Impact of Coercive Control on Individual and Relational Functioning of Married Individuals: Role of Self-Silencing and Coping Self-Efficacy

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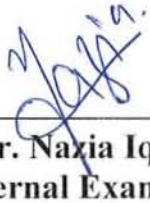

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This thesis is dedicated to my beloved parents and siblings. For their endless love, support and encouragement...

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Abstract

The current study was aimed to investigate the impact of coercive control on individual and relations functioning (mental health & marital quality) of married individuals and to see how self-silencing and coping self-efficacy effects this relationship. Sequential exploratory mixed method approach was used. Present study comprised of two studies. Study 1 was qualitative study in which 7 Focus Group Discussions (FGDs) and expert interviews were carried out with married men and women to understand the phenomenon of coercive control in Pakistani context. Thematic analysis was used for analysis of FGDs. Study 2 was quantitative study which was divided in three phases. Phase I was the development and validation of coercive control scale. For the purpose of development of scale item pool was generated and sent for the experts review. After receiving their feedback 36 out of 78 items were dropped and 42 items were finalized. Psychometric properties were determined by applying the Coercive Control Scale (CCS) on married individual. The sample for exploratory factor analysis comprised of 500 individuals (men = 251 and women = 249) from general population. A factor loading of .40 was set as a selection criterion for an item to be retained in the scale. Using oblique rotation in EFA, a solution of six factor was revealed. Further content and construct validity were established for the scale. Phase II of Study 2 was a Pilot Study, which was aimed at checking the psychometric properties of the scales used in the study. Coercive Control Scale (indigenously developed in present study), Mental Health Continuum Short Form (Keyes, 2009; translated by Faran & Malik, 2015), ENRICH Couple Satisfaction Scale (Olson Sigg, & Larson, 2008 translated by Fatima, 2017), Silencing the Self Scale (Jack, 1992; translated by Munir, 2014) and Coping Self-Efficacy Scale (Chesney, Neilands, Chambers, Taylor, & Folkman, 2006; translated by Younis, 2017) were used. Results showed that all the scales had satisfactory psychometric properties. Phase III of Study 2 was Main Study which was aimed at hypotheses testing (N = 483). Coercive control was negatively related to mental health, marital quality, coping self-efficacy and was positively related to self-silencing. Findings revealed the mediating role of coping self-efficacy in the relationship between coercive control and mental health, coercive control and marital quality. Moderating role of self-silencing, gender, marriage type and marriage duration were formed for coercive control for predicting mental health, marital quality and coping self-efficacy.

INTRODUCTION

Chapter I

INTRODUCTION

Intimate Partner Violence (IPV) is occurring worldwide, which is present in all human societies. IPV is a common problem, which has no boarders and it goes beyond every culture and covers all social classes. The roots of this problem are found in the patriarchal system and in the systematic dominance of women by men. IPV is considered a deep rooted health and social issue among developed and under-developed countries like Pakistan (Andersson et al., 2009). In a report of World Health Organization (2010), IPV was defined as "within an intimate relationship use of behavior which causes physical, sexual and psychological harm, involving acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors" (p.11). IPV is regarded as a typical pattern of coercive behaviors in which the abuser maintains power and control through physical abuse, psychological abuse, sexual aggression, social isolation, threats, and other tactics (McColgan, Dempsey, Davis, & Giardino, 2010).

Empirical evidence suggests the existence of various forms, types, and patterns of violence (Graham-Kevan & Archer, 2003; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Johnson, 1995, 2005a; Johnson & Ferraro, 2000; Johnston & Campbell, 1993; Leone, Johnson, Cohan, & Lloyd, 2004). The most commonly researched type of IPV is physical (Alhabib, Nur, & Jones, 2012; Ellsberg, Heise, Pena, Agurto, & Winkvist, 2001). However, from the past few years researchers have been trying to draw the attention towards the invisible but equally damaging forms of violence i.e. non-physical violence (Cook & Goodman, 2006; Graham-Kevan, & Archer, 2003; Johnson & Leone, 2005; Johnson & Ferraro 2000; Karakurt & Silver, 2013; Outlaw, 2009; Strauchler et al., 2004; Swan & Snow 2002; Walz, 2014).

IPV whether it is physical or non-physical affects women's physical and mental health by direct pathways i.e. Injury and indirect pathways, i.e. chronic health problems which are the result of continuous stress (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Non-physical violence impacts the individual and relational functioning of the person experiencing it. The negative impacts of non-physical violence effect the personal, mental, marital and social functioning of the person (Banomi et al., 2006). A number of researchers have recognized the consequences of non-physical abuse on the

well-being of women (Follingstad & Rogers, 2014; Jewkes, 2010; Karakurt & Silver, 2013; Lammers, Ritchie, & Robertson, 2005; Sorbo, Grimstad, Bjorngaard, Schei, & Lukasse, 2013; Zlotnick, Johnson, & Kohn, 2006).

