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Domestic Violence Against Women in South Asia and South-East Asia: A Comparative Scoping Review of Prevalence, Forms, and Mental Health Outcomes

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Abstract

Background

Domestic violence and abuse (DVA), including intimate partner violence (IPV), is a major public health concern with profound consequences for women's mental health. Evidence from South Asia (SA) and Southeast Asia (SEA) remains fragmented. This scoping review aimed to map the prevalence and forms of DVA experienced by women in these regions and synthesize evidence on associated mental health outcomes.

Methods

This review followed Arksey and O'Malley's scoping review framework and the PRISMA-ScR guidelines. Six electronic databases (SCOPUS, Web of Science, PubMed/MEDLINE,

PsycINFO, CINAHL, and Google Scholar) were systematically searched for English-language studies published from 2015 onward. Search terms included domestic violence, intimate partner violence, women, South Asia, Southeast Asia, and mental health outcomes. Of 545 records identified, 270 remained after duplicate removal. Following title, abstract, and full-text screening, 23 studies met the inclusion criteria. Eligible studies included women aged ≥18 years from SA or SEA who had experienced any form of DVA and reported mental health outcomes. Studies unrelated to women, DVA, mental health outcomes, or conducted during emergencies or pandemics were excluded.

Results

Domestic violence was highly prevalent across both regions, with lifetime prevalence generally ranging from 33%–51% in SA and 16%–63% in SEA. Women experienced multiple forms of abuse, including physical, psychological, sexual, economic abuse, neglect, and controlling behaviours, with psychological and emotional violence being the most frequently reported. Patriarchal gender norms, economic dependence, and unequal power relations consistently increased women's vulnerability, particularly among pregnant women, migrants, ethnic minorities, and rural women. Depression was the most common mental health consequence, followed by anxiety, psychological distress, suicidal ideation, and post-traumatic stress disorder. Women also reported social isolation, guilt, emotional dysregulation, reduced quality of life, and increased risks of psychiatric disorders.

Conclusions

DVA is strongly associated with adverse mental health outcomes among women in SA and SEA, highlighting the need for integrated, culturally sensitive interventions. Routine screening for violence and mental health problems, strengthened support services, trauma-informed care, and further research on effective prevention and intervention strategies in primary care and community settings are essential to improve women's health and well-being.

Keywords: Domestic violence, intimate partner violence, mental health, depression, PTSD, women

Introduction

Violence against women constitutes a pervasive global public health, social, and human rights crisis with far-reaching implications for health, well-being, and gender equality. The World Health Organization (WHO) defines violence as the intentional use of force or power that results in harm, or has a high likelihood of doing so, encompassing physical, sexual, psychological, and economic dimensions [1]. Within this broad framework, intimate partner violence (IPV) and other forms of domestic violence and abuse (DVA) represent some of the most common manifestations, reflecting entrenched gender inequalities, power imbalances, and social norms that tolerate or condone violence within homes and communities [2,3]. DVA refers to violent or abusive acts, physical, psychological, or sexual—perpetrated by an intimate or romantic partner or family member, regardless of the setting. These behaviours are rarely isolated, occurring repeatedly and coercively with serious short- and long-term consequences for women's physical and mental health [4,5].

The scale of this problem is substantial. Recent global estimates indicate that approximately (27%) of ever-partnered women aged 15–49 years have experienced physical and/or sexual IPV during their lifetime, while nearly (37%) have experienced at least one form of IPV globally across diverse settings and populations [6]. These figures translate into hundreds of millions of women affected worldwide, underscoring that DVA is both a personal tragedy and but a profound societal burden.

Globally, psychological and emotional abuse are among the most prevalent forms of DVA, often co-occurring with physical and sexual violence, and contributing to significant psychological distress even when physical harm is absent. Evidence indicates that domestic violence is deeply rooted in social and cultural norms that legitimise male authority, restrict women's autonomy, and treat violence as a private family matter, further discouraging disclosure and help-seeking [7].

The mental health consequences of domestic violence are well documented in global research, with survivors exhibiting elevated risks of depression, anxiety, post traumatic stress disorder (PTSD), suicidality, substance use disorders, sleep disturbances, and diminished self-esteem [8]. These outcomes often persist long after the abuse ends, reflecting the enduring impact of chronic fear, coercive control, and emotional trauma [9]. For example, recent long-term research highlights that women exposed to IPV continue to experience high rates of depression, anxiety, sleep disorders, and PTSD decades after exposure, underscoring the far-reaching effects of violence on psychological functioning [10]. The implications extend beyond mental health, affecting women's physical well-being, employment opportunities, parenting, and social participation, thereby reinforcing cycles of disadvantage and marginalisation [10,11,12].

Despite its global prevalence and grave health consequences, the evidence base on domestic violence and its mental health impacts remains uneven, particularly in SA and SEA, regions characterised by diverse socio-cultural contexts, significant gender inequality, and heterogeneous health systems [13,14]. Studies from SA indicate that IPV prevalence can exceed global averages; for example, lifetime IPV in SA has been reported as high as (35%) and above in certain population subgroups, with psychological abuse frequently predominating [15]. National evidence further suggests substantial variation within countries: in India, recent national data show that nearly (29%) of married women aged 15–49 experience physical violence, with emotional and sexual violence also prevalent and strongly associated with mental health morbidity [16]. Qualitative research from SA contexts highlights additional barriers to recognition and response, including stigma, expectations of family obedience, concerns about family honour, and limited legal and social support, which collectively contribute to under-reporting and inadequate service provision [17].

While mental health outcomes have been widely studied in high-income settings, there is a relative scarcity of systematic, regionally grounded research in SA and SEA that maps the full spectrum of forms of domestic violence, assesses their prevalence, and examines their associated mental health effects [17]. Existing studies often focus on physical and sexual violence, while less attention has been directed to economic abuse, coercive control, neglect, and non-physical forms of violence, despite evidence that these forms can have profound psychological impacts [9]. Moreover, available research varies in methodology, measurement, and scope, with few longitudinal or intervention-oriented studies that can reveal temporal patterns, causal pathways, or effective responses within these culturally diverse settings [14]. These gaps hinder the development of evidence-informed, culturally sensitive policies and interventions and limit the ability of health systems to integrate mental health services into violence prevention and response.

Given this context, this scoping review aimed to systematically map the forms and prevalence of domestic violence against women in SA and SEA and document its associated mental health consequences, providing a regionally grounded evidence base to inform culturally sensitive interventions, policies, and future research.

