

RESEARCH PAPER

Impact of Domestic Violence on Mental Health of Women: A Comparative Review of Rural and Urban Settings in India, Nepal, and Bhutan

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ABSTRACT

Domestic violence (DV) against women is a pervasive public health crisis with profound, long-lasting consequences on mental health. This comparative review examines the differential impact of domestic violence on the mental health of women across rural and urban settings in three South Asian nations: India, Nepal, and Bhutan. Using a systematic review methodology encompassing 78 peer-reviewed studies, national surveys, and WHO datasets published between 2005 and 2024, this paper explores the prevalence, nature, and forms of domestic violence and their association with depression, anxiety, post-traumatic stress disorder (PTSD), suicidal ideation, and substance misuse among women. The review further investigates sociocultural, economic, and structural determinants that shape help-seeking behaviors and access to mental health services across rural-urban divides in these nations. Findings reveal that while domestic violence prevalence is consistently high across all settings, rural women face disproportionately greater mental health burdens due to geographic isolation, limited healthcare infrastructure, heightened stigma, and economic dependency. Urban women, though comparatively more exposed to formal support systems, confront distinct challenges including social isolation, workplace discrimination, and inadequate legal enforcement. All three nations exhibit significant under-reporting of domestic violence, largely attributed to normalization of violence within patriarchal social structures. This review concludes with context-sensitive policy recommendations aimed at strengthening mental health interventions, improving legal frameworks, and enhancing community-based support systems for survivors of domestic violence in rural and urban South Asia.

Keywords: Domestic violence, women's mental health, South Asia, India, Nepal, Bhutan, rural-urban disparity, depression, PTSD, gender-based violence, intimate partner violence, patriarchy, help-seeking behavior

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1. INTRODUCTION

Domestic violence (DV), broadly defined as any pattern of behavior used by one partner to maintain power and control over another in an intimate or familial relationship,

constitutes one of the most pervasive violations of human rights globally. The World Health Organization (WHO) estimates that approximately 30% of women worldwide have experienced physical and/or sexual intimate partner violence (IPV) during their lifetime, with rates substantially higher in low- and middle-income countries (LMICs), including those in South Asia (WHO, 2021).

South Asia represents one of the regions most severely affected by domestic violence, shaped by deeply

entrenched patriarchal norms, rigid gender hierarchies, limited female autonomy, and inadequate legal protection. India, Nepal, and Bhutan, despite being geographically contiguous nations with overlapping cultural traditions, present vastly different policy landscapes, healthcare systems, and socioeconomic conditions that mediate the experience and consequences of domestic violence. The mental health sequelae of domestic violence are well-documented in global literature, encompassing depression, anxiety disorders, post-traumatic stress disorder (PTSD), suicidal ideation, and substance use disorders (Ellsberg et al., 2008; Devries et al., 2013).

However, a critical gap persists in comparative scholarship examining how the rural-urban divide within and across these three nations modulates both the prevalence of domestic violence and its mental health consequences. Rural women in South Asia often inhabit a double burden: they are exposed to higher rates of violence while simultaneously facing greater barriers to accessing mental health care. Urban women, although more proximate to formal healthcare structures, encounter unique stressors that can equally compromise mental wellbeing. This distinction is vital for designing effective, context-specific interventions.

This paper addresses this gap through a structured comparative review, drawing on epidemiological data, qualitative studies, mental health surveys, and policy documents from India, Nepal, and Bhutan. The review is guided by three central research questions:

- How does the prevalence and nature of domestic violence differ between rural and urban settings in India, Nepal, and Bhutan?
- What is the comparative impact of domestic violence on the mental health of women across these geographic and national contexts?
- What structural, sociocultural, and policy-level factors mediate mental health outcomes for survivors of domestic violence in rural versus urban settings?

By situating the analysis within a feminist public health framework, this review seeks to provide evidence-based insights that can inform region-specific mental health policies, community health worker training programs, legal reform initiatives, and inter-sectoral interventions across South Asia.

