

Psychological Consequences of Domestic Violence on Women in Karnali Province, Nepal

Received 05 August 2026

Acceptance 13 September 2026

Published October 2026

Bhima Chunara

Chunarabhima2@gmail.com

Abstract

Domestic violence (DV) against women is a major public health and human rights problem in Nepal, with especially high structural vulnerability in the remote, mountainous Karnali Province. Beyond physical injury, exposure to intimate partner and family violence carries profound and lasting psychological consequences. This paper synthesizes empirical and qualitative evidence from Nepal and comparable South Asian contexts to describe the psychological outcomes associated with DV and to propose a mixed-methods research design for Karnali Province. A narrative synthesis of national survey data, provincial human rights monitoring reports, and peer-reviewed literature on intimate partner violence (IPV) and mental health was conducted, followed by the design of a cross-sectional, mixed-methods study protocol. National evidence indicates that roughly one in four ever-partnered Nepali women experience some form of IPV in their lifetime, and this exposure is consistently associated with depressive and anxiety symptoms, post-traumatic stress disorder (PTSD), suicidal ideation, and, in cases involving head trauma, longer-term cognitive impairment. Provincial monitoring reports suggest that Karnali carries a disproportionate share of reported DV incidents relative to its health-service capacity, while help-seeking remains low. DV constitutes a substantial, under-documented mental-health burden for women in Karnali Province.

Keywords: *Domestic violence, Intimate partner violence, Mental health, Depression, Post-traumatic stress disorder, Karnali Province.*

Introduction

Domestic violence (DV) refers to a broad range of behaviors, some of which are also recognized as intimate partner violence (IPV). It disproportionately affects women and is a global public health and human rights issue. It includes physical abuse, sexual abuse, emotional/psychological abuse, and controlling behaviors in intimate and/or family relationships and its harm extends well beyond physical injury. Unlike many other health exposures, DV typically occurs within the very relationships and households that are supposed to offer safety, support, and belonging.

In global public health, intimate partner violence (IPV) is a major issue and a fundamental violation of human rights. Controlling aggression, sexual coercion, psychological abuse, and controlling behaviors are all considered forms of intimate relationship violence. In low- and middle-income countries such as Nepal, women are disproportionately affected; approximately 27% of ever-partnered women reported experiencing physical, sexual, or emotional violence from a current or former intimate partner (Barini et al., 2025).

Systematic evidence also associates exposure to DV with depression, generalized anxiety, post-traumatic stress disorder (PTSD), suicidal ideation, substance use, sleep disturbance and, in the case of physical violence, cognitive impairment typical of traumatic brain injury (TBI) (Karakurt et al., 2014). They also affect families and health systems. Women who live with ongoing psychological distress may find it harder to work, to care for children, to take part in community life, or to make decisions about their own health and futures. Children who grow up in households where violence occurs are themselves at heightened risk of emotional and behavioral difficulties, so the psychological consequences of DV can extend across generations.

Nepal has taken important legislative steps to address DV. The Constitution of Nepal guarantees women's right to live free from violence, and the Domestic Violence (Offence and Punishment) Act of 2009 formally criminalized domestic violence and established mechanisms for protection and redress. In practice, however, implementation is uneven. Many women do not know their legal rights, face pressure from family and community to reconcile with perpetrators, or live far from police stations, courts, and service providers. The structural issues in Karnali Province, including poverty, inadequate health infrastructure, and social stigmas that increase women's vulnerability to DV and make it difficult to access services, create a high-risk environment. The prevalence of IPV is high throughout the country according to the Nepal Demographic and Health Survey (NDHS) 2022, while recent monitoring of human rights by local organizations has recorded high numbers of DV cases in Karnali (INSEC, 2024–2025). These contextual factors indicate that the psychological burden of DV in Karnali is not only immediate and significant but also under-documented, and that interventions and studies need to be targeted accordingly.