Methods

The study adopted a scoping review approach as it enables a wide range of literature to be systematically searched to answer broad research questions, scoping the literature for evidence and identifying gaps [18,19]. Arksey and O'Malley's (2005) scoping review framework [20] along with the preferred reporting

items for systematic reviews and meta-analyses extension for scoping reviews checklist (PRISMA-ScR) were utilised to structure the methodology [21]. Registered on Open Science Framework https://osf.io/78ecg/overview.

Stage 1: Identifying the research question.

The research review question was What does the academic literature reveal about women's experiences and the prevalence of different forms of domestic violence in SA and SEA, and how are these experiences associated with mental health outcomes, including anxiety, depression, stress, trauma, psychological distress, and suicidal ideation?

Stage 2: Identifying relevant studies

The following electronic databases were searched : SCOPUS, Web of Science, PubMed/Medline, PsycINFO, CINAHL, Google Scholar, SCOPUS and PubMed. The search focused on all the articles published in the last 10 years from the year 2015 onwards and written in English. The following keywords were used:

("domestic violence" OR "intimate partner violence" OR "gender-based violence" OR "spousal abuse" OR "partner abuse")
AND
(women OR female)
AND
("SA" OR "Southeast Asia" OR "India" OR "Pakistan" OR "Bangladesh" OR "Sri Lanka" OR "Nepal" OR "Bhutan" OR "Maldives" OR "Afghanistan" OR "Myanmar" OR "Thailand" OR "Vietnam" OR "Laos" OR "Cambodia" OR "Indonesia" OR "Malaysia" OR "Philippines" OR "Timor-Leste" OR "Brunei" OR "Singapore")
AND
("mental health" OR "depression" OR "anxiety" OR "stress" OR "trauma" OR "PTSD" OR "psychological impact")

Stage 3: Study selection

A total of 545 articles were retrieved from the database search and transferred to EndNote. After removing duplicate records(n=275), 270 articles remained for title and abstract screening. Screening was conducted according to the predefined inclusion and exclusion criteria (Table 1). Rigour in determining article selection was ensured through a systematic and transparent screening process. YP and VK

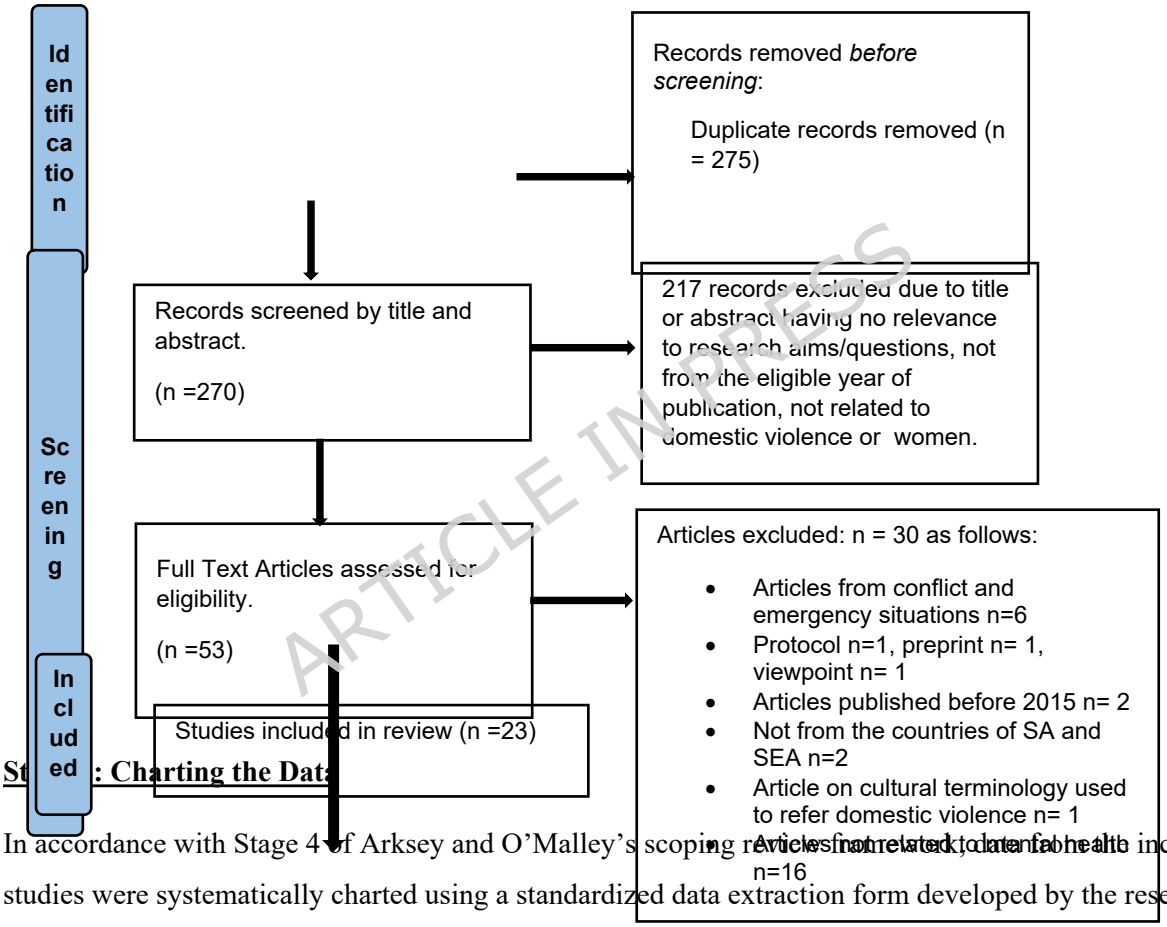
independently screened the titles and abstracts according to the predefined inclusion criteria. Their screening decisions were subsequently reviewed by MG to ensure consistency and methodological rigour. Any discrepancies were resolved through discussion and, where necessary, through consultation with JM. This multi-reviewer approach minimized selection bias and enhanced the reliability of the study selection process. Following title and abstract screening, 217 articles were excluded due to lack of relevance to the research question. A total of 53 full-text articles were then assessed for eligibility using the inclusion and exclusion criteria, of which 30 were excluded (see Figure 1). Finally, 23 articles were included in the review. Critical appraisal of the final articles was not undertaken as we wanted to scope the available literature on the topic and not exclude articles based on quality indicators.