Intimate partner violence not only damage the individual well-being of the person but it also have massive impact on the relational functioning i.e. marital quality, relationships with children, relatives and social functioning (Senlet, 2012). A number of empirical evidences were found in literature regarding the marital dissatisfaction, increase in personal distress, fewer benefits of the relationship and marital dysfunction after experiencing violence in marital life (Langhinrichsen-Rohling, Schlee, Monson, Ehrensaft, & Heyman, 1998; Stith, Green, Smith, & Ward, 2008; Testa & Leonard, 2001; Williams & Frieze, 2005). The effects of IPV on mental health reported in Pakistani studies identified a number of problems including anxiety, depression (Ali, Israr, Ali, & Janjua, 2009; Ayub et al., 2009; Karmaliani et al., 2008), feelings of worthlessness, suicidal ideation and attempts (Ali et al., 2011; Ayub et al., 2009; Karmaliani et al., 2008; Rabbani, Qureshi, & Rizvi, 2008), and difficulties in making decisions (Ali, Mogren, & Krantz, 2011).

Research in social psychology shows that women give more importance to maintaining close relationships (Josephs, Markus, & Tafarodi, 1992). Women are more likely to keep balanced, conflict free relations with others, specifically with spouse and family (Whiffen, Foot, & Thompson, 2007). Moreover, in the process of maintaining a harmonious relationship, women engage in behaviors like suppressing or "silencing" their true feelings in case of conflict with their partner. This can maintain the relationship harmony but will have negative impact on the mental health of women (Whiffen et al., 2007). The construct of self-silencing was proposed to explain the link between marital dissatisfaction and its negative mental health outcomes (Jack, 1991). Recently researchers have identified that men also self-silence but the reason behind their self-silencing is different (Smolak, 2010). However, the focus of researchers has been on self-silencing of women (Remen, Chambless, & Rodebaugh, 2002). Women use self-silencing as a coping mechanism to deal with marital conflict which indirectly make them more vulnerable to negative mental health outcomes (Condylis, 2012; Whiffen et al., 2007). Individuals who are good in silencing themselves are also good in denying the severity of IPV because they are prone to censor their experiences

(Gilbert & Gordon, 2017). From early childhood girls in Pakistan are trained to remain quite in front of male members of the family, she is trained in such a way to mold herself in a self-sacrificing individual, who is happy to keep her husband and in laws happy (Hamid, Johansson, & Rubenson, 2010; Winkvist & Akhtar, 2000). Many married women choose to stay with an abusive partner for the sake of their children, financial support, fear of in-laws, stigmatization by the society, lack of emotional and moral support from friends and family, most importantly they wish that their spouse will change his attitude and behavior one day (Andersson et al., 2010; Niaz, 2004).

The direction between IPV leading towards negative impacts is not deterministic. According to Wretman, Rizo, Macy, Guo, and Ermentrout (2017), there are a number of factors which can affect the association between experience of IPV and its negative consequences. In the previous literature the coping efforts of the victims have specifically been shown to mitigate the impact of IPV on mental health and relationship functioning (Calvete, Corral, & Estevez, 2008; Krause, Kaltman, Goodman, & Dutton, 2008; Lee, Pomeroy, & Bohman, 2007). Current literature indicates that coping ability not only influences the negative impact of IPV but is also affected by the presence of IPV (Calvete et al., 2008; Clements & Sawhney, 2000; Kocot & Goodman, 2003). In the presence of social support and the coping ability of the victim, abuse is less likely to happen or its impact on individuals functioning can be minimized (Beeble, Bybee, Sullivan, & Adams, 2009; Goodman, Dutton, Vankos, & Weinfurt, 2005).

With the scarcity of researches in Pakistan that have thoroughly examined the impact of coercive control and the perception of married individuals regarding control in marital life and how it affects their individual and relational functioning, this study was aimed at exploring the coercive control experiences by married individuals and how it impacts their individual and relational functioning. In particular, this study will explore the roles of self-silencing and coping self-efficacy between the pathway of coercive control and its negative impact on mental health and marital quality, whether they will mitigate or enhance the negative impact of coercive control.

Coercive Control

The concept of coercive control was proposed by Stark (2007). He used the term of "women trapped within a cage" and explained the underlying concept of coercive control. According to him the bars of the cage were referred as a man's use of various tactics like using psychological suppression, use of intimidation, harassment, isolation, humiliation, exploitation, and the monitoring of his partner's daily life activities. Moreover, he said that regardless of physical violence being involved, most of the coercive controlling tactics are not considered as abuse. The previous studies indicate that the negative impact of abuse by intimate partner is more likely to affect women when abuse is used under the perspective of coercive control (Ansara & Hindin, 2010; Campbell et al., 2003; Johnson & Leone, 2005; Johnson, Leone, & Xu, 2014).

According to Stark (2007) the process of coercion as the deliberate use of threats or force to get the desired response and control is defined as depriving, exploiting and giving commands to obey indirectly by manipulating the partner's behavior. Manipulation of behavior is done by not taking the opinion of partner and taking away the access to all the support a partner need to think rationally or independently. Experiencing coercion and control at a time results in a situation of un-freedom or entrapment. According to him it is a gendered based phenomenon, which is specifically targeted towards women.