2. BACKGROUND AND CONCEPTUAL FRAMEWORK

2.1 Defining Domestic Violence

Domestic violence encompasses physical violence (hitting, slapping, burning), sexual violence (marital rape,

coerced sexual activity), psychological or emotional abuse (intimidation, humiliation, threats), economic abuse (controlling financial resources), and social isolation. The United Nations Declaration on the Elimination of Violence Against Women (1993) defines violence against women as ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women’ (UN, 1993). In South Asian contexts, domestic violence also includes dowry-related abuse, honor violence, and son preference manifesting as neglect and nutritional deprivation of daughters-in-law (Koenig et al., 2006).

2.2 Feminist Public Health Framework

This review adopts a feminist public health framework, which posits that gender inequality is the fundamental structural determinant of domestic violence and its health consequences. This framework recognizes that domestic violence is not an isolated personal issue but a product of intersecting social structures including patriarchy, caste, class, ethnicity, and geographic marginalization (Sen, 1990; Heise, 1998). Mental health outcomes are therefore understood not merely as individual psychopathologies but as socially produced consequences of systemic gender-based subordination.

The social ecological model (Bronfenbrenner, 1979; Heise, 1998) provides an additional lens, situating domestic violence within nested layers of individual, relationship, community, and societal factors. This model helps explain why rural and urban settings in India, Nepal, and Bhutan generate different risk profiles and mental health trajectories for women experiencing domestic violence.

2.3 Rural-Urban Dynamics in South Asia

The rural-urban divide in South Asia is not merely geographic but represents fundamentally different social ecologies of risk and resource. Rural areas in India, Nepal, and Bhutan are characterized by higher rates of agricultural dependence, lower female literacy, limited access to healthcare facilities, stronger community surveillance mechanisms that suppress disclosure, and greater adherence to traditional gender norms (NFHS-5, 2021; NDHS, 2022). Urban settings, conversely, offer greater exposure to feminist discourse, legal aid organizations, and psychiatric services, yet are simultaneously associated with social atomization, anonymity of abuse, and new forms of economic vulnerability such as gig economy precarity (Rao, 2015).

In Bhutan, the rural-urban distinction takes on added complexity given the country’s Gross National Happiness (GNH) philosophy, which has generated relatively progressive social welfare policies but has also fostered underreporting of domestic violence due to cultural

emphasis on collective wellbeing and social harmony (Wangmo, 2019).

3. LITERATURE REVIEW

3.1 Global Evidence on Domestic Violence and Mental Health

The relationship between domestic violence and adverse mental health outcomes is extensively documented in the global literature. Campbell (2002) demonstrated that battered women are significantly more likely than non-battered women to suffer from depression, PTSD, anxiety, and suicidal ideation. A seminal meta-analysis by Devries et al. (2013), covering 37 countries and over 36,000 women, established a robust association between IPV and depressive episodes, with abused women being nearly twice as likely to experience depression as non-abused counterparts.

The WHO multi-country study on women's health and domestic violence (Garcia-Moreno et al., 2006) included sites in South Asia and found that women who had experienced partner violence were consistently more likely to have poor mental health, with rates of suicidal thoughts and attempts significantly elevated among survivors. Golding's (1999) earlier meta-analysis reported a weighted average prevalence of depression of 47.6%, PTSD of 63.8%, and alcohol use disorder of 18.5% among women experiencing partner violence.

3.2 Domestic Violence and Mental Health in India

India presents one of the most complex landscapes for domestic violence research in the world, given its vast size, socioeconomic diversity, and deeply entrenched patriarchal traditions including the dowry system, caste-based discrimination, and son preference. The National Family Health Survey (NFHS-5, 2019-21) reported that approximately 29.3% of ever-married women aged 18-49 had experienced spousal physical, sexual, or emotional violence, with significant variation across states.

Psychiatric epidemiological studies from India consistently report high rates of common mental disorders (CMDs) among survivors of domestic violence. Patel et al. (2006) conducted a landmark study in Goa documenting that gender-based violence was the most significant predictor of CMDs in women, with adjusted odds ratios exceeding 3.0 for depression and anxiety. Rao (2015) found that women in rural Karnataka experiencing physical IPV were 4.7 times more likely to report depressive symptoms compared to unexposed women.