Table 1: Inclusion and Exclusion criteria

Inclusion Criteria
Articles published from 2015 onwards (i.e., within the last 10 years).
Studies conducted in SA and SEA countries.
Studies including women aged ≥ 18 years.
Articles examining women's experiences of any form of domestic violence.
Studies investigating the impact of domestic violence on mental health outcomes, including anxiety, stress, depression, trauma, psychological distress, and suicidal ideation.
Exclusion Criteria
Studies not focused on women.
Studies not related to domestic violence.
Studies that did not examine the relationship between domestic violence and mental health outcomes.
Studies conducted in the context of the COVID-19 pandemic, war, or other emergency or humanitarian situations.(Disaster situations, pandemics, and other large-scale crises can substantially alter social, economic, and psychological circumstances, often leading to increased stress, disruption of support systems, and changes in the

prevalence and dynamics of domestic violence. Excluding such studies allowed us to avoid potential confounding effects).

Figure 1. PRISMA Flow diagram detailing method of study selection.



Stage 4: Charting the Data

In accordance with Stage 4 of Arksey and O'Malley's scoping review framework, data from the included studies were systematically charted using a standardized data extraction form developed by the research team. The charting form was designed to capture relevant information from each study, including author(s), year of publication, country of study, study objectives, study design, participant characteristics, methodology, key findings, relevant to the research question. Data extraction was undertaken by YP and VK, and the extracted information was subsequently reviewed by MG and JM to ensure consistency, completeness, and accuracy.

Stage 5: Collating, Summarizing, and Reporting the Results

Reflexive thematic analysis was employed to identify themes across the included articles [19]. Both MG and JM were actively involved throughout the analytical process. Initially, each author independently conducted the analysis, following which the interpretations, codes, and emerging themes were compared and discussed collaboratively. Any disagreements or variations in coding and theme development were resolved through consensus to ensure rigor, transparency, and credibility in the analysis. The results section presents the characteristics of the included studies along with the major themes identified.

Results

Overall distribution: Out of 23 studies included in the present review (see details in table 2), 11 were from SA countries: three articles from India [16,22,23]; two each from Nepal [24,25], Pakistan [26,27], and Sri Lanka [28,29]; and one each from Bangladesh [30] and Bhutan [31]. In the SEA region, four articles were from Thailand [32,33,34,35], two each from Myanmar [36,37] and Indonesia [38,39], one each from Vietnam [40] and Cambodia [41], and two were review studies [17,42].

The majority of included studies employed quantitative designs, with cross-sectional analyses predominating. Seven studies used cross-sectional designs to examine associations between domestic violence and mental health outcomes [16,22,33,34,37,38,32] while four were quantitative observational studies [26,25,2728].

Large-scale population-based surveys were represented by two studies [35,41] while two studies conducted secondary analyses of nationally representative household survey data [36,29]. Mixed-methods approaches were employed in two national-level studies, integrating quantitative prevalence estimates with qualitative insights into women's experiences [31,40].

Qualitative methodologies were used in three studies to explore lived experiences and psychosocial impacts of domestic violence [39,23,24]. In addition, the review included two evidence synthesis studies [17, 42] and one randomized controlled trial evaluating an intervention related to violence and mental health outcomes [30].

The included studies encompassed diverse populations of women across community and clinical settings. Most studies focused on women from the general population, drawing on community-based samples and national surveys [31,16,22,24, 25, 27,40,29,33,35,27, 41].

Several studies examined specific subpopulations, including pregnant women and women attending health facilities [30,36], rural women, migrant populations [16,32], and Indigenous or ethnic minority

groups [34]. Other studies focused on women survivors accessing support or protection services [26,38,39], while a small number specifically examined women with diagnosed mental health conditions who were also experiencing domestic violence [23].

In context to types of perpetrators responsible for domestic violence 11studies identified intimate partners as the primary perpetrators of violence [16,22,26,25,23,28,29,33,35,36,38]. Among the remaining 12 studies, eight reported family members as perpetrators, [17,30,24,27,42,40,39,34]. with one study explicitly specifying adult male relatives [34].In addition, three studies identified non-partner perpetrators, including family members, friends, or strangers [31,37,41] , while one study reported violence perpetrated by non-intimate partners, encompassing individuals such as employers, co-workers, acquaintances, or others within the victims' social environment [32].

The findings were synthesized into three overarching themes and eight subthemes, which are presented below.

1. Prevalence and Types of DVA in the SA and SEA

- **Prevalence of DVA in SA and SEA**

Studies from SA report high rates of domestic violence perpetrated by husbands/intimate partners and family members. Four studies from India—including one systematic review synthesizing evidence from 137 studies [16,22,23,42] documented that domestic violence is highly prevalent among Indian women, with a median of about 41% reporting lifetime experience of abuse and 30% reporting it in the past year when multiple forms of violence were assessed.

Beyond India, similar patterns were evident in neighbouring countries. In north Pakistan, extremely high levels were reported, with 88.8% of 160 married women experiencing DV [27]. Comparable evidence also emerged from Nepal, where violence against women was found to be widespread and often normalized within families [24]. In Sri Lanka, 26% of women reported experiencing IPV [28], while Bhutan's mixed methods study revealed that 44.6% of women aged 15–64 years had experienced at least one form of IPV in their lifetime [31]. Similarly, in Bangladesh, 57% of women reported experiencing DV [30].

Taken together, these country-level findings are reinforced by broader regional syntheses. A qualitative systematic review drawing on data from India, Pakistan, Bangladesh, Nepal, and Sri Lanka documented widespread physical, emotional, and psychological abuse among South Asian women, with approximately 33% to 51% of women across these countries experiencing domestic or intimate partner violence [17].

Across SEA, prevalence rates of domestic violence were high but showed considerable variability across countries. In Thailand, prevalence estimates ranged from 16% to 58.7% across different populations and settings [32,33]. However, national survey findings from Thailand reported comparatively lower lifetime prevalence estimates for IPV and sexual violence [35]. In Myanmar, the lifetime prevalence of any domestic violence was reported as 61.8% [36], while in Vietnam approximately 62.9% of women reported experiencing at least one form of domestic violence in their lifetime [40]. In Cambodia, around 21% of women reported at least one act of physical or sexual violence [41].

- **1.2 Types and Forms of DVA**

Across both SA and SEA, women experienced multiple and overlapping forms of violence, including physical, psychological/emotional, sexual, economic abuse, neglect, and controlling behaviours.

In India, physical violence estimates had a median around 29%, sexual violence around 12%, and psychological abuse around 22% [42]. Another study from north India reported lifetime prevalence rates of 43.4% for psychological violence, 27.2% for physical violence, and 26.4% for sexual violence [22]. Similarly, women in eastern India reported experiencing physical, emotional, and sexual violence that were often perceived as socially accepted within the community [23]. Another study from north India further reported extremely high levels of emotional violence (over 93%), economic abuse (85.5%), and physical assault among domestic violence survivors [16].

