructing help-seeking: cultural and religious barriers (stigma, gender expectations, religious misinterpretation), institutional and structural limitations (absence of gender-sensitive treatment services), and interpersonal challenges (emotional turmoil, lack of family support) (Iqbal, 2026). Notably, IPV is not reported as a theme in this study's findings at the level of detail available in this review; the study documents barriers to treatment for women whose substance use disorder is already established, not the pathway by which it developed. A systematic review of stigma and social support as predictors of SUD treatment outcomes in Pakistan, which narrowed an initial pool of 52 studies to 8 meeting inclusion criteria, similarly found that stigma and family reaction shape treatment engagement and relapse, without addressing IPV as a contributing factor (Shahid & Asmat, 2023).

What is absent. No study identified and verified in this review Pakistani or South Asian regional measures IPV exposure and a woman's own substance use in the same sample using validated instruments for both constructs. This is not a subtle omission requiring inference from indirect evidence; it is a direct gap in the available literature as searched and verified for this review. The three India-based studies discussed in Section 2 (Satyanarayana et al., 2015; Indu et al., 2018; Periyasamy et al., 2024) examine husband's alcohol use as a risk factor for IPV and its effects on wives' mental health, but none of them measure the wives' own substance use as an outcome.

The theoretical case, clearly bounded. The self-medication hypothesis (Khantzian, 1985) provides a plausible mechanism by which IPV-related psychological distress depression, suicidal ideation, and poor perceived quality of life, all documented in Section 3 could lead a woman to use alcohol or drugs as a coping response. International data lend indirect support to a version of this mechanism at the population level: the Burden of Proof meta-analysis found that physical gender-based violence (not specific to intimate partners, and not specific to Pakistan) was associated with a minimum 20% increased risk of drug use disorders, a weak-to-moderate (two-star) association, while no credible association was found with alcohol use disorders after conservative adjustment (Stein et al., 2025). This framework and this international data point are offered here only to explain why researchers and clinicians might reasonably hypothesize this pathway they do not constitute evidence that it occurs in Pakistani or South Asian women, and this review takes no position on whether it does.

Why this gap likely exists. Three factors plausibly contribute to the absence of direct evidence, independent of whether the underlying phenomenon exists. First, stigma toward women's substance use is severe enough in Pakistan to impede even basic prevalence research, as Batool et al. (2017) demonstrates directly through its own failed recruitment. Second, no clinical setting identified in this review routinely screens for both IPV and substance use in the same encounter (a point developed further in Section 5), meaning co-occurrence would likely go undetected even where present. Third, IPV research in Pakistan has concentrated on mental health and, to a lesser extent, physical/reproductive outcomes as its primary outcome variables, leaving substance use outside the scope of most existing study designs.

Summary of the evidence gap. No verified Pakistani or South Asian evidence currently supports the claim that IPV exposure contributes to women's own subsequent substance use. This appears to represent an important research priority (developed further in Section 7), not an established finding of this review.

Section 5: Barriers to Help-Seeking and Health-System Challenges

The preceding sections documented not only the burden of IPV and its associations with partner substance use and adverse health outcomes, but also a recurring secondary finding: women exposed to IPV rarely disclose it to anyone, and rarely access any formal service. This section examines the barriers underlying that pattern directly.

Disclosure patterns. In the Karachi population-based study, only 27% of women exposed to IPV had disclosed this to anyone at all, and disclosure was almost always to parents rather than to a formal service (Ali, Mogren, & Krantz, 2013). This figure is consistent with the broader pattern documented across the Pakistani literature reviewed in Section 1 and suggests that formal-service data of any kind in this field likely understates true prevalence and need.