The remoteness of Karnali, its rugged topography, and its shortage of health workers make it harder for people to reach legal avenues and mental-health care. Many settlements are a day or more of walking from the nearest health post with trained staff, and seasonal weather can cut off communities entirely. Women remain at risk and their autonomy is constrained, as social norms and early marriage are still prevalent in certain rural areas. Other contextual factors, such as high rates of seasonal male labor migration, economic dependence on in-laws, and harmful traditional practices that stigmatize women, can further isolate women and limit their access to informal sources of support. One in four women in the country experiences some type of IPV during their lives (MoHP et al., 2023; Sapkota et al., 2024), and a high proportion of cases occur in low-resourced provinces, which makes the absolute number large. Structural vulnerability, high prevalence, and low service levels suggest a significant unmet need for mental-health care among women survivors in Karnali.

To facilitate the discussion, the following working definitions will be used. Depression is a constellation of clinically significant symptoms, including low mood, changes in appetite and sleep, difficulty concentrating and, in the most severe cases, suicidal ideation. Anxiety refers to ongoing worry, panic, and somatic symptoms of anxiety. Post-traumatic stress disorder (PTSD) refers to intrusive memories, avoidance, negative changes in mood or thinking, and hyperarousal after

traumatic events. Suicidal ideation and self-harm are both thoughts and behaviors that relate to one's intention to kill or injure oneself. Physical abuse can cause traumatic brain injury (TBI), with cognitive effects that can have long-term cognitive and emotional impacts (Karakurt et al., 2014). These categories may overlap and are often present together in the same survivors of DV.

Objective

To investigate and analyze the psychological impacts and mental health consequences of domestic violence among women in Karnali Province, Nepal.

Literature Review

Systematic reviews and meta-analyses consistently show that women exposed to IPV have higher odds of depression, anxiety, PTSD, and suicide attempts compared with unexposed women, with risk increasing according to the severity, frequency, and combination of abuse types (Karakurt et al., 2014). The relationship is widely understood to be bidirectional in part, since pre-existing mental-health difficulties may increase vulnerability to abuse, but longitudinal and mechanistic evidence indicates that violence itself is a causal contributor to poor mental health. Chronic fear, loss of control, humiliation, social isolation, and repeated threat are all well established pathways to psychological injury.

A growing body of evidence also links IPV to long-term neurological and cognitive outcomes, particularly where repeated head trauma occurs. A recent synthesis of clinical findings suggests that the effects of intimate partner violence on brain health can persist for the remainder of a survivor's life (The Guardian, 2025). Strangulation blows to the head and being shaken or thrown against objects can cause concussion and subtler forms of brain injury that often go unrecognized, because survivors rarely present to health services with a head injury as the primary complaint.

Analyses of the NDHS 2022 and related peer-reviewed studies report substantial IPV prevalence in Nepal, with roughly one-quarter of ever-partnered women reporting some form of physical, sexual, or emotional IPV in their lifetime. This exposure correlates with elevated depressive and anxiety symptoms across multiple studies (MoHP et al., 2023; Sapkota et al., 2024). A 2024–2025 wave of Nepalese research, including a propensity-score-matched analysis, found significant associations between IPV and generalized anxiety and depressive symptoms among Nepalese women, with compounded risk where male controlling behaviors co-occur (Barini et al., 2025). A separate nationwide study similarly documents a substantial burden of mental-health difficulty among IPV-exposed women alongside persistently low rates of formal help-seeking (Kurvinen et al., 2025).

Evidence from neighboring South Asian countries points in a similar direction. Across the region, patriarchal family structures, norms that tolerate or justify violence within marriage, dowry-related pressures, and the expectation that women endure hardship to preserve family honor have been described as shaping both the occurrence of violence and women's responses to it. Qualitative studies from the region frequently describe women's distress in terms of "tension," persistent worry, sleeplessness, and feeling trapped idioms that do not always map neatly onto diagnostic categories but

that are clearly consistent with depression, anxiety, and trauma-related disorders. These findings highlight the importance of culturally adapted measurement and of qualitative work that captures how women themselves understand and describe their suffering.