Kelly and Johnson (2008) defined control as a continuum. Exerting control to a certain limit on one's partner is a common phenomenon. According to Dunbar and Burgoon (2005) the role of displaying power to create fear, dominating or controlling one's partner has been considered a very significant aspect in all relationships, particularly intimate relationships where partners are depending on each other to achieve their goals. According to some researchers the traits of showing power, dominating, controlling or even manipulating ones partner are not fundamentally malicious (Buss, Gomes, Higgins, & Lauterbach, 1987) however, they can cause negative impact when the goals of two partners clash (Dunbar & Burgoon, 2005). For instance, it is seen that partners are likely to criticize, humiliate or ignore their spouse when they are not happy and satisfied with their marriage, more specifically when none of their wishes and desires are fulfilled (Aida & Falbo, 1991; Lindahl & Malik, 1999).

Coercion is defined as a method in which demand of fulfilling a certain task is linked with a credible negative effect if demands are not fulfilled (Dutton, Goodman, & Schmidt, 2005). They were of the view that demands of coercion are either direct or indirect verbal communication and expectations which should be fulfilled otherwise it end ups in undesirable consequences including physical violence, humiliation etc. It is mainly dependent on the context in which demands are taken as coercive and threatening. An example of this context dependent nature of coercive control was illustrated by Jasinski, Blumenstein, and Morgan (2014):

A male partner may report that his wife stops him from keeping contact with his friends and the wife does so because his husband friends are addicted to drugs however, the female partner may report that her husband stops her from meeting and interacting with friends so that she cannot tell anyone about the abuse done by her spouse. These both scenario comes under the domain of control but the two situations are totally different. A main factor to consider is that how much power is maintained by a partner to actually enforce his or her control (Dutton et al., 2005).

Types of Heterosexual Violence

Some of the groundbreaking research came from Johnson and his co-researchers (Johnson, 2005, 2006; Johnson & Ferraro, 2000; Kelly & Johnson, 2008). They classified heterosexual violence in four main typologies which are explained below:

Intimate terrorism or coercive control. In this type violence is enacted by taking general control of one's romantic partner. It is violence enacted in the service of taking general control over one's partner. Coercive controlling patterns are recognized by its embeddedness in a pattern of control which is general. The offender is involved in a number of acts that permit him to apply general control on his partner contrary to her will.

Violent resistance. In this type violence is enacted in opposition of intimate terrorism. However, it is not regarded as self-defense, but in some cases the key motive is to protect oneself from physical violence. Sometimes it functions mainly as an example of anger and resistance, even if the victim/resistor believes that it can in turn incite more violence from controlling partner. For some of the victims/resistors the chief objective to resist is retribution.

Situational couple violence. In this type violence is context or situation specific. Violence or conflicts arises that lead to arguments which when intensified, lead to acts of violence. This type of violence is not embedded in a general pattern of coercive control, however, it can be chronic and severe, even homicidal. On average, situational couple violence involves fewer and less severe incidents than intimate terrorism.

Mutual violent control. This type of violence is recognized in few incidents. It appears to involve mutual or combined patterns of coercive control, in effect a violent battle for control of the relationship (Kelly & Johnson, 2008).

According to Kelly and Johnson (2008) when distinctions are made on the basis of type of violence, the prevalence of coercive controlling violence in heterosexual relationships initiated by men is found to be 89-97%. Differentiating between the types of IPV also makes it easy to make distinction in the consequences of specific type of violence. According to Johnson, Leone, and Xu (2008) coercive controlling type of IPV occurs more regularly and is more harmful and distressing as compare to situational couple violence. The type of coercive controlling violence is linked with a number adverse impact for psychological health such as depression, PTSD, having low self-esteem, experiencing intense fear, and a feeling of losing one's identity (Johnson & Leone, 2005; Kelly & Johnson, 2008). According to number of researchers, coercive control is more likely to lead to other severe forms of violence and creating disturbance even after separation (Ansara & Hindin, 2010; Campbell et al., 2003; Johnson, 2008; Ornstein & Rickne, 2013).

According to Kelly and Johnson (2008) during the past years a lot of researches have highlighted the significance of studying coercive control in the context of IPV among men and women as its impact is equally damaging as physical violence. Results of various studies have shown that a coercive controlling pattern of abuse can lead to or increase the chances of other severe form of violence such a physical violence in relationships (Antai, 2011; Robertson & Murachver, 2011; Tanha, Beck, Figueredo, & Raghavan, 2010; Tjaden & Thoennes, 2000).