In Pakistan, psychological violence was reported by 69.4% of women, physical violence by 37.5%, and sexual violence by 21.2% [27]. In Sri Lanka, physical violence was reported by 15% of women, psychological/emotional abuse by 18%, sexual violence by 5%, and controlling behaviours by 12% [28]. Likewise, women in Bangladesh reported controlling behaviour (36.8%), emotional abuse (27.5%), and multiple forms of violence [30].

Across SEA, psychological and emotional violence emerged as the most common forms of abuse. In Indonesia, neglect with psychological abuse was the most common form of domestic violence [38]. Similarly, studies from Thailand reported psychological violence as the most prevalent form [32,33]. In Myanmar, emotional violence was most commonly reported form, followed by physical and sexual violence [36]. Vietnam and Cambodia also documented high levels of emotional and psychological abuse alongside physical and sexual violence [40,41].

- **1.3 DVA Among Vulnerable Groups**

Several studies highlighted particularly high levels of violence among vulnerable populations. In Bangladesh, pregnant women reported substantial exposure to domestic violence, including controlling

behaviours and emotional abuse [30]. In Myanmar, 6.7% of married women reported physical violence during pregnancy [36].

Similarly, among Myanmar migrant women workers in Thailand, 58.7% reported experiencing one or more forms of violence within the past 12 months [32]. Studies among ethnic minority women in northern Thailand also documented experiences of psychological, sexual, and economic abuse [34].

In Indonesia, studies among women with mental illness and domestic violence survivors documented experiences of physical, psychological, and neglect-related abuse [38,39]. Across both regions, higher rates of violence were repeatedly observed among structurally vulnerable groups, including rural women, migrants, pregnant women, and ethnic minorities.

2. Gender Norms, Economic Structures, and Kinship Influences on DVA

Across SA and SEA, domestic violence is strongly shaped by the interplay of gender norms, economic structures, and kinship systems. Studies from Vietnam, Thailand, Cambodia, Bhutan and Myanmar, indicate that patriarchal beliefs, male controlling behaviours, acceptance of unequal gender roles, and the normalization of violence within intimate relationships contribute significantly to women's risk of victimization [40,33, 41,31, 36].

Economic disadvantage is another important determinant. Studies among Myanmar migrant workers, and women in India, Pakistan, Bangladesh, and Nepal show that poverty, financial insecurity, limited educational opportunities, and economic dependence on male partners increase vulnerability to abuse and restrict women's ability to leave violent relationships [17,32]. Economic violence, including control over income and restriction of employment, frequently reinforces women's dependence [17,32].

Regional differences are also evident. In SEA, violence is more commonly discussed in relation to relationship power dynamics and male controlling behavior, whereas South Asian studies emphasize the role of patrilocal residence, family honor, in-law involvement, and extended kinship structures in perpetuating abuse [24,28,29,22]. Despite these differences, the evidence across both regions suggests that patriarchal gender norms, economic inequality, and family structures interact to sustain domestic violence and its adverse mental health consequences for women.

3. Mental Health Outcomes of DVA

- **3.1 Depression**

Findings from the reviewed studies indicate that depression was the predominant mental health condition associated with domestic violence in SA and SEA. Out of the 23, 13 studies reported depression as a mental health outcome of domestic violence. Seven from SA [16,24,26,25,27,23,28], and four from SEA [40,38,39,32] and two were review studies [17,42].

In SA, studies on domestic violence and depression were mainly conducted in India [16,24,23], Pakistan, Nepal, and Sri Lanka. Among 80 rural married women in central India who experienced intimate partner violence, 95% exhibited depressive symptoms on the DASS-21 scale, with severity ranging from mild (25%), moderate (47.5%), severe (18.8%), to extremely severe (2.5%). Exposure to physical, psychological, or sexual violence was independently associated with moderate to severe depression, and about (25.3%) of women overall reported depressive symptoms, with prevalence significantly higher among those who had experienced domestic violence. Women in Sambalpur City reported clinically diagnosed depression along with anxiety and sleep disturbances as long-term psychological consequences of repeated IPV [16]. A review of SA studies also highlighted high frequencies of depressive symptoms, PTSD, and suicide attempts among abused women [42].

In Pakistan, nearly two-thirds of women exposed to domestic violence experienced depressive symptoms, significantly higher than non-abused women, and depression was associated with physical, emotional, and psychological violence, alongside poorer quality of life [26]. In Gilgit-Baltistan (Pakistan), about half of abused women showed depressive symptoms, strongly linked to physical and psychological violence. Overall depression prevalence (cut-off ≥10) varied by IPV pattern, with 21% of women in the systematic IPV class classified as depressed, compared with 5% in the sexual violence class, 4% in the moderate violence class, and 1% in the low exposure group [25]. In Sri Lanka, the Women's Wellbeing Survey-2019 reported that 30% of married women had poor mental health, including depressive symptoms, based on the Kessler Psychological Distress Scale [28].

In Indonesia, SEA women experiencing domestic violence had very high depressive symptom levels: 50% severe, 29.3% moderate, and 20.7% mild, measured by the Beck Depression Inventory II, with longer duration of violence, lower economic status, and lower education associated with higher depression [38]. In Myanmar, 34.1% of ever-pregnant women reported mental distress including depressive symptoms, measured by the Hopkins Symptom Checklist-10; poor health, family debt, and partner controlling behaviour increased the likelihood of distress [37]. In Vietnam, women who experienced violence by a husband or partner had significantly higher mental health distress, including depressive symptoms, compared to non-abused women [40]. Among Myanmar migrant women in

Thailand, depression emerged as the most prominent mental health component, with higher scores (mean 7.51) among women exposed to violence, highlighting the significant psychological impact of abuse [32].

- **3.2 Anxiety**

Anxiety was a frequently reported mental health outcome of domestic violence. In India, Sathe et al. (16) reported an 80% prevalence of anxiety in a cross-sectional, community-based study, with higher scores linked to sexual violence and secrecy surrounding family matters. In Pakistan, abused women had significantly higher anxiety levels, with Malik et al. reporting strong correlations across all forms of violence [26, 27]. A qualitative systematic review by Masih et al. [17] highlighted that, despite cultural minimization of emotional harm, anxiety consistently emerged across studies from India, Pakistan, Bangladesh, Bhutan, Nepal, Afghanistan, the Maldives, and Sri Lanka. Parallel findings were observed in Southeast Asia among Myanmar migrant women in Thailand, where Linn et al. [32] reported that violence directly increased mental health problems, with anxiety as a prominent component. Overall, these studies indicate a clear and consistent association between domestic violence and elevated anxiety symptoms.