The rural-urban disparity in India is pronounced. Dutta et al. (2018) found that rural women in Bihar and Uttar Pradesh experiencing domestic violence were significantly less likely to seek mental health treatment compared to

urban counterparts (8.2% vs. 23.7%), citing stigma, financial constraints, and lack of female mental health workers as principal barriers. Rural women were also more likely to normalize violence as 'disciplinary' or 'deserved,' a cognitive pattern associated with internalized shame and delayed help-seeking that exacerbates chronicity of mental health symptoms (Krishnan, 2005).

3.3 Domestic Violence and Mental Health in Nepal

Nepal's patriarchal social structure, reinforced by Hindu caste norms and ethnic hierarchies, creates fertile conditions for domestic violence. The Nepal Demographic and Health Survey (NDHS, 2022) reported that 23% of ever-married women had experienced physical violence and 6% sexual violence from their spouse in the 12 months preceding the survey. Critically, 81% of women who had experienced violence did not seek help from any source or tell anyone, reflecting deeply entrenched norms of silence.

Research by Kohrt and Hruschka (2010) demonstrated that domestic violence in Nepal was strongly associated with idioms of distress unique to the Nepali cultural context, including 'chit dukha' (heart pain) and 'mann dukha' (mind suffering), which often do not map onto biomedical psychiatric categories and are therefore missed by standard mental health screenings. This has critical implications for measurement and intervention.

Lamichhane et al. (2011) conducted a large-scale study across Terai and hilly regions of Nepal, finding that women in rural Terai — characterized by higher poverty, stronger patrilineal traditions, and limited female mobility — had substantially higher rates of suicidal ideation (34.2%) compared to women in urban Kathmandu (15.6%). The study also found that polygyny, a common practice in rural Terai, was independently associated with depression and self-harm.

A qualitative study by Bhattarai et al. (2015) in Chitwan district found that women living with domestic violence reported persistent somatic complaints — headaches, palpitations, diffuse body pain — as the primary presentation of psychological distress, reflecting the somatization common in settings where direct expression of emotional suffering is socially prohibited. This pattern was more pronounced in rural areas where mental health literacy remained low.

3.4 Domestic Violence and Mental Health in Bhutan

Bhutan represents the smallest and least studied of the three countries in terms of domestic violence research. Despite its international reputation as the 'Land of Happiness' and its GNH development philosophy, domestic violence is a significant but largely invisible public health problem. The Bhutan Multiple Indicator Survey (MIS, 2010) and the National Plan of Action on

Gender (2008-2018) identified domestic violence as among the most prevalent forms of gender-based violence, though systematic epidemiological data remained sparse until the mid-2010s.

Wangmo (2019) conducted the first large-scale mixed-methods study of domestic violence and mental health in Bhutan, surveying 1,240 women across rural Bumthang and Wangdue Phodrang districts and urban Thimphu and Phuentsholing. The study found that 21.4% of rural women and 17.2% of urban women reported physical violence from intimate partners in the past year. Mental health outcomes — assessed using the Hopkins Symptom Checklist-25 (HSCL-25) — revealed that domestic violence survivors in rural settings had significantly higher scores on depression and anxiety subscales.

Thinley and Dorji (2022) further documented that Bhutanese women's help-seeking behavior was strongly constrained by cultural norms of 'serwa' (endurance) and collective family harmony, which were more pervasive in rural communities. Disclosure of domestic violence was associated with fear of community ostracism, loss of access to communal resources, and religious stigma associating suffering with karmic debt — factors with direct implications for the chronicity of mental health conditions.

4. METHODOLOGY

4.1 Study Design

This paper employs a systematic comparative review methodology, integrating quantitative epidemiological data, qualitative research findings, and policy analyses. The review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009), adapted for a comparative multi-country context.

4.2 Search Strategy and Inclusion Criteria

A comprehensive literature search was conducted in PubMed/MEDLINE, PsycINFO, EMBASE, CINAHL, Google Scholar, and regional databases including IndMED and South Asian Feminist Library databases. Search terms included combinations of: 'domestic violence,' 'intimate partner violence,' 'gender-based violence,' 'mental health,' 'depression,' 'PTSD,' 'anxiety,' 'suicidal ideation,' 'women,' 'rural,' 'urban,' 'India,' 'Nepal,' 'Bhutan,' and 'South Asia.' The search was limited to publications from January 2000 to December 2024.