Theories Explaining Use of Coercive Control

Social power theory. Social power according to Raven (2008) is defined as the ability to influence the other person by changing their views or behavior. Social power theory given by French and Raven (1959) is most widely used model by modern day researchers. This theory is quite popular among researchers to explain social influence in sexual interactions, acts of sexual harassment, in work settings, conflict in relationships, religion, schools, and family relationships (Blanton & Vandergriff-Avery, 2001; Gabel, 2011; Nag, Nongmaithem, & Tripathi, 2008; Otto-Salah et al., 2008; Popovich & Warren, 2010; Raven, 1999; Saam, 2007; Schwarzwald & Koslowsky, 1999). Dutton et al. (2005) also used this theory which helped them in understanding the framework of coercive control. It has been observed in the literature that a conceptual understanding of what exactly coercive control is missing. Although, the elements of model of social power can be used to provide most probable explanations for why the controlling acts becomes coercive. Following are the components of model of social power.

Motivation to influence. The first component of model of social power refers to the desires of the agent whether intentional or unintentional to influence the target (Raven, 1993). There are various motivations behind using coercive control which include satisfying a psychopathic desire to harm, an internal desire of exerting power, to get sexual access and impose control on women as learned from their families, to dominate in the relationship and to harm the other partner due to selfishness (Hines & Malley-Morrison, 2012: Miller, 2001).

Power strategies. It involve the assessment by the agent to see the availability of power bases. The proponents of theory of social power state that using power puts the agent in a position to specify the most effective tactics relying on the information he/she has about the target including their opinions, attitude or feelings. Because of personal nature of intimate relations the person have access to the information of daily lives of their partner such as their feelings, beliefs, records of hospitals, bank account records, job related information, friends, and relatives (Stark, 2007). Which enables the abuser to identify the most efficient ways to exert control and power.

Preparation strategies. It includes the behaviors or actions of agents which they display to increase the likelihood of influencing their partner. A number of

strategies are used which are named as planning and setting the stage, improving bases of power, making the target vulnerable and use of surveillance. Preparation strategies include a number of examples like involving the target in intimate relationships, use of threats, repeatedly making the target realize that the agent can punish or reward them, producing feeling of shame or inducing a perception of obligation and monitoring the target.

Choice of mode. According to Raven (1993) it refers to the acts and behaviors that includes the precise actions which the agent takes in order to exercise power on the target. To exert power the situation is kept in mind and then agent selects the suitable behavior. These behaviors include using direct verbal communication, using physical contact or force, withdrawing communication (i.e., verbal & physical), use of punishment and reward for target. The selection of mode is basically dependent on the base of power which is used and the preparation strategies which are applied.

Effects. According to Raven (1993) the strategies applied by the agent can result in either success or failure. The effectiveness is evaluated by the agent by assessing the rate of compliance in target, which means that whether the target changed her behavior or she showed resistance in changing her behavior after the influence attempt. The psychological and emotional responses are also monitored by the agent to see how the target is responding and it also determine the success and failure rate.

Gender theory. The framework of theory of gender is based on feminist approach although, it still has its own specific theoretical perspective (Connell, 2009). As it is associate with IPV in studies, the theory of gender can be used to further explain the underlying role of gender in coercive control.

Coercive control as gendered. According to DeKeseredy and Schwartz (2011) the feminist theorists suggests that it is initiated at small level, societies having influential people, differences in power and patriarchy. The supporters of feminist approach have long been arguing with researchers of family violence regarding the gendered dimensions of abuse. According to family violence perspective, gender symmetry exist in intimate partner violence (Fergusson, Horwood, & Ritter, 2005). However according to feminist perspective role of gender is specified when particular type of violence is identified (Johnson, 2011). Previous studies shows that when violence is specified on the basis of its type, situational couple violence showed almost

same rates of execution in men and women. However, for coercive controlling violence it is seen that the rate of perpetration is not similar for both genders and men are found to be the primary perpetrators (Kelly & Johnson, 2008). Proponents of feminist viewpoint have identified the need to explore the gender specific nature of coercive control, not because high perpetration rates are found for men due to the fact that men have an innate need to exert control and maintain their authority (Johnson, 2011; Stark, 2007).

According to Próspero and Kim (2009) literature on IPV and use of psychological abuse indicates that men who have traditional viewpoints of regarding gender are more likely to indulge in various forms of violence. Stark (2007) is of the viewpoint and has argued that coercive control is a purely gender specific phenomenon. The reason behind endorsing this viewpoint is that coercive control involves the micro-regulation of daily life activities and stereotypical women roles including women way of dressing, cooking, cleaning, socializing and caring for children. A possible explanation of usage of coercive control is the presence of symbolic relations and the values or meanings which are attached to both genders socially.