Cultural, social, and legal barriers to legal remedy. A mixed-methods field study conducted in Quetta over six months, combining semi-structured interviews, focus groups, and structured surveys with 55 women survivors of domestic violence and 42 professionals (15 legal practitioners, 15 social workers, 12 police officers), found that fear of social stigma (76.36%), family influence (63.64%), lack of

legal awareness (56.36%), and economic dependence (50.91%) were the dominant social barriers to accessing legal protection (Khan, Kakar, Muhibullah, & Kakar, 2026). On the institutional side, the same study found police inefficiency or delay (69.09%), court delays or procedural complexity (60.00%), and limited legal aid (52.73%) as dominant barriers, with statistically significant associations between age and social/cultural barriers ($\chi^2 = 4.12$, $p = 0.042$) and between education and legal/procedural barriers ($\chi^2 = 5.67$, $p = 0.017$). The study's authors themselves note that its findings are geographically bounded to Quetta and may not generalize to other parts of Pakistan, a limitation this review maintains rather than smooths over.

Service-delivery barriers at a systems level. A field-based study conducted across three Punjab districts (Multan, Lahore, and Vehari), drawing on interviews and focus groups with 146 women survivors of violence and 110 service providers and community facilitators, identified three intersecting demand-side barriers: the cultural imperative to marry and preserve marriage regardless of violence, the normalization of spousal violence within families and communities, and the negative social consequences (loss of reputation, family ostracism) that follow from reporting (Shaheed & Warraich, 2023). On the supply side, the same study documented weak inter-departmental coordination, understaffing, inconsistent training in gender-sensitive service provision, and specific to the one-stop Violence Against Women Centre model examined unclear jurisdictional authority between the dedicated police station and the broader police system. As with the Quetta study, these findings are explicitly bounded to the three districts studied and should not be read as representative of Punjab as a whole, let alone Pakistan nationally.

Barriers specific to substance use treatment. Distinct from, and not shown in this review to be connected to, the IPV-related help-seeking barriers above, women with substance use disorders in Pakistan face their own documented barriers to treatment. The interpretative phenomenological analysis of 12 women with SUD identified cultural and religious barriers (internalized and externalized stigma, gendered expectations), institutional limitations (absence of gender-sensitive treatment services, poor integration with mental health care), and interpersonal challenges (lack of family support) as the three master themes obstructing help-seeking (Iqbal, 2026). The systematic review of stigma and treatment outcomes similarly found that negative reactions from close relatives were a major driver of relapse, while perceived social support improved engagement (Shahid & Asmat, 2023). The facility-based study in Lahore found no dedicated rehabilitation infrastructure for women at all in its study setting (Batool et al., 2017).

Synthesis: two barrier systems that do not currently intersect in the evidence. A structural observation emerges from placing these two literatures side by side: Pakistan's documented IPV-response infrastructure (shelters, crisis centers, GBV courts, police desks) and its documented substance-use treatment infrastructure (rehabilitation centers, addiction services) are described in entirely separate studies, by different research teams, addressing different populations, with no verified Pakistani source in this review examining a woman who might need both. This is consistent with, and likely a direct contributor to, the evidence gap identified in Section 4: if no service setting screens for both IPV and substance use together, a woman experiencing both would be unlikely to be identified within either literature as a documented case of co-occurring IPV and substance use, regardless of how common that co-occurrence might actually be. This separation between service systems mirrors the separation observed throughout the research literature and reinforces the need to critically examine the methodological quality, consistency, and limitations of the current evidence base before drawing broader conclusions.

Section 6: Critical Appraisal of the Evidence

Methodological Strengths

Despite the limitations detailed below, the evidence base assembled in this review has several notable strengths. First, it draws on a nationally representative source the PDHS-based analysis (Shaikh, 2024) alongside community-based and facility-based studies, allowing broad population-level estimates to be considered together with more granular, context-specific findings from Karachi (Ali, Mogren, & Krantz, 2013), Gilgit-Baltistan (Nowshad et al., 2022), Quetta (Khan et al., 2026), and Punjab (Shaheed & Warraich, 2023). Second, several of the included studies employed validated measurement instruments most notably the WHO IPV screening instrument used in the Gilgit-Baltistan cohort (Nowshad et al., 2022) lending at least some cross-study comparability to what is otherwise a heterogeneous measurement landscape. Third, the core finding regarding Pathway A (partner substance use as a risk factor for IPV) converges across markedly different study designs and settings: nationally representative survey data (Shaikh, 2024), a PRISMA-informed narrative synthesis (Ali et al., 2021), and independent qualitative and quantitative studies from South India (Satyanarayana et al., 2015; Indu et al., 2018; Periyasamy et al., 2024). This convergence across design types is a stronger form of corroboration than repetition within a single design would provide. Fourth, the inclusion of regional South Asian evidence allows Pakistani findings to be assessed against a broader cultural and structural backdrop rather than in isolation, strengthening confidence that the patterns observed are not artifacts specific to any one Pakistani sample.