- **3.3 Emotional and Psychological Distress**

Distress emerged as a major mental health issue in studies on domestic violence across SA and SEA. Nine studies explicitly examined distress—six from SA [31, 16, 26, 30,24] and three from SEA [27, 32,40]—using terms such as stress, emotional distress, psychological distress, or mental distress.

Across SA studies, psychological distress consistently manifested as depression, PTSD, sleep disturbances, withdrawal, and psychosomatic symptoms, including headaches and fatigue [26, 24]. Notably, women frequently exhibited emotional suffering through physical symptoms such as headaches, stomach troubles, heart palpitations, insomnia, and unexplained body pain, highlighting how psychological stress can translate into bodily “breakdown” [26]. In rural India, 94% of women experiencing IPV reported psychological distress, with PTSD present in 68.8% of participants and 51.2% experiencing severe PTSD, indicating a very high prevalence of stress and distress [16]. Similarly, studies from Pakistan documented elevated stress, psychological distress, and emotional strain among abused women, [26,27] while a randomized trial in Bangladesh demonstrated that emotional distress increased with the severity and frequency of violence, with over 60% of women facing severe abuse reporting significant distress [30].

In SEA, comparable patterns were observed, although sample characteristics and measurement methods varied. The national survey in Vietnam highlighted that domestic abuse has "serious consequences for … mental health," reflecting increased psychological strain among women [40]. In Thailand, Linn et al. [32] studied Myanmar migrant women, a highly vulnerable and under-represented population, finding that violence directly contributed to mental health problems, with stress scores being the highest. The study's use of structural equation modeling further elucidated how socioeconomic and psychosocial factors amplified emotional strain. Additionally, the Cambodia national survey [41] revealed a strong association between IPV and emotional distress, which remained significant even after adjusting for age and education, indicating an independent effect of partner violence on women's emotional wellbeing.

- **3.4 Suicidal Ideation and behaviours**

Other important mental health outcomes frequently reported across the studies on domestic violence in South and SEA included suicidal ideation, thoughts, and behaviors. Nine papers discussed this theme, six from SA [16, 24,28,29,42,31] and three [27,35,41] from SEA

In SA, most evidence on suicidal ideation among women experiencing IPV comes from Bhutan [31] , India [16] and Sri Lanka [28,29] , with studies largely based on population or community samples. Population-level data consistently demonstrate a strong association between IPV and suicidal thoughts. For instance, in Bhutan a national survey [31] reported that 16.2% of women who experienced physical and/or sexual partner violence had seriously considered suicide, compared with only 5.8% of women without IPV experiences. Similarly, a national study from Sri Lanka [28] found that women with IPV experiences had nearly six times higher odds of reporting suicidal ideation, even after adjusting for sociodemographic factors. This study also identified additional risk factors, including lower education, limited decision-making power, and husband's alcohol use, as significantly associated with suicidal thoughts. In another study in Sri Lanka national analysis further indicated that about 36% of women who experienced partner violence had thought about suicide, while nearly 15% reported a suicide attempt, highlighting the strong association between IPV, self-harm, and suicidal behavior among women in Sri Lanka [29]. In India, a community-based sample of ever-married women in Delhi revealed dramatically higher rates of suicidal ideation among women exposed to physical or sexual violence, ranging from 63% to 90% depending on the type and timing of abuse [24]. Two qualitative systematic reviews further supported these findings [26, 42].

Evidence from SEA shows a similar pattern. In Cambodia, a national survey reported that 16% of women who experienced IPV had considered ending their lives, compared with 5% of those without IPV

experiences [41]. Studies from Thailand and Indonesia, including a large population survey by Panyayong et al. [35] and qualitative research by Ilmi et al. [39], corroborate this trend. Collectively, these studies indicate that suicidal ideation and behaviours are consistently and strongly associated with domestic and IPV across South and SEA.

- **3.5 Other Mental Health Outcomes**

Studies reported a range of other adverse mental health outcomes associated with (DV) in South and SEA. Feelings of worthlessness, loss of self-confidence, guilt, and social isolation were frequently reported, particularly when women were separated from family support systems. Outcomes such as unhealthy mental status, reduced quality of life, loss of emotional or behavioral control, and higher likelihood of lifetime psychiatric and substance use disorders, were reported [24,26,32,27,35]. A qualitative study from Indonesia additionally documented eating and sleep disturbances, emotional instability, and strained social relationships among survivors [39].

Discussion

The aim of this scoping review was to map the existing literature on the experiences, forms, and prevalence of domestic violence among women in South and SEA, and to document its effects on their mental health. This article demonstrates that DVA against women remains pervasive across SA and SEA, with IPV consistently emerging as the dominant form of abuse. Across both regions, women are rarely exposed to a single or isolated form of violence; instead, the evidence reveals co-occurring and cumulative patterns of physical, sexual, psychological, emotional, economic, and controlling abuse**.** This multidimensionality reflects a broader conceptualization of domestic violence as a chronic and relational process embedded within everyday social and familial structures, rather than as discrete acts of physical harm. Such findings are directly relevant to the research question, underscoring that domestic violence in these contexts is systemic, normalized, and sustained through gendered power relations.

In SA, the prevalence estimates identified in this review are among the highest reported globally and are consistent with evidence from other low- and middle-income countries (LMICs). Population-based studies and systematic reviews from India [16,42], Pakistan [26,27], Bangladesh [30], Nepal [24,25] , Sri Lanka [28,29], and Bhutan [31] indicate lifetime prevalence of domestic or IPV ranging from approximately one-third to over one-half of ever-partnered women, with substantially higher rates observed in rural [16] clinic-based [38], and marginalized populations [35,32], psychological, emotional, and controlling forms of violence were more prevalent than physical or sexual abuse across most settings. This pattern closely mirrors findings from LMICs such as Ethiopia, Uganda, Nigeria, and Tanzania,

where emotional abuse and coercive control frequently exceed physical violence in prevalence and severity [43,44,45].

Qualitative evidence from SA further contextualizes these prevalence patterns, illustrating how domestic violence is frequently normalized through cultural norms that emphasize women's obedience, marital endurance, and preservation of family honor [16,23,39]. Such normalization sustains high levels of violence and contributes to underreporting, delayed help-seeking, and prolonged exposure to abuse. Similar processes of normalization have been documented in Kenya and Rwanda**,** where social acceptance of wife-beating and gendered moral frameworks legitimize abuse and constrain women's agency [47, 44]. The prominence of economic abuse and controlling behaviors in Bhutan [31], India [16,42], Bangladesh [30] and Vietnam [40] reflects structural gender inequalities that limit women's autonomy and reinforce dependency on abusive partners—patterns also evident in Peru, Bolivia, and Nicaragua**,** where economic dependence and informal labor significantly heighten women's vulnerability to partner violence [48, 49, 50].