Impact of Coercive Control on Individual and Relational Functioning

It is a well-documented fact in the previous literature that coercive control and psychological abuse is equally damaging for the individual experiencing it, as the trauma of physical abuse (Litrownik, Newton, Hunter, English, & Everson, 2003). The process of coercive control is long term and it has implications on the physical, psychological and economic well-being of the victim (Johnson, 2008). According to Pence and Paymer (1993) coercive control is exerted by the abuser by using various tactics including using threats, isolating the victim, intimidating the victim, limiting access to financial and social resources (Dutton et al., 2005). A number of researches have been conducted indicating the negative impact of coercive control and how it impacts the daily life functioning. The negative consequences of coercive control effect the individual and relational functioning of married individuals. In the past literature researchers have highlighted negative impact on the mental and physical health. The non-physical injuries or symptoms reported as a result of coercive control in literature includes depression, anxiety, PTSD, self-harm, eating disorders, sleep disturbance, para-suicidal activity, low self-esteem, low self-confidence, erosion of social skills, and

a lack of confidence in own perceptions, thought processes, hypertension, gastrointestinal problems (Anderson, 2002; Dillon, Hussain, Johnson & Leone, 2005; Dutton et al., 2005; Kirkwood, 1993; Williamson, 2010). Moreover, those women who experience coercive control alone are more likely to report depression and PTSD after three years of trauma as compare to those women who experience coercive control with physical violence indicating that exposure to coercive control provided less chances of recovering from the negative impacts (Blasco-Ros, Sánchez-Lorente, & Martinez, 2010). According to Dutton, Goodman, and Bennett (1999) the negative mental health consequences of violence are independently related to coercive control. Crossman, Hardesty, and Raffaelli (2016) revealed that women experiencing non-violent coercive control use more coping strategies, risk, harassment, and perceived threat than mothers with no violence or no control. Coercive control was found to be negatively related to mental health of women (Mazher, 2017).

Coercive control is also found to have profound negative impact on the relational functioning of married individuals. According to Stark (2007) presence of coercive control in a relationship is an indicator of severe violence which can cause the death of the victim, because many victims of homicide do not have a record of physical violence but they experience extreme forms of coercive control. Victim of coercive control is also likely to experience feeling of isolation as the abusive partner will keep the victim away from family, relatives, and friends so that no close relationships are available to get help in case of emergency (Kelly & Johnson, 2008). Studies have shown that in distressed relationships where there is husband-to-wife violence, there are fewer benefits of the relationship than in happy non-violent relationships. (Langhinrichsen-Rohling et al., 1998). Violence in marital relationship leads to depression, drug and alcohol problems, and women are more likely to take time off from their work and use more mental health and criminal's justice services (Anderson, 2002; Ehrensaft, Moffitt, & Caspi, 2006; Tjaden & Thoennes, 2000). Women experiencing IPV show lower level of marital quality and higher level of distress by their first anniversary and IPV negatively impacts their marital functioning and psychological well-being (Schumacher & Leonard 2005; Testa & Leonard, 2001). Any kind of marital distress has associations with psychological distress (Proulx et al., 2007). Marital dissatisfaction predict the onset of psychopathology, including mood, anxiety, and substance use disorders (Whisman & Baucom, 2012). Depression is the most widely studied problem associated with marital discord (Beach, Fincham, & Katz, 1998; Fincham & Beach, 1999).

Relationship with children is also affected as a result of IPV between the partners, parents become less sensitive towards their children, less engaged, less positive communication between parent and child and adopt strict parenting styles (Carlson, 2009; Casanueva, Martin, Runyan, Barth, & Bradley, 2008; Gustafsson, Coffman, & Cox, 2015; Levendosky & Graham-Bermann, 2001). According to Stith et al., (2008) a significant and negative relationship exist between marital quality and IPV but he argued that, it is not possible to know whether low marital quality leads to IPV, or whether low quality results from experiencing IPV. It has been found that marital dysfunction increases as increase in partner aggressiveness (Lawrence & Bradbury, 2001). It is found in literature that women are more prone than men to go through severe and coercive forms of IPV including sexual coercion, coercive control and physical violence in married life (Swan, Gambone, Caldwell, Sullivan, & Snow, 2008). A number of researchers have found that presence of any form of IPV whether physical, psychological, or controlling behaviors in marital relationships is negatively related to the marital quality of the victim (Ahmed, 2017; Mazher, 2017; Razera, Mosmann & Falcke, 2016). Presence of IPV not only effects the person experiencing it but other family members for example children are also affected by it. Fathers who use coercive controlling violence do not allow children to spend time with mothers and grandparents, visiting other children houses and engaging in extra-curricular activities which makes the child isolated, disempowering and constrained worlds which could hamper children resilience, development and contribute to emotional/behavioral problems. Mazher (2017) conducted a study and found that presence of children was positively associated with coercive control.

Factors Affecting Coercive Control

Many researchers have highlighted the role of gender and how coercive control and other forms of violence are exerted by both gender. However, a general perception about IPV is that it is highly gendered and men are the primary perpetrators (Murphy, 2009; Stark, 2007). In a study conducted by Myhill (2015) it was found that prevalence of situational violence was fairly symmetrical in both male and female but coercive controlling abuse was highly gendered, with women overwhelmingly the victims. Various forms of IPV including coercive control, psychological abuse, sexual assault, intimidation, coercion, threats, and severe physical violence are found to be perpetrated by men against women (Conroy, 2016; Tanha et al., 2010). On the other hand a study

found use of coercive control was similar in men and women, however the tactics used by both gender are different (Robertson & Murachver, 2011). A number of researchers has highlighted that having low education, being housewife, and infertility in women are the risk factors for IPV (Brownridge, 2006; Geffner, Jaffe, & Sudermann, 2000; Graham-Bermann & Edleson, 2010; Vatnar & Bjorkly, 2010).