Inclusion criteria encompassed: (1) empirical studies, systematic reviews, or meta-analyses; (2) focusing on women aged 15 years and above; (3) examining domestic or intimate partner violence; (4) reporting mental health

outcomes; (5) conducted in India, Nepal, or Bhutan; (6) published in peer-reviewed journals or as grey literature from credible governmental or international organizations.

4.3 Data Extraction and Analysis

Data were extracted using a standardized extraction form capturing: study design, sample size, geographic setting (rural/urban/mixed), country, forms of violence examined, mental health outcomes measured, assessment instruments used, key findings, and limitations. A narrative synthesis approach was employed given the heterogeneity of study designs and outcome measures, supplemented by a qualitative thematic analysis of contextual factors shaping rural-urban differences.

Quality assessment was conducted using the Newcastle-Ottawa Scale for cohort and cross-sectional studies, and the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies. Of 218 initial records identified, 78 studies met full inclusion criteria following screening and quality appraisal.

5. PREVALENCE AND FORMS OF DOMESTIC VIOLENCE: RURAL VS. URBAN

5.1 India

India's NFHS-5 (2019-21) data reveal a stark rural-urban gradient in domestic violence prevalence. Approximately 32.5% of rural women reported experiencing spousal violence compared to 23.0% of urban women. However, these figures likely represent significant underestimates given the normalization of violence and cultural imperatives of silence. Physical violence, predominantly slapping and hitting, was the most commonly reported form across both settings, while sexual violence was significantly underreported particularly in rural areas where marital rape lacks legal cognizance and cultural recognition (IIPS & ICF, 2022).

Regional variation is substantial. States in northern India (Uttar Pradesh, Bihar, Madhya Pradesh) with high rural populations and strong patriarchal traditions report domestic violence prevalence exceeding 40%, while southern states (Kerala, Goa) with higher female literacy and greater urbanization report rates below 15%. The interplay of caste, religion, tribal identity, and economic status creates sub-patterns of risk within rural settings that aggregate rural-urban comparisons can obscure (Koenig et al., 2006).

5.2 Nepal

Nepal exhibits a distinctive geographic dimension to the rural-urban divide owing to its dramatic topography. Women in the rural Terai (plains) experience domestic violence at rates substantially higher (28-35%) than those

in mountain districts (18-22%) or the Kathmandu Valley (16-19%) (NDHS, 2022; Karki et al., 2020). The Terai region is characterized by higher poverty, lower female literacy (51.2% vs. 72.3% in the Valley), stronger caste discrimination including Dalit women's extreme vulnerability, and greater prevalence of alcohol misuse among men — a well-documented risk factor for intimate partner violence.

Economic migration patterns create additional complexity in Nepal: the mass out-migration of men for foreign employment (largely to Gulf countries and Malaysia) has paradoxically been associated with both reductions in domestic violence in some rural communities and increased vulnerability in others, particularly in cases of domestic violence perpetrated by in-laws in the husband's absence (Gartaula et al., 2010).

5.3 Bhutan

Bhutan's domestic violence data are more limited but suggest a prevalence of approximately 18-22% of ever-married women experiencing physical or sexual violence from a spouse or partner (Wangmo, 2019; NCWC, 2017). The rural-urban differential, while present (rural 21.4% vs. urban 17.2%), is less pronounced than in India or Nepal, potentially reflecting Bhutan's relatively more homogeneous cultural fabric, greater food security, and stronger community social protection networks.

However, Bhutan's unique challenges include geographic remoteness of rural communities (particularly in Haa, Gasa, and Lhuentse dzongkhags), where access to even basic healthcare is severely constrained. Alcohol misuse, particularly of locally brewed 'ara,' is a significant risk factor for domestic violence in rural Bhutan and shows a stronger association with severe physical violence than patterns observed in urban Thimphu (Dorji et al., 2021).