Across SEA, prevalence estimates varied widely by country and study population, yet domestic violence remained a significant public health and human rights concern throughout the region. National surveys from Myanmar [36], Vietnam [40], Cambodia [41] and Indonesia [38] frequently reported lifetime prevalence exceeding half of ever-partnered women, while emotional or psychological violence consistently emerged as the most common form of abuse. Comparable prevalence patterns have been reported in the Philippines and Timor-Leste, where national demographic and health surveys document high levels of IPV alongside strong social norms supporting male authority and discipline of wives [51]. In contrast, lower prevalence estimates reported in some Thai national surveys[33] likely reflect methodological and sociocultural factors—including narrow definitions of violence, social desirability bias, and fear of disclosure—rather than a true absence of abuse. This interpretation is supported by substantially higher prevalence documented among migrant women [32]; ethnic minorities [35], pregnant women[30,36], highlighting the intersection of gender with migration status, ethnicity, and socioeconomic disadvantage, a pattern widely documented across LMICs [52,53].

When situated within the broader LMIC literature, the findings of this review closely mirror global prevalence patterns. Pooled estimates from 53 LMICs suggest that more than one-third of women experience IPV during their lifetime, with particularly high concentrations in urban slums and socioeconomically deprived settings [54]. Country-specific analyses from Latin America further demonstrate that IPV prevalence remains high even in middle-income contexts with established legal protections, underscoring the limits of legal reform in the absence of structural and cultural change [49,

50]. The consistency of these patterns across diverse cultural and geographic contexts underscores that domestic violence is not merely a culturally specific phenomenon but a manifestation of structural and symbolic violence rooted in gender inequality, economic marginalization, and social acceptance of violence against women.

Taken together, this review advances the literature by demonstrating that domestic violence in South and South-East Asia reflects broader LMIC patterns while also revealing region-specific expressions shaped by kinship systems, gender norms, and economic structures.

These findings challenge narrow definitions of domestic violence and emphasize the need for inclusive conceptualizations that reflect women's lived experiences. Variations in prevalence likely reflect differences in gender norms, legal frameworks, social acceptance of violence, and methodology rather than true differences in risk.

The comparison between SA and SEA further suggests that while domestic violence is pervasive across both regions, the social contexts through which it is experienced may differ. Studies from SA more frequently highlighted the influence of kinship structures and family-based gender hierarchies, whereas studies from SEA more often emphasized controlling partner behaviours and migration-related vulnerabilities. These findings illustrate how similar patterns of violence and mental health consequences may arise through different sociocultural pathways across the two regions.

Mental Health Outcomes of Domestic Violence

This review demonstrates that domestic violence is strongly and consistently associated with adverse mental health outcomes among women in South and South-East Asia, indicating that violence functions as a central and enduring determinant of women's psychological wellbeing in these contexts. In relation to the research question, the findings suggest that mental health consequences are not transient reactions to isolated incidents but reflect chronic and cumulative harm arising from sustained exposure to intimate partner and domestic violence. Across diverse study designs and country settings, depression emerged as the most robust and consistently reported outcome [23,22,26,25,27,23,28], followed by anxiety [16,26,27,17,32], psychological distress, [31,16,26,30,24,27,32,40], suicidal ideation, [16,24,28,29,42,31] and three [27,35,41] revealed trauma-related symptoms, highlighting a continuum of mental health impact rather than discrete diagnostic effects.

The consistency of elevated depressive symptoms among abused women—often reaching clinically severe levels—across community-based studies, national surveys, and reviews highlights depression as a core and cross-contextual consequence of domestic violence. This pattern closely aligns with recent

LMIC literature demonstrating two- to three-fold higher odds of depression among women exposed to physical, sexual, or psychological violence, even after adjustment for socioeconomic factors [48,54]. Longitudinal evidence from LMICs further suggests that depression among survivors is frequently persistent, reflecting the chronic, recurrent, and relational nature of abuse rather than transient distress [55]. Findings from Peru and Uganda [48, 54] reinforce this interpretation by demonstrating that the violence–depression association remains robust even when poverty and education are controlled for, while also indicating that gender-inequitable norms, limited social support, and economic dependency intensify depressive outcomes. The particularly high burden of depression observed among pregnant women [30, 36] experiencing IPV further suggests that periods of heightened biological, emotional, and social vulnerability may exacerbate the psychological consequences of abuse supported by findings from large survey from 57 LMIC [56].

Anxiety emerged as a frequent co-occurring outcome, particularly among women exposed to sexual, psychological, and controlling forms of violence. Although less consistently reported than depression, its presence across multiple studies suggests that anxiety represents a pervasive yet under-recognized consequence of domestic violence, especially in sociocultural contexts where emotional suffering is normalized or minimized. This aligns with findings from other LMICs, including Egypt, [57] where anxiety disorders are strongly linked to IPV exposure. Evidence from Georgia [58] further extends the literature by identifying anxiety as a potential mediating pathway between violence and depressive symptoms, highlighting the need for integrative models that capture overlapping and sequential mental health effects rather than isolated diagnoses.

Psychological distress manifested through somatic symptoms—such as headaches, fatigue, sleep disturbances, and bodily pain—was also highly prevalent, reflecting the embodiment of chronic stress and trauma in contexts where mental illness is stigmatized or lacks formal recognition. These findings are consistent with research from South India [59] and other LMIC settings [17] showing that women exposed to IPV, particularly those partnered with alcohol-dependent husbands, experience severe distress that is more readily expressed through physical symptoms. The relative absence of focused research on somatic complaints in the reviewed literature points to an important gap, suggesting that current evidence may underestimate the mental health burden of domestic violence by failing to capture culturally salient expressions of distress.

The association between domestic violence and suicidal ideation and self-harm emerged as one of the most concerning findings of this review. Population-level studies across South and SEA consistently demonstrated markedly higher odds of suicidal thoughts among women experiencing IPV, even after

adjusting for socioeconomic and demographic factors. These findings align with evidence from South Africa [60]) and multi-country LMIC studies [2] indicating that suicidal ideation represents a severe endpoint of cumulative abuse and psychological entrapment. The Sri Lankan evidence showing nearly fourfold higher odds of household self-harm among women exposed to recent IPV further illustrates how violence reverberates beyond individual survivors, affecting household and community mental health [29]. Additional vulnerabilities—including low education, limited autonomy, economic insecurity, and partner alcohol use—appear to compound suicide risk, reinforcing the intersection of violence with broader structural disadvantage.