Civil-society monitoring and reporting indicate that Karnali experiences a disproportionate share of reported DV and human-rights incidents relative to its population and service capacity, with early marriage and patriarchal norms repeatedly identified as contributing factors (INSEC, 2024–2025). While robust epidemiological studies focused solely on Karnali remain limited, combining national survey results with local reporting suggests a significant unmet need for trauma-informed mental-health services in the province.

Several features of the Karnali context warrant particular attention. First, mental-health services are extremely limited. Specialist providers such as psychiatrists and clinical psychologists are concentrated in a small number of urban centers, and primary-care facilities often lack staff trained to identify or treat common mental disorders. Second, women's mobility and decision-making are often constrained by household hierarchies, so seeking care may require the permission of, or accompaniment by, family members, who may include the perpetrator. Third, social stigma attached to both mental illness and marital conflict discourages disclosure; women who speak out may fear blame, loss of family support, or retaliation. Finally, harmful traditional practices and beliefs, including menstrual restrictions and accusations of witchcraft have been documented in parts of western Nepal and can compound psychological harm by adding social exclusion and humiliation to violence within the home. Because of these overlapping factors, the psychological consequences of DV in Karnali may be more severe, and more likely to go untreated, than in better-served parts of the country.

This paper draws on an ecological framework encompassing individual, relationship, community, and societal levels to conceptualize both the risk of exposure and the psychological consequences of DV. Individual factors include prior mental-health status, age, and education; relationship factors include male controlling behaviors and substance use; community factors include prevailing social norms and service availability; and societal factors include gender inequality, poverty, and the strength of law and enforcement. This framework, adapted from Bronfenbrenner's ecological model, explains both exposure risk and barriers to help seeking and recovery, and it supports multi-level intervention design.

The framework is useful for the Karnali context because it makes clear that psychological outcomes are not determined by violence alone. A woman with strong family support, economic independence, and access to counselling may experience the same violence very differently from a woman who is isolated, impoverished, and far from services. Protective factors, such as supportive relatives, peer networks, women's groups, and responsive local authorities, can buffer the effects of abuse, while risk factors can amplify them. Interventions that target only one level, for example

individual counselling without attention to household safety, community norms, or legal protection, are therefore unlikely to be sufficient on their own.

Methodology

A cross-sectional, mixed-methods design is proposed, combining a population-based household survey with in-depth qualitative interviews of survivors, community health workers, and service providers. The quantitative component will estimate the prevalence of DV and of mental health outcomes and test associations between them. The qualitative component will explain how women experience psychological harm, how they cope, and what prevents them from seeking help. The two strands will be integrated at the interpretation stage so that survey findings can be contextualized by women's own accounts.

- Setting: Selected districts representing Karnali's ecological zones (mountain, hill, and mid-hill). Districts will be chosen to reflect variation in remoteness, ethnic and caste composition, and availability of health and protection services.
- Quantitative sample: Multistage cluster sampling of households to enroll women aged 15–49 (target $n \approx 800\text{--}1,000$), with sample size calculated to detect differences in depressive symptoms with adequate statistical power, assuming an approximate 25% IPV prevalence (MoHP et al., 2023). Wards or villages will serve as primary sampling units, followed by random selection of households and one eligible woman per household, to avoid compromising safety by interviewing multiple women in the same home.
- Qualitative sample: A purposive sample of approximately 25–30 participants (survivors and key informants), continuing until thematic saturation is reached. Key informants will include Female Community Health Volunteers, nurses and health-post staff, policewomen's cell officers, local government representatives, and staff of non-governmental organizations.
- Female interviewers trained in gender-based violence (GBV) and trauma-informed interviewing techniques.
- Private interview settings, informed consent procedures, and the participant's right to withdraw at any time.
- A safety protocol includes emergency referral pathways to local GBV services, psychosocial counsellors, and health facilities.
- Ethical approval from an institutional review board and relevant local authorities.

Interviewers will be trained to recognize signs of distress, to pause or end an interview when needed, and to respond to disclosures of imminent danger or suicidal thoughts according to the study's safety protocol. Studies on violence should be framed in neutral terms, for example as studies on women's health and life experiences, so that participants are not placed at risk if a family member asks about the interview's purpose. Interviews will be conducted only when privacy can be assured, and if someone else is present, the interviewer will change the topic and return at another time. Interviewers

will also receive support, including regular debriefing, because repeated exposure to distressing accounts can affect their own wellbeing.