Some researchers have also highlighted that IPV is more prevalent in younger ages and the rate of victimization decreases as age increases (Capaldi, Knoble, Shirtt, & Kim, 2012; Catalano, 2012; Truman, 2011; Truman & Langton, 2015). Lower age at the time of marriage is also considered a risk factor of IPV and women of old age are less likely to experience any form of abuse (Ahmadi et al., 2017; Abramsky et al., 2010; Arefi, 2003; Narimani & Aghamohammadian-Sherbaaf, 2005). Coercive control is also found to be affected by the employment status of women. It is found in literature that employment of women reduces the risk of violence (Farmer & Tiefenthaler, 2004b; Villarreal, 2007). However, literature also shows contrary results in which presence of an abusive partner is linked with increase violence, job insecurity, taking frequent holidays from work, and low performance at work (Brush, 2002; Moe & Bell, 2004; Swanberg & Logan, 2005; Taylor & Smith Barusch, 2004). Similarly a study conducted by Watson (2010) on a sample of Latin women found that low socio economic status was a risk factor to increase the vulnerability to IPV A study conducted by Westmarland and Kelly (2013) highlighted the effects of coercive control. The study highlighted that these constraints on their agency and voice often contribute to a profound disempowerment, loss of self and loss of confidence in victims.

Reporting of coercive control is not so common because it is an ongoing process. Most of the time the victim is unaware that he/she is experiencing coercive control because it occurs in the daily life settings and there is no proof of abuse. However, during past few years researchers have highlighted that non-physical abuse (i.e., coercive control) is equally damaging for the individual and relational function of the person experiencing it. In the literature a lot of adverse effects on individual functioning has been reported however, in the current study negative impact of coercive control on mental health will be studied.

Mental Health

The absence of any kind of mental illness like depression or anxiety is referred to as mental health. Mental health has enormous beneficial consequences for individual functioning and for society, however mental illness is linked with only psychological perspective on lifespan development (Westerhof & Keyes, 2010). Westerhof and Keyes (2010) highlighted the importance of exploring the developmental outcomes in mental health apart from pathological outcomes by incorporating the study of optimal mental health.

According to Keyes (2002), mental health is defined as a syndrome of symptoms of positive feelings and positive functioning in life. A combination of emotional, psychological and social well-being of an individual makes him mentally healthy. He differentiates "flourishing" as a condition in which a person combine a high level of subjective well-being with an optimal level of psychological and social functioning. He explains "languishing" to a condition where low levels of subjective well-being are combined with low levels of psychological and social wellbeing. Those individuals who are neither in languishing state nor in flourishing state are thought to have moderate mental health.

According to World Health Organization (2005) mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". The three main components of this definition are Wellbeing, Effective functioning of an individual, and Effective functioning for a community.

A new definition of mental health was proposed by Galderisi, Heinz, Kastrup, Beezhold, and Sartorius (2015) in an attempt to give an inclusive definition, avoiding as much as possible restrictive and culture-bound statements. According to them "Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent

important components of mental health which contribute, to varying degrees, to the state of internal equilibrium".

According to Street and Arias (2001) concept of mental health includes subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential.

Keyes (2006) identified three components of mental health including emotional, psychological, and social wellbeing. Emotional wellbeing includes happiness, interest in life, and satisfaction. Psychological wellbeing includes liking most parts of one's own personality, being good at managing the responsibilities of daily life, having good relationships with others, and being satisfied with one's own life. Social wellbeing refers to positive functioning and involves having something to contribute to society (social contribution), feeling part of a community (social integration), believing that society is becoming a better place for all people (social actualization), and that the way society works makes sense to them (social coherence).

Keyes (2002) developed a two continua model of mental health. He said that the no presence of pathology do not describe or imply mental health, and that the existence of mental health, or "flourishing" is measurable. By evaluating these linked yet conflicting constructs can give a more clear understanding of an individuals level of mental health. A number of empirical evidence have supported the model. Keyes tested his model on a number of population, college students were one of them. According to Jones, You, and Furlong (2011) the existing model of mental health based on typical psychological bases was not a sufficient measure of the full spectrum of human emotion. Keyes (2005) studied the relation between mental health and mental illness. This study provided strong support for the two continua model, a confirmatory factor model with two related factors proved to be superior to the single factor model. To assess mental health, it is best to view both the absence of mental illness as well as the presence of mental health. Findings consistently show that adults and adolescents who are diagnosed as anything less than in complete mental health (i.e., flourishing without mental illness) are functioning worse in terms of physical disease, healthcare utilization, work productivity, and psychosocial functioning (Keyes 2002, 2005, 2006). Interestingly, languishing individuals function as poorly on most outcomes as those

with a mental illness. Most importantly, level of mental health distinguishes level of functioning among adults with a mental illness, and not only among those who are free of a mental illness. Thus, individuals who are flourishing but have an episode of mental illness function better (e.g., fewer missed days of work) than those with moderate mental health, who in turn function better than individuals who are languishing and have an episode of mental illness.