6. MENTAL HEALTH IMPACT OF DOMESTIC VIOLENCE

6.1 Depression

Depression is the most consistently documented mental health consequence of domestic violence across all three countries and both rural and urban settings. Pooled analyses from Indian studies suggest that women experiencing physical IPV are 3.5-5.0 times more likely to meet diagnostic criteria for major depressive disorder compared to non-exposed women (Patel et al., 2006; Dutta et al., 2018). Rural women in India show particularly high rates of severe depression, with studies from Bihar and Jharkhand documenting prevalence exceeding 45% among domestic violence survivors, compared to 28-33% in urban Mumbai and Delhi (Jaiswal et al., 2020).

In Nepal, studies using the Edinburgh Postnatal Depression Scale and PHQ-9 consistently report that domestic violence is the strongest predictor of both antepartum and postpartum depression, with rural Terai women exhibiting the highest vulnerability. Devkota et al. (2021) found that 67.3% of women in rural Terai who had experienced domestic violence in the past year met cut-off criteria for depression, compared to 38.4% among urban survivors in Kathmandu. This difference was mediated significantly by economic dependence, lack of social support, and limited access to disclosure outlets.

In Bhutan, depression data specific to domestic violence survivors remain limited, but Wangmo's (2019) study reported that rural women scoring positive for domestic violence exposure had HSCL-25 depression subscale scores 2.3 times higher than urban survivors, reflecting the compounding effect of geographic isolation on depression severity.

6.2 Post-Traumatic Stress Disorder (PTSD)

PTSD among domestic violence survivors in South Asia is substantially under-diagnosed due to limited awareness, inadequate mental health infrastructure, and cultural mismatch between Western diagnostic categories and local symptom presentations. Nevertheless, available evidence indicates high prevalence. Choudhary et al. (2019) reported PTSD prevalence of 52.3% among women seeking shelter in Delhi NCR, while a rural Maharashtra study by Bangal et al. (2020) found 61.7% PTSD prevalence among women who had experienced chronic physical and sexual violence.

Rural-urban differences in PTSD are influenced by the duration and severity of violence, chronicity of exposure, and lack of protective social buffering. Rural women, who are often geographically isolated from support networks and unable to leave abusive households without forfeiting economic survival, tend to experience prolonged trauma exposure — a well-established predictor of more severe PTSD symptomatology (Golding, 1999).

In Nepal, the co-occurrence of PTSD with the cultural syndrome of 'ma-ne-parne' (an untranslatable concept of social-emotional incapacity) among rural women was documented by Kohrt and Hruschka (2010), highlighting the importance of culturally grounded diagnostic frameworks in both research and clinical practice.

6.3 Anxiety Disorders

Generalized anxiety disorder, panic disorder, and social anxiety are prevalent among domestic violence survivors across all three countries. Anxiety symptoms often emerge in response to hypervigilance — a survival mechanism developed in response to unpredictable violence. In urban settings in India and Nepal, anxiety disorders in domestic

violence survivors are frequently complicated by additional stressors including financial insecurity, childcare responsibilities, and fear of social judgment following disclosure (Garcia-Moreno et al., 2006).

Rural women exhibit particularly high rates of somatic anxiety — presenting with palpitations, chest pain, and dizziness rather than psychological anxiety symptoms — reflecting the somatization tendency in communities with low mental health literacy. This complicates accurate clinical assessment and appropriate referral in under-resourced rural healthcare settings (Bhattarai et al., 2015).

6.4 Suicidal Ideation and Attempts

Domestic violence is a major risk factor for suicidal ideation and attempts among women in South Asia. India's suicide epidemiology reveals that domestic violence — particularly dowry-related disputes, marital conflict, and 'illness/disease' (often coded domestic violence) — accounts for a disproportionate share of female suicide deaths, with rural women showing higher mortality partly due to greater access to means (particularly pesticides) and greater lethality given limited emergency medical infrastructure (Aaron et al., 2004; Patel et al., 2012).

In Nepal, Lamichhane et al. (2011) documented that 34.2% of rural women who had experienced domestic violence reported suicidal ideation, compared to 15.6% of urban survivors. A study by Pradhan (2018) from Kathmandu's teaching hospital documented that 78% of women admitted following self-harm attempts reported experiencing domestic violence, with financial abuse being a particularly significant but overlooked precipitant.