Discussion

This paper drew upon national survey data, monitoring reports, and published studies to expound the likely psychological outcomes of domestic violence (DV) for women in Karnali Province and design a mixed-methods assessment of them. The reviewed evidence offers consistent support that exposure to intimate partner violence (IPV) leads to depression, anxiety, post-traumatic stress, and suicidal thoughts, and, when accompanied by assaults to the head or neck, persistent neurocognitive impairment (Barini et al., 2025; Karakurt et al., 2014; The Guardian, 2025). The discussion below addresses the implications of these findings for Karnali, the relevance of the ecological framework, and research considerations.

The association between IPV and adverse mental health outcomes appears consistent across populations and contexts. The evidence on the dose-response nature of that association, namely, higher levels of abuse corresponding to greater symptom severity (Karakurt et al., 2014), was found in Nepal too, where propensity-score-matched analyses identified IPV as a risk factor for anxiety and depression (Barini et al., 2025). The design of the latter study, which adjusted for potential confounders by comparing exposed and unexposed individuals with similar characteristics, adds credibility to the causal nature of the observed associations. Nevertheless, the reverse causality hypothesis cannot be dismissed, given that women with pre-existing mental health problems may be more likely to experience IPV. Therefore, the proposed cross-sectional design is appropriate in this study, and future investigations may consider a longitudinal design to establish the directionality of the associations.

While a quarter of women in Nepal report experiencing IPV in their lifetime (MoHP et al., 2023; Sapkota et al., 2024), the province may differ significantly from the national level in several respects. First, geographical isolation and a lack of mental health professionals contribute to the under-recognition of psychological distress with women unable to access services even if they seek help. Local monitoring data indicate that instances of DV, including those unreported to authorities, significantly outnumber available support services (INSEC, 2024-2025). Second, low levels of formal help-seeking have also been documented nationally (Kurvinen et al., 2025), but they are likely to be even lower in Karnali, where traditional practices encourage marital harmony at any cost to the woman's wellbeing, including in-laws' control, social isolation, and migration for employment. Therefore, the reviewed evidence suggests that the mental health status of women exposed to DV in Karnali may be significantly compromised, with limited access to mental health services.

The ecological framework is useful in understanding these findings, as it situates IPV exposure within multiple nested environments, each of which moderates individual-level mental health outcomes. At the individual level, protective factors include educational attainment and access

to mental health services. At the relationship level, partners' controlling behaviors and substance abuse contribute to distress. At the community level, social norms of gender equality and the prevalence of harmful traditional practices moderate the impact of DV on mental health. Finally, at the societal level, poverty and the absence of legal resources undermine women's ability to protect themselves, despite the existence of the 2009 Domestic Violence (Offence and Punishment) Act. These factors interact to produce the observed associations, with women who married young, have less education, belong to socially disadvantaged groups, and reside in remote areas reporting the highest levels of IPV exposure and distress. Thus, the ecological model guides the identification of potential interventions at various levels, including individual counseling, community-level attitude change, and policy adjustments.

The reviewed evidence suggests that women in Nepal and South Asia are more likely to report physical symptoms such as tension, sleep disturbances, and fatigue or use culturally specific terms to describe sadness and hopelessness (see Evidence from Nepal and South Asia, above). Such presentations of distress may be overlooked by healthcare professionals who are not trained to recognize them as symptoms of depression or PTSD. Additionally, the measurement instruments used in the proposed study, including PHQ-9, GAD-7, and PCL-5, were largely developed in Western countries and may not capture the nuances of local expressions of distress. Therefore, the planned pilot testing of the screening tools, the use of validated Nepalese adaptations of the measures and qualitative exploration of distress expression are justified. The qualitative findings will further inform the accuracy of the chosen cut-off scores.