Risk of Bias

The evidence base is subject to several recurring sources of bias that warrant caution in interpretation. Selection bias is present in the qualitative and purposive-sampling studies (Iqbal, 2026; Khan et al., 2026), which recruit participants willing to discuss stigmatized experiences and may not represent those who decline. Recall bias affects all studies relying on retrospective self-report of IPV, particularly those using lifetime recall windows (Ali et al., 2021). Social desirability bias plausibly operates in both directions toward under-reporting of IPV itself and toward under-reporting of any resulting substance use, given the compounded stigma both carry; the finding that only 27% of exposed women disclosed IPV to anyone (Ali, Mogren, & Krantz, 2013) illustrates the scale of likely under-detection. Regional sampling bias is substantial: the evidence base clusters around a small number of cities and provinces, and findings from any one location should not be generalized to Pakistan as a whole. Cross-sectional design is near-universal across the Pakistani sources reviewed, precluding causal inference and leaving reverse and bidirectional explanations equally plausible throughout Sections 2 through 4. Publication and reporting bias cannot be ruled out, as studies with null or small effects may be underrepresented in the indexed literature searched for this review; notably, the one study in this evidence base that formally tested for publication bias using Egger's regression (Stein et al., 2025) found none in its global dataset, but no equivalent test exists for any Pakistani source reviewed here.

Taken together, these biases most plausibly work in the direction of underestimating true prevalence (via under-disclosure and social desirability) while inflating confidence in specific point estimates (via cross-sectional design and potential publication bias toward positive findings). This warrants cautious interpretation of specific numeric estimates but does not negate the overall direction of the evidence: that IPV is prevalent, that partner substance use is a recurring correlate, and that IPV is associated with adverse mental health outcomes.

Quality and Consistency of Evidence

High consistency: Pathway A (partner substance use as a risk factor for IPV) is supported convergently across national, community, and regional South Asian evidence (Section 2). Moderate consistency: The association between IPV and mental health outcomes depression, suicidal ideation, postpartum depression is documented across multiple Pakistani studies, though effect sizes vary considerably by population and instrument (Section 3.1). Limited consistency: Physical health outcomes rest on a single quantified Pakistani data point (Ali et al., 2021), and reproductive/maternal outcomes have no quantified Pakistani evidence at all (Section 3.2). Insufficient evidence: Survivor substance use following IPV (Pathway B) has no direct supporting study Pakistani or South Asian regional in the verified evidence base (Section 4).

Overall conclusion: The evidence base is sufficient to support the existence and general direction of some associations particularly Pathway A and the IPV–mental health relationship but is insufficient to support the hypothesized survivor substance-use pathway, which should be regarded as a priority research gap rather than a documented empirical finding. Consequently, confidence is highest for the consistency of observed associations across studies, and lowest for any claim about effect magnitude or causal direction.

Section 7: Research Gaps and Future Directions

Drawing on the critical appraisal in Section 6, this section synthesizes the epidemiological, methodological, clinical, and policy gaps identified throughout this review into a concise set of priorities for future work, without introducing new evidence.

Epidemiological gaps. No Pakistani study has measured IPV exposure and a woman's own substance use in the same sample using validated instruments for both. Geographic coverage is concentrated in a handful of cities and provinces (Karachi, Lahore, Quetta, Rawalpindi/Islamabad, Gilgit-Baltistan, and three Punjab districts), leaving Balochistan outside Quetta, interior Sindh, and much of rural Khyber Pakhtunkhwa and southern Punjab unrepresented. Priority: add validated substance-use screening items to the existing PDHS infrastructure, which already provides national IPV measurement.