Risk and Protective Factors

Those factors which increases the chances of poor mental health are referred as risk factors. It can include a variety of factors ranging from individual functioning to relational functioning of the person. As more and more risk factors are found in the surroundings, the probability to develop poor mental health or mental disorders increases. Abuse of any kind has been identified as particularly very toxic for mental health of an individual (Merikangas, Avenevoli, Costello, Koretz, & Kessler, 2009). A meta-analysis was conducted by Silva, Loureiro, and Cardoso (2016) to identify the risk factors of poor mental health. The findings indicated that being a women and getting married at young age was identified as a risk factor for developing mental disorder or poor mental health (Mundt et al., 2014). Another risk factor was having lower socioeconomic status or low income which can lead to poor mental health (Lam & Boey, 2005; Meyer, Castro, & Augilar, 2014). Lower levels of job satisfaction is also identified as a risk factor for lower mental health (Gruebner et al., 2012). Abuse of any kind in current relationship whether physical, psychological, economic, verbal, and coercion is regarded a very strong risk factor for developing poor mental health (Graham-Kevan & Archer, 2003; Golding, 1999; Kelly & Johnson, 2008). Negative live events like sexual or physical abuse in childhood is also identified as a risk factor for developing mental health issues in adulthood (Kelly et al., 2010). Non-availability of any kind of social and emotional support can also contribute in developing poor mental health (Caron, Latimer, & Tousignant, 2007; Kelly et al., 2010). Ali et al. (2009) carried out a study to determine the causes of depression in women which showed that factors like younger age at marriage, lack of autonomy in marriage decisions, marital rape, and domestic abuse by in-laws were contributing towards poor mental health. A study highlighted the factors which were significantly associated with IPV victimization in African population. It included poverty, use of alcohol, and physical and sexual torture experiences (Kinyanda et al., 2016).

Those factors which reduces the chances of poor mental well-being are referred as protective factors. It can comprise of the individual abilities including strengths and abilities and availability of resources to rely on in case of adverse situations. These protective factors range from individual abilities to finding support from other close relationships. Presence of more protective factors in an individual's life decreases the probability of developing poor mental health. According to Catteno and Goodman (2015) availability of protective factors makes it easy for a women to leave an abusive relationship and in this way her mental health is improved. According to Benishek and Lopez (1997) a number of factors exists which can protect the individual from developing any mental disorder or poor mental health. These factors include support from social group, optimistic thinking, positive attitude towards self and self-regard, appropriate cognitive appraisal strategies, having high self-esteem, use of coping. Researchers have identified that availability of social support and high quality of life is linked with lower incidences of IPV, better mental health, and lower chances of depression (Beeble et al., 2009; Fowler & Hill, 2004). A meta-analysis conducted by Coker et al. (2002) found out that presence of social support was the strongest protective factor against mental health issue and IPV. Less incidence of depression and anxiety were reported from women who had a source of social support present (Carlson, McNutt, Choi, & Ross, 2002). Folkman and Lazarus (1984) identified coping as protective factor against mental health problems and IPV. Use of coping strategies has been linked with better mental health outcomes in case of adversity (Lee et al., 2007; Mitchell et al., 2006). Stability in job and financial resources has also been identified as a protective factor in previous researches (Adams, Tolman, Bybee, Sullivan, & Kenndy, 2012).

Impact of Intimate Partner Violence on Mental Health

A number of studies have highlighted the mental health consequences of IPV. PTSD and Depression are the most commonly identified negative outcome of abuse in intimate relationships (Devries et al., 2013; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Nangolo & Peltzer, 2003; Rees et al., 2011; Wong, Huang, DiGangi, Thompson, & Smith, 2008). Studies conducted in Pakistani context showed that IPV had significant negative relation with psychological wellbeing, positive relation with depression and more mental health issues as compare to those women who do not

experience abuse (Ali, Mogren, & Krantz, 2013; Hassan & Malik, 2012; Mazher, 2017).

In samples of women with IPV high rates of mental disorders have been found, e.g., a mean prevalence estimate of 64% of PTSD and 48% major depression (Golding, 1999). Basile, Arias, Desai, and Thompson (2004) and Mechanic, Weaver and Resick (2008) found that different types of IPV (i.e., physical, psychological, & verbal violence) were associated with PTSD and depressive symptoms. Most research addressing mental health consequences of IPV focused on acts of physical violence (Madu, Ndom, & Ramashia, 2010; Mechanic et al., 2008). A study was conducted to assess the prevalence and health consequences of IPV among women in Karachi results of the study showed that 34% of women reported physical abuse, 15% reported being physically abused during pregnancy. 72% of women reported being anxious and depressed due to the violence they experienced (Fikree & Bhatti, 1999). According to Arias and Pape (1999) psychological abuse contribute significantly to PTSD. Presence of sexual violence shows mixed finding in predicting PTSD symptomatology (Basile et al., 2004; Mechanic et al., 2008).