The findings from The Guardian (2025) suggesting that women who suffer head trauma or neck compression as part of IPV experience neurocognitive impairments represent an important consideration. They highlight the need to screen for such symptoms, although the proposed study will not have the resources to assess neurocognitive function. Perhaps, the findings can prompt further intervention among women with such symptoms to ensure they receive appropriate neurological evaluation and care.

Practice and policy considerations follow from the above discussion. First, while increased treatment availability is important, it will be insufficient in Karnali due to the structural barriers to help-seeking. Therefore, investments in making existing services accessible and safe, including mobile outreach, are critical to reducing the mental health care treatment gap. Second, task-sharing models should be considered, wherein Female Community Health Volunteers and nurses receive basic training in psychosocial assessment and crisis intervention, including screening for GBV. Third, the findings will need to inform policy, including coordination between health, law enforcement, and NGO sectors in response to GBV, and targeting norms and stigma at the community level. Individual-level interventions, such as counseling in healthcare settings, will be ineffective without structural support, including legal aid and safety planning. Finally, the ecological model suggests that effective

interventions may not target a single level but rather cut across individual attitudes, community resources, and policy environments.

Based on the reviewed literature, the prevalence of lifetime IPV in Karnali Province is likely to mirror or exceed national estimates, with the NDHS 2022 reporting approximately 27% lifetime prevalence of any IPV nationally (MoHP et al., 2023), and with substantial proportions of women expected to report emotional abuse and controlling behaviors specifically. Women exposed to IPV are expected to show significantly higher odds of clinically meaningful depressive and anxiety symptoms and higher PTSD symptom scores compared with unexposed women, with co-occurrence of multiple abuse types associated with worse outcomes (Barini et al., 2025; Karakurt et al., 2014). Low help-seeking behavior is anticipated because of stigma, limited-service availability, and geographic barriers; local reporting indicates that many cases in Karnali are managed informally or remain unreported altogether (INSEC, 2024–2025; Kurvinen et al., 2025).

The reviewed literature and local reports point to a strong, consistent relationship between DV and adverse psychological outcomes. In Karnali Province, structural and service constraints likely exacerbate both exposure and its consequences. Mental-health manifestations of DV range from mood and anxiety disorders to PTSD and elevated suicide risk. Emerging research also links repeated physical abuse to traumatic brain injury and long-term cognitive and neurological problems (The Guardian, 2025), underscoring the need to consider both psychiatric and neurocognitive assessment in severe cases. Prevention and response must therefore be multi-sectoral, spanning health, legal, and social-protection systems, and adapted to the province's realities through mobile outreach, training of peripheral health workers, community awareness, and confidentiality safeguards.

It is also anticipated that the survey will reveal a gradient in outcomes by social position. Women who married early, have little formal education, belong to marginalized caste or ethnic groups, or live in the most remote areas may report both higher exposure and worse mental health, reflecting the accumulation of disadvantage. Qualitative accounts are expected to reveal themes of isolation, fear, shame, loss of self-worth, and a sense of entrapment, as well as of resilience, including reliance on female relatives, peer support, spiritual or religious practices, and children as sources of meaning and motivation. Understanding these protective resources is as important as documenting harm, because they can be built upon in culturally grounded interventions.

Some women may be expected to describe their distress mainly in physical terms, such as persistent headaches, body pain, weakness, or breathlessness, rather than in terms of sadness or fear. This has practical implications for health-service delivery: unless health workers are trained to ask sensitively about violence and emotional wellbeing, they may treat symptoms without recognizing the underlying cause. Finally, the findings are likely to demonstrate a wide gap between need and service use. Even women with severe symptoms may never have spoken to a health worker, counsellor, or police officer about their situation. If confirmed, this gap would suggest that expanding services alone

is not enough; services must also be made visible, trusted, safe, and accessible to women who face practical and social barriers to using them.