Beyond depression and anxiety, survivors experienced a broad constellation of mental health consequences, including PTSD, diminished self-worth, social withdrawal, impaired quality of life, and increased risk of comorbid psychiatric and substance use disorders. Recent LMIC-based studies from SA [61] and sub-Saharan Africa [62] demonstrate particularly high PTSD prevalence among women exposed to repeated physical and sexual violence, reflecting sustained fear, hypervigilance, and re-experiencing of trauma. Importantly, psychological abuse and controlling behaviors were strongly associated with reduced self-worth and social withdrawal even in the absence of physical violence, extending existing literature by highlighting the profound mental health impact of non-physical forms of abuse. Elevated substance use [63] and psychiatric comorbidity among survivors may represent maladaptive coping responses in settings characterized by limited access to mental health care.

Taken together, these findings extend existing LMIC literature by demonstrating that the mental health impacts of domestic violence are multidimensional, cumulative, and deeply shaped by structural and social inequities. Migrant women, pregnant women, and those living in rural or socioeconomically marginalized settings emerged as particularly vulnerable, likely due to social isolation, economic dependence, and restricted access to support services. In relation to the research question, this review underscores that addressing the mental health consequences of domestic violence in South and SEA requires approaches that move beyond symptom-specific interventions toward integrated, trauma-informed, and structurally responsive models of care that address both violence exposure and the conditions that sustain it.

Implications for policy and practice

The findings underscore the need to strengthen existing national policies on domestic violence and mental health in SA and SEA, such as the Protection of Women from Domestic Violence Act (India) (PWDVA, 2005) [64], Domestic Violence Prevention Acts in Bangladesh and Sri Lanka, and ASEAN frameworks

on violence against women [65–67]. While these policies broadly align with global frameworks, including the WHO Mental Health Action Plan [68] and WHO violence prevention guidelines [69], implementation remains fragmented across health, legal, and social sectors, and services are often poorly coordinated rather than integrated and survivor-centred [70]. Strengthening routine mental health screening for survivors within primary care, maternal health, and community health programs, alongside frontline worker training for community health workers and social welfare officers, is critical for early identification and referral [71].

Lessons may also be drawn from countries that have demonstrated promising approaches to addressing domestic violence against women. Spain's specialized courts and coordinated national framework, Australia's prevention-focused initiatives, the United Kingdom's integrated prevention and response strategies involving legislative reforms, multi-agency coordination, and survivor support services, Brazil's women-centred policing model, and Rwanda's integrated One-Stop Centres highlight the value of multi-sectoral collaboration, survivor-centred services, and strong legislative support [72-76]. These experiences suggest that comprehensive approaches combining prevention, protection, mental health support, and coordinated service delivery can strengthen responses to domestic violence and improve outcomes for survivors. Adapting such strategies to local cultural, social, and resource contexts may help enhance domestic violence prevention and mental health care in SA and SEA. Future research should evaluate the feasibility, acceptability, and effectiveness of adapting these models within diverse LMIC settings and identify context-specific factors that facilitate successful implementation.

Recommendation for future research

There is an urgent need for primary research due to the scarcity of evidence, particularly in SA and SEA. Future research should move beyond a narrow clinical focus to examine chronic stress, emotional suffering, and suicidality, including non-physical forms of domestic violence. Evidence remains limited on routine mental health screening for IPV, effective implementation in primary and community care, and training and task-sharing models in LMICs [68]. Studies should include diverse populations such as rural, indigenous, pregnant, postpartum, and older women, and explore culturally relevant psychological impacts. Although this review focused primarily on adverse mental health outcomes, future research should also examine resilience, coping strategies, help-seeking behaviours, and sources of support that may mitigate the effects of domestic violence and inform strengths-based interventions. Efforts should improve the measurement of psychological harm to inform evidence-based, context-specific interventions and policies.

Limitations

Most studies were cross-sectional, limiting the ability to establish temporal or causal relationships between domestic violence and mental health outcomes. Longitudinal and intervention-based research was scarce. Measurement of abuse and mental health varied, with physical and sexual violence commonly assessed but economic abuse, neglect, and controlling behaviors often overlooked. Mental health outcomes were inconsistently defined, with limited use of diagnostic tools. Evidence was unevenly distributed across South and SEA, with more studies from India, Thailand, and Myanmar, and fewer from Bhutan, Sri Lanka, Nepal, and Cambodia.

Conclusion

This scoping review maps substantial evidence linking DVA with adverse mental health outcomes among women in SA and SEA, while highlighting persistent gaps in integrated, survivor-centred responses. Despite the presence of legal and policy frameworks, mental health screening, referral pathways, and frontline workforce capacity remain uneven and poorly coordinated. Future research should prioritise implementation and health-systems studies to strengthen routine screening, task-sharing, and multi-sectoral integration of mental health services for survivors in low- and middle-income settings.

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Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Authors' contribution

MG conceptualized the study, developed the study design, and led the data extraction process. MG also conducted the primary synthesis and analysis of the extracted data and drafted the initial version of the manuscript. YP and VK contributed substantially to data extraction, verification, and organization of study materials, and assisted in data analysis and interpretation of findings. JM critically reviewed the manuscript gave input. All authors read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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Table 2: Characteristics of the selected studies

Author	Country and Year	Objective	Study Design	Tools used for data collection	Population	Types and prevalence of domestic violence
Aye et al., 2021	Myanmar	To capture domestic violence statistics across genders and its association with mental distress.	Cross-sectional	DV questionnaire was adopted from the Demographic and Health Survey programme. Hopkins Symptom (distress) Checklist-10 (HSCL-10).	934 women were ever-married, and 249 women were never-married (aged 18–49)	Physical, emotional and sexual violence IPV relatives, friend and strangers
Aye et al.,2024	Myanmar	To study the prevalence of physical violence during pregnancy, measure related maternal mental distress, and isolate secondary socioeconomic predictors.	Secondary analysis of a cross-sectional, household-based study	Demography and Health Survey questionnaire and the Hopkins Symptom Checklist-10	1045 ever pregnant women aged 18-49 years	Physical violence
Bandara et al., 2024	Srilanka	To examine the association between intimate partner violence and the occurrence of suicide and self-harm at the household level in Sri Lanka,	Quantitative	Secondary analysis of Demographic Health and Family Survey and Suicide count data from Police division	16390 women in the age group of 16-	Physical, sexual and psychological violence perpetrated IPV