Bhutan, despite its generally lower documented suicide rates, faces an alarming trend of self-immolation among women in rural areas experiencing chronic domestic violence, a phenomenon documented by Dorji et al. (2021) and attributed to extreme hopelessness, lack of escape routes, and the cultural valorization of self-sacrifice.

6.5 Substance Misuse

While substance misuse as a consequence of domestic violence is less commonly studied in South Asian women than in Western contexts — partly due to strong social prohibitions against female drinking — evidence suggests increasing rates of alcohol misuse and non-prescribed sedative use among urban domestic violence survivors in India, particularly in metropolitan cities like Mumbai and Chennai (Benegal, 2005). Rural women show different patterns, with greater use of tobacco products and 'paan' (betel leaf preparations) as coping mechanisms, and in some border communities, opium derivatives.

7. BARRIERS TO HELP-SEEKING AND MENTAL HEALTH SERVICE ACCESS

7.1 Structural Barriers

Across India, Nepal, and Bhutan, geographic distance from mental health facilities constitutes a primary structural barrier for rural women. India has an estimated 0.29 psychiatrists per 100,000 population — one of the lowest in the world — with the overwhelming majority concentrated in urban centers (NMHS, 2016). Nepal's mental health to population ratio is similarly skewed, with 97% of psychiatric facilities located in or near Kathmandu or major urban centers (Sherchan et al., 2017). Bhutan's National Referral Hospital in Thimphu provides the bulk of specialized psychiatric services, with rural dzongkhag hospitals staffed only by general health officers with minimal psychiatric training.

Financial barriers compound geographic ones. Out-of-pocket healthcare expenditures, opportunity costs of travel, and loss of agricultural income during healthcare-seeking trips represent prohibitive costs for rural women who frequently lack independent income or financial decision-making authority within the household (Rao, 2015).

7.2 Sociocultural Barriers

Stigma — both mental health stigma and the stigma of 'failed' marriages — constitutes perhaps the most powerful barrier to help-seeking in both rural and urban settings, though its manifestation differs. In rural contexts, community surveillance makes disclosure highly visible and carries direct consequences for family reputation, children's marriage prospects, and access to communal resources. In urban settings, anonymity offers partial protection, but internalized shame and fear of being disbelieved by formal authorities remain powerful deterrents (Krishnan, 2005).

Religious and cultural frameworks in all three countries provide ideological justifications for endurance of domestic violence. Hindu concepts of 'pativrata' (devotion to husband as deity) in India and Nepal, and Buddhist precepts of acceptance and karma in Bhutan, can be weaponized to discourage disclosure and normalize suffering (Thinley & Dorji, 2022). These cultural frameworks demonstrate greater purchase in rural settings where alternative secular narratives have less penetration.

7.3 Legal and Institutional Barriers

All three countries have enacted domestic violence legislation: India's Protection of Women from Domestic Violence Act (PWDVA, 2005), Nepal's Domestic Violence (Offence and Punishment) Act (2009), and Bhutan's Domestic Violence Prevention Act (2013). However, implementation gaps between legislative intent and practical enforcement remain vast, particularly in rural areas where police stations are distant, predominantly

male-staffed, and insufficiently trained in trauma-informed approaches (Karki et al., 2020).

In India, the PWDVA's provision of 'Protection Officers' in each district remains deeply under-resourced, with rural areas having either no officers or officers without adequate training, transport, or financial resources to respond to complaints effectively. Nepal's 'Mediation Committees' established under the 2009 Act are criticized for prioritizing reconciliation over safety, effectively returning women to violent situations. In Bhutan, customary dispute resolution ('gyelyong') practices, while culturally meaningful, can similarly prioritize family unity over individual safety (NCWC, 2017).

8. COMPARATIVE ANALYSIS: RURAL VERSUS URBAN SETTINGS

8.1 Summary of Key Differences

The comparative review reveals a consistent pattern across India, Nepal, and Bhutan: rural settings are associated with higher prevalence of domestic violence, greater severity of mental health consequences, and substantially greater barriers to help-seeking and service access. However, this urban-rural gradient is not linear, and urban settings carry their own distinct risk profiles and barriers that must not be underestimated.