Policy and Practice Level

- Integrate mental-health screening into primary care (brief PHQ-9/GAD-7 screens) with clear referral protocols to psychosocial services.
- Train community health workers (including Female Community Health Volunteers and nurses) in basic psychosocial first aid and confidential GBV screening.
- Establish mobile outreach clinics for remote areas to provide counselling and legal information.
- Strengthen referral pathways linking health, police, legal aid, and local NGOs, ensuring survivor-centered procedures throughout.
- Conduct community awareness campaigns addressing norms around early marriage, male controlling behaviors, and stigma, engaging local leaders as champions of change.
- Build provincial capacity for data collection to monitor DV trends and service uptake, disaggregated by district, caste/ethnicity, and age.

Conclusion

Women in Karnali Province are likely to suffer from depression, anxiety, PTSD, suicidal ideation, and lasting adverse cognitive impacts in cases of physical head trauma due to domestic violence. To mitigate this burden, immediate strengthening of trauma-informed mental health services is needed along with better detection in primary care, more community involvement to decrease stigma, and stronger referral pathways. The evidence reviewed here shows that the psychological consequences of DV are neither rarer nor minor, and that they are likely to be magnified in a province where poverty, remoteness, gender norms, and limited services converge. Protecting women's mental health is inseparable from protecting their safety, rights and dignity, and it is essential to the wellbeing of their families and communities. The burden can only be quantified, the pathways explored and culturally relevant interventions proposed through empirical, province-level research using the mixed-methods approach suggested in this paper. Such research, conducted ethically and in partnership with women and local institutions, can provide the evidence that policymakers, health planners, and service providers need to act.

References

- Barini, G., Onger, L., & Mogeni, P. (2025). Mental health outcomes and intimate partner violence among Nepalese women: A propensity score matched study. *PLOS Mental Health*, 2(7), Article e0000374. <https://doi.org/10.1371/journal.pmen.0000374>
- Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., Astbury, J., & Watts, C. H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Medicine*, 10(5), Article e1001439. <https://doi.org/10.1371/journal.pmed.1001439>

- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14(2), 99–132.
- Informal Sector Service Centre. (2025). *Nepal human rights year book 2025*. INSEC.
<https://www.insec.org.np/hr-yearbook/>
- Informal Sector Service Centre. (2026). *Nepal human rights year book 2026* (English ed.). INSEC.
<https://inseconline.org/wp-content/uploads/2026/02/Year-Book-2026-English.pdf>
- Jenkins, N. D., Ritchie, C. W., Ritchie, K., Muniz Terrera, G., & Stewart, W. (2025). Intimate partner violence, traumatic brain injury and long-term mental health outcomes in midlife: The Drake IPV study. *BMJ Mental Health*, 28(1), Article e301439. <https://doi.org/10.1136/bmjment-2024-301439>
- Karakurt, G., Smith, D., & Whiting, J. (2014). Impact of intimate partner violence on women's mental health. *Journal of Family Violence*, 29(7), 693–702. <https://doi.org/10.1007/s10896-014-9633-2>
- Kurvinen, M., Ekström, A. M., & Deuba, K. (2025). Burden of intimate partner violence, mental health issues, and help-seeking behaviors among women in Nepal. *Women's Health*, 21, Article 17455057251326416. <https://doi.org/10.1177/17455057251326416>
- Ministry of Health and Population [Nepal], New ERA, & ICF. (2023). *Nepal Demographic and Health Survey 2022: Final report*. Ministry of Health and Population [Nepal]; ICF.
- Sapkota, P. M., Pandey, A. R., Adhikari, B., Shrestha, G., Piya, R., Lamichhane, B., Garu, S., Joshi, D., & Baral, S. C. (2024). Intimate partner violence in Nepal: Analysis of Nepal Demographic and Health Survey 2022. *PLOS ONE*, 19(8), Article e0308107.
<https://doi.org/10.1371/journal.pone.0308107>
- Shaikh, M. A. (2025). Intimate partner violence among Nepalese women and associated factors in 2021–2022. *PLOS Global Public Health*, 5(3), Article e0003267.
<https://doi.org/10.1371/journal.pgph.0003267>
- Trevillion, K., Oram, S., Feder, G., & Howard, L. M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS ONE*, 7(12), Article e51740.
<https://doi.org/10.1371/journal.pone.0051740>