		using national data.				
Chuemchit et al,. 2018	Thailand	To investigate the nationwide prevalence of domestic violence, male partner controlling behaviors, coping strategies, and health consequences.	Cross-sectional (nationwide survey)	Quantitative	1444 Married/cohabiting women aged 20–59 in Thailand	Psychological, physical, sexual, controlling behavio
Clark et al.,2019	Nepal	To classify latent patterns of IPV experience among married women, map community variability, and assess links to depressive symptoms.	Quantitative	WHO Multi-country study questionnaire	1440 Women	Sexual, emotional, physical
General Statistics Office & UNFPA 2019	Vietnam	To assess the prevalence, frequency, and cross-generational consequences of partner/non-partner violence and calculate economic costs.	Mixed Methods	Interviews and in depth interviews	5967 Ever-married/partnered women (aged 15–64)	Physical, sexual, psychological, and economic abuse, controlling behavio caused by IPV and known family members
Gunarathne et al., 2024	Sri Lanka	To analyze national survey data to determine how IPV impacts	Quantitative (logistic regression)	Kessler Psychological Distress Scale	1611 Married women from national survey (WWS 2019)	Physical, sexual, emotional

		married women's mental health and suicidal ideation.				
Gurning et al., 2020	Indonesia	To establish clinical risk factors (duration of abuse, economic class, education) that predict depression levels among female domestic violence victims.	Cross sectional	ICD-10 (A1) version of the Mini International Neuropsychiatric Interview. Beck Depression Inventory-II questionnaire.	82 patients violence survivors	physical, psychologicalPhysi l abuse alone Psychological abus alone and sexual abuse
Hussain et al.,2020	Pakistan	To look into the prevalence of domestic violence, risk factors, and its impact on mental health.	Quantitativ e	Karachi domestic violence screening scale and mental health inventory	160 Married Women	Psychological, Physical, Sexual IP and family membe
Ilmi et al.,2023	Indonesia	To explore the psychosocial history, psychosomatic impacts of depression, and dynamic coping strategies used by female domestic violence survivors.	Qualitative case study	In depth interviews	6 Women aged 17+ who reported domestic violence to the Integrated Service Center for Empowerment of Women and Children (UPT P2TP2A) in Makassar	Physical, verbal, an neglect emotional IPV and other fami members
Kalokhe et al., 2017	India	Review of decade of quantitative studies to	Systematic review of 137 quantitativ	Review	Women experiencing DV	Physical, psychological, sexu economic abuse, violence perpetrat

		summarize Indian women's experiences with domestic violence and chart research gaps.	e studies			by other family members
Linn et al., 2024	Thailand	To use structural equation modeling to analyze the effects of violence on the mental health and quality of life of Myanmar migrant women workers.	Cross sectional	WHO VAW instrument, WHOQOL-BREF, DASS 21, The Medical Outcome Study Social Support Survey	378 Migrant women aged 18 and above, workers from Myanmar who have at least worked for one year in Thailand	Physical, psychological and sexual violence IPV and Non-intimate partners (including other individuals, which could be employers, co-workers, acquaintances, or others in their environment)
Malik et al., 2021	Pakistan	To identify the relationship of domestic violence with depression, anxiety, and quality of life in hospitalized married women.	Co Relational	DASS 21 and WHO Quality of Life Scale	116 patients who were victims of DV	Verbal, physical, emotional and sexu violence
Masih et al., 2024	South Asia	To review global academic literature to identify the physical and psychological impacts of domestic abuse on South Asian	Qualitative Systematic Review	Cochrane	South Asian women (from countries including India, Pakistan, Bangladesh, Bhutan, Nepal, Afghanistan, the Maldives, and	Intimate partner violence (physical, sexual, emotional/psychol ical), extended fam abuse, coercion, an economic control

		women.			Sri Lanka)	
Ministry of Women's Affairs 2015	Cambodia	To calculate national estimates on the frequency, causes, and mental/reproductive health impacts of physical, sexual, and economic partner violence.	Population-based survey	WHO multicountry women's questionnaire,	4000 Women aged 15–64	Physical, sexual, emotional and economic IPV and non-partners also occurs: friends, siblings, parents, acquaintances, strangers and othe
National Commission For Women and Children, Royal Government of Bhutan (2017)	Bhutan	To measure different forms of violence against women/girls, assess links to health, and identify risk factors/coping strategies.	Mixed Methods	Self-Reported Questionnaire	2184 Women aged 15–64 years	Physical, sexual, emotional/psychol ical, economic, and controlling behavio by intimate partne and physical and sexual violence by non-partners, including family members, friends, and strangers, sinc age 15 years.
Panjaphothiwat et al. 2021	Thailand	To estimate the domestic violence prevalence within the Lahu hill tribe and pinpoint corresponding risk factors for children, women, and the elderly.	Cross-sectional (quantitative)	Questionnaire	Lahu tribe: 430 women (16–59),	Physical, emotiona sexual, economic, substance-related violence IPV and adult male relative
Panyayong et al,. 2018	Thailand	To evaluate the lifetime and 12-month	National cross-sectional	World Mental Health-Composite	3009 Thai women aged 18+	IPV and sexual violence

		prevalence of physical/intimate partner violence and map its association with diagnosed psychiatric disorders.	population-based survey	International Diagnostic Interview V.3.0 (WMH-CIDI 3.0).	(community-based sample)	
Rai and Rai 2020	India	To explore the nature and causes of IPV on women's lives and personal experiences of women diagnosed with mental illness.	Qualitative	In-depth interviews	12 Women in reproductive age group experiencing IPV and diagnosed with MH	IPV
Sathe et al., 2024	India	To describe patterns of intimate partner violence (IPV) and associated mental health issues among rural women.	Community-based cross sectional study	WHO multicountry women's questionnaire, and self-report scales to measure depression, anxiety	80 consenting married women in rural India	Physical, emotional sexual, economic abuse from IPV
Sharma et al., 2019	India	To investigate the association between domestic violence against women and their mental health status in a community setting.	Community-based cross-sectional study	SRQ 20	827 married women in Delhi	Physical, sexual, psychological (all forms)
Shrestha et	Nepal	To explore local community	Qualitative	In-depth interviews	A total of 21 interviews with	Physical violence, psychological and

al., 2024		stakeholders' and survivors' perceptions of violence against women, its causes, and its mental health impacts.		and focus group discussions	Health Care providers, Women accessing maternal and child health services and Stakeholders working in Violence Against Women, FGDs with violence survivors	sexual violence fro husbands and fami members
Ziaei et al., 2016	Banglade sh	To evaluate associations of specific/multipl e lifetime domestic violence patterns with prenatal distress and salivary cortisol levels	RCT	Shortened Conflict Tactic Scale and SRQ-20	3504 Pregnant women	physical, sexual, emotional domesti violence and controlling behavio causedd by IPV or family member