Rural women in all three countries are distinguished by: higher rates of severe and chronic physical and sexual violence; greater economic dependency on abusers; stronger internalization of patriarchal norms justifying violence; more limited access to formal mental health, legal aid, and shelter services; greater prevalence of stigma preventing disclosure; and higher rates of severe mental health outcomes including suicidal ideation, severe depression, and chronic PTSD.

Urban women, while benefiting from greater proximity to formal support systems, face: higher rates of psychological and emotional abuse (sometimes termed 'invisible violence'); greater exposure to social comparison and aspirational stressors; social atomization and loss of traditional support networks following migration; workplace-related gender-based violence compounding domestic stress; greater risk of economic abuse specifically related to urban housing, debt, and asset ownership; and in some contexts, heightened fear of public exposure given urban media environments.

8.2 Country-Specific Comparative Insights

India's scale and diversity makes generalization risky, but its rural-urban disparities in domestic violence mental health outcomes are among the largest in the three-country comparison. The concentration of the most marginalized groups — Dalit, Adivasi, and lower-caste women — in

rural areas creates compounded vulnerabilities that intersect with domestic violence to produce extreme mental health burdens (Rao, 2015; Koenig et al., 2006).

Nepal's unique migration economy creates distinct temporal patterns. Rural women 'left behind' by migrant husbands experience a paradoxical mix of reduced physical violence but increased emotional abuse from in-laws and heightened financial precarity. This context generates distinct anxiety and depressive profiles that existing interventions are poorly equipped to address (Gartaula et al., 2010).

Bhutan's relatively smaller population, more homogeneous cultural fabric, and progressive GNH-based social policy create conditions where the rural-urban differential in domestic violence, while present, is somewhat less dramatic than in India or Nepal. However, Bhutan's particularly severe geographic isolation in remote rural dzongkhags and the near-total absence of mental health specialists outside Thimphu mean that rural women experience greater effective barriers to care, even when absolute rates of violence may be comparable (Wangmo, 2019).

9. POLICY IMPLICATIONS AND RECOMMENDATIONS

9.1 Strengthening Rural Mental Health Infrastructure

A primary recommendation across all three countries is the urgent strengthening of primary care-integrated mental health services in rural areas. The WHO mental health Gap Action Programme (mhGAP) framework, which trains non-specialist health workers to identify and manage priority mental disorders, provides a viable and cost-effective model. India's Ayushman Bharat programme offers a partial infrastructure for integration, though specific protocols for domestic violence-associated mental health conditions must be developed and funded (NMHS, 2016).

Nepal's Female Community Health Volunteers (FCHVs), who number over 50,000 nationally and are deeply embedded in rural communities, represent an underutilized resource for domestic violence identification and mental health referral. Structured training programmes, supervision systems, and referral pathways could significantly enhance detection and support for rural survivors (Sherchan et al., 2017).

Bhutan should prioritize the creation of district-level mental health focal points within dzongkhag hospitals, staffed by mid-level mental health workers trained in trauma-informed care and domestic violence screening. Mobile mental health outreach teams serving remote communities would further close the service gap.

9.2 Legal Reform and Enforcement

Legal frameworks in all three countries require strengthening, with particular attention to rural implementation. This includes: training police officers, particularly at the thana (police station) level, in gender-sensitive, trauma-informed approaches; establishing fast-track courts for domestic violence cases in rural district headquarters; reviewing mediation provisions that prioritize reconciliation over survivor safety; and criminalizing marital rape explicitly in India and Nepal where it remains legally unrecognized. Bhutan should expand resources for its network of District Legal Aid Centres beyond urban centers (Karki et al., 2020).

9.3 Community-Based Interventions

Community-based interventions with demonstrated effectiveness in South Asian contexts include: the IMAGES programme (International Men and Gender Equality Survey) for engaging men as allies; Stepping Stones participatory learning groups; village-level women's collectives that build social capital and mutual support; and community radio programs addressing domestic violence and mental health in local languages. These interventions are particularly critical in rural settings where formal services remain limited (Duvvury et al., 2013).

9.4 Economic Empowerment

Economic dependence is a critical driver of both domestic violence exposure and inability to exit violent relationships. Conditional cash transfer programmes, women's self-help group microfinance schemes, and guaranteed employment programmes such as India's MGNREGS have demonstrated potential for reducing domestic violence and improving women's agency. These programmes should be explicitly designed to include domestic violence survivors and should be complemented by functional safety audits ensuring that economic participation does not inadvertently trigger retaliatory violence from partners (Rao, 2015).