Methodological gaps. Nearly every Pakistani study identified is cross-sectional, precluding causal or temporal inference. Sample sizes in qualitative work are small by design, and instruments are rarely validated specifically for Pakistani cultural and linguistic contexts. Priority: longitudinal cohort designs capable of establishing temporal sequence, and cross-cultural validation of core IPV and substance-use instruments in Urdu and regional languages.

Clinical gaps. No health-system protocol identified in this review integrates IPV screening with substance-use screening at the point of care, meaning any true co-occurrence would likely go undetected under current practice. Priority: pilot integrated screening in antenatal, primary care, and existing addiction-treatment settings, paired with prospective data collection.

Policy gaps. Existing legal protections are documented as poorly enforced (Khan et al., 2026; Shaheed & Warraich, 2023), and no policy document reviewed addresses IPV and substance use jointly. Priority: pilot and evaluate integrated GBV/substance-use referral pathways building on existing one-stop service models (e.g., the Multan VAWC).

Future research priorities, in order of feasibility: (1) add substance-use items to PDHS; (2) fund a longitudinal cohort study designed explicitly around the IPV–substance-use–health triad; (3) validate core instruments in Pakistani languages; (4) pilot integrated clinical screening; (5) evaluate integrated service models. This sequence reflects a plausible path from lowest to highest implementation cost, not an empirically established optimal order.

Conclusion

This narrative review set out to synthesize the Pakistani and regional evidence connecting intimate partner violence, partner substance use, and women's health comorbidities, and to evaluate critically whether this evidence supports a further, frequently assumed pathway: that IPV exposure contributes to women's own subsequent substance use. The evidence supports a clear answer on both counts, and the distinction between them is the review's principal contribution: this review identified strong evidence for one pathway (partner substance use → IPV) but insufficient Pakistani or regional evidence for the hypothesized survivor pathway (IPV → women's own substance use).

IPV is common among Pakistani women, with a nationally representative lifetime prevalence estimate of approximately one in three ever-married women (Shaikh, 2024), and is consistently associated with a husband's or partner's alcohol or substance use as a relationship-level risk factor a pattern corroborated across Pakistani, urban, and regional South Asian evidence of varying but convergent design (Pathway A, Section 2). IPV is also consistently associated with adverse mental health outcomes, particularly depression and suicidal ideation, though evidence on physical and reproductive health consequences remains considerably thinner (Section 3). By contrast, no Pakistani or South Asian study identified and verified in this review measures whether IPV exposure contributes to a woman's own subsequent substance use (Pathway B, Section 4); this pathway is supported only by theoretical reasoning (Khantzian, 1985) and by international data that is neither IPV-specific nor Pakistan-specific (Stein et al., 2025). This gap is plausibly compounded by severe stigma toward women's substance use, the absence of integrated IPV/substance-use screening in clinical settings, and a research literature that has, to date, studied these two service systems in complete isolation from one another (Section 5).

The evidence base, while sufficient to support Pathway A and the IPV–mental health relationship with appropriate caution about causal inference (Section 6), is not sufficient to support Pathway B as an established finding. Presenting Pathway B as though it were equally evidenced a conflation this review found to be common in adjacent literature would misrepresent the current state of knowledge. Future research, clinical practice, health-system development, and policy in Pakistan should treat the connection between IPV and women's substance use as a priority research question requiring dedicated, co-measured investigation, not as a settled matter to be assumed.

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Conflict of Interest

The authors declare no conflicts of interest.

Ethics Statement

This is a narrative review based on secondary, publicly available published literature. No primary data were collected from human participants, and formal ethics committee approval was therefore not required. The authors followed standard ethical principles of accurate representation, appropriate attribution, and transparent reporting of all cited sources throughout the review process.

Data Availability Statement

This review did not generate new datasets. All data discussed are drawn from previously published, publicly accessible sources, which are cited in the reference list.

Author Contributions

All authors (Attia Rani, Hafeez Haider, Naghma Tareen, and Zeeshan Mehfooz Sindhu) contributed to the conceptualization, literature review, drafting, and critical revision of the manuscript, and approved the final version for submission.

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