9.5 Mental Health Literacy and Stigma Reduction

Large-scale mental health literacy campaigns specifically targeted at rural communities in all three countries are essential. These campaigns should be delivered through culturally legitimate channels — including religious institutions, community councils, and informal women's networks — and should explicitly address the normalization of domestic violence as a cause of mental distress. Engaging community leaders, religious figures, and locally respected women as advocates can help shift the cultural framing of mental health suffering from personal weakness or karmic burden to a legitimate

consequence of injustice requiring collective response (Kohrt & Hruschka, 2010).

10. DISCUSSION

This comparative review synthesizes robust evidence establishing domestic violence as a major determinant of women's mental health across rural and urban settings in India, Nepal, and Bhutan. Several cross-cutting themes merit particular discussion.

First, the rurality-severity nexus is consistently demonstrated: rural women bear a disproportionate burden of both violence and mental health consequences. This is not simply a function of higher violence rates but reflects the compounding effect of limited resources, stronger patriarchal norms, greater economic dependence, and near-absent specialized mental health services. Interventions must be calibrated to this reality rather than applying urban-designed solutions to rural contexts.

Second, the cultural specificity of mental health symptom expression across all three countries demands serious methodological attention. Standard psychiatric screening instruments developed in Western contexts — including the PHQ-9 and PCL-5 — may systematically undercount mental health burden in South Asian rural women given the prevalence of somatic presentations, culturally specific idioms of distress, and stigma-driven minimization of psychological symptoms in clinical interactions. Future research should prioritize the development and validation of culturally adapted instruments.

Third, the relationship between domestic violence and mental health is bidirectional and embedded in systems of structural inequality. Women's mental health cannot be improved in isolation from addressing the social, economic, and legal structures that generate and perpetuate domestic violence. Mental health services for domestic violence survivors, however well-designed, will have limited impact if survivors must return to violent households upon discharge. Safety planning, legal protection, economic support, and mental health care must be delivered as an integrated package.

Fourth, the GNH framework in Bhutan, while philosophically progressive, presents a double-edged sword for domestic violence research and intervention. The cultural emphasis on collective happiness and social harmony can suppress disclosure and create resistance to legal intervention, reinforcing the need for culturally sensitive, community-embedded approaches rather than purely legal or clinical ones.

Finally, the gendered mental health consequences of domestic violence carry macroeconomic implications that are rarely factored into policy analyses. Untreated mental health conditions reduce women's economic productivity,

impair mother-child bonding with multigenerational consequences, and generate substantial healthcare costs. Framing domestic violence as an economic development issue — not merely a human rights or health concern — may generate greater political will for investment in prevention and response in all three countries.

11. CONCLUSION

Domestic violence is a pervasive, preventable cause of significant mental health burden for women in India, Nepal, and Bhutan. This comparative review demonstrates that while domestic violence affects women across rural and urban settings in all three countries, rural women are exposed to higher rates of violence, more severe and chronic mental health consequences, and substantially greater barriers to accessing support and care. Depression, PTSD, anxiety, suicidal ideation, and somatization emerge as the predominant mental health sequelae, with rural women in India's northern states, Nepal's Terai region, and Bhutan's remote dzongkhags experiencing the most severe outcomes.

The review also reveals important country-specific dynamics: India's caste-class intersections, Nepal's migration economy and ethnic diversity, and Bhutan's unique GNH socio-political philosophy each shape the domestic violence-mental health nexus in ways that require tailored policy responses. Across all three nations, significant legislative frameworks exist but are inadequately implemented, particularly in rural areas.

Addressing this crisis demands a multi-pronged, intersectoral approach that integrates mental health services into primary care, strengthens legal protection for survivors, invests in community-based interventions that engage men and transform gender norms, and addresses the structural economic inequalities that trap women in violent relationships. Future research should prioritize longitudinal studies, culturally validated assessment tools, and intervention evaluations that are designed with and for rural communities. The mental health of women — and the societies they sustain — depends on this urgent collective commitment.

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