Moreover, findings show that when stalking is present in IPV it can become a risk factor for more intense and severe forms of violence (McFarlane, Campbell, & Watson, 2002) and more chances of developing psychopathology (Norris, 2011). Just as physical injuries demand care and attention, it is important that the psychological and emotional wounds of abused individuals having long lasting effect on their mental health should be addressed. It has been reported that less interest is given to the non-physical type of abuse as compare to the visible forms of abuse, even after the major findings of researches which clearly shows that after statistically controlling for the effects of physical abuse, non-physical abuse has been associated with adverse mental health outcomes (Street & Arias, 2001). Women who experience abuse face problems like psychosocial/mental health issues including substance use, family and social problems, depression and anxiety. Musculoskeletal issues included degenerative joint disease, low back pain, trauma-related joint disorders, cervical pain, acute sprains and strains and women reproductive issues included menstrual disorders and vaginitis. It was also found that abused women were at a higher risk of being diagnosed with a sexually transmitted disease, acute respiratory tract infection gastroesophageal reflux

disease, chest pain, abdominal pain, urinary tract infections, headaches, and abrasions (Bonomi et al., 2009).

Baldry (2003) studied the relative contribution of psychological and physical abuse to the development of psychological symptoms in domestic violence cases. Psychological abuse was found to be a strong predictor of anxiety and depression, low self-esteem, and intrusion/ avoidance symptoms than physical abuse however, both types of abuse were correlating with each other significantly. Dillon et al., (2013) conducted a review of literature on the physical and mental health outcomes of IPV. The result of the literature review showed that the prevalence of IPV varied across cultures. However IPV was linked with a number of negative mental health outcomes, which included depression, PTSD, anxiety, self-harm, and sleep disorders. They also found IPV to be associated with poor physical health outcomes including poor functional health, somatic disorders, chronic disorders and chronic pain, gynecological problems, and increased risk of STIs. An increased risk of HIV was reported to be associated with a history of sexual abuse and violence.

Psychological abuse during pregnancy has been linked with adverse mental health, thoughts of harming oneself, and higher risk of postnatal depression (Tiwari et al., 2008). Researchers have also attempted to understand the epidemiology of IPV experienced by both men and women. The results indicated that child sexual abuse was associated with IPV among men, whereas child physical and sexual abuse was associated with IPV among women. The sex differences indicate that women experienced a wider range of poor mental health outcomes compared to men (Afifi et al., 2009). A meta-analysis was carried out by Beydoun, Beydoun, Kaufman, and Zonderman (2012) and results showed that women were 2-3 times more likely to develop major depressive disorder and 1-2 times more likely to develop elevated depressive symptoms and postpartum depression due to exposure to IPV as compare to non-exposed women. A study was conducted to estimate the prevalence of IPV, forms of domestic abuses faced by both genders and the psychological consequences of domestic abuse i.e. depression and anxiety which were associated with IPV. Results of the study showed 35% reported physical abuse, 52% reported psychological abuse and 30% reported sexual abuse. Among the sample 60% had depression and 67% had anxiety. Moderate and severe degrees of depression and anxiety were more common in female victims (Niaz, Hasan, & Tariq, 2002).

According to Cerulli, Talbot, Tang, and Chaudron (2011) mothers reporting IPV are more likely to be diagnosed with mood or anxiety diagnoses, specifically current depressive diagnoses, panic disorder, and there is a trend for more posttraumatic stress disorder (PTSD) among abused mothers. In a study conducted by Antai, Oke, Braithwaite, and Lopez (2014) the comparative effect of economic abuse and other forms of abuse in predicting depression and other mental health disorders was assessed. The result of the study showed that after controlling for sociodemographic confounders, positive association was revealed between economic, physical, or psychological abuse and suicide attempts and psychological distress. Psychological and economic abuse were the strongest predictors of suicide attempts and psychological distress, respectively. Economic abuse was also negatively associated with psychological distress.

Presence of abusive and controlling partner is likely to have adverse effect on the individual functioning as well as the relational functioning of the person experiencing it. If an individual is mentally disturbed due to his/her abusive partner it is also going to effect the marital quality and other relationships of the couple. Literature has identified many adverse effects of coercive control on relational functioning however, in the present study negative impact of coercive control on marital quality will be assessed.

Marital Quality

Marriage is regarded as an important type of personal relation which link individuals with each other. Marriage is considered as a common event in the lifespan of most men and women (Berscheid & Regan, 2005). Marriage is not limited to close personal relationships but it also a social institution which affects the life of people. Marriage is the basic requirement for the formation of family in terms of producing and raising children, as it officially allows sexual relationship and strengthen the bond between husband and wife (Ponzetti & Mutch, 2006; Stutzer, & Frey, 2006). Marital quality is one of the components of the relationship satisfaction, which means that it is basically a person's assessment of positive aspects that exist in the relationship (Arriaga, 2001; Haack & Falcke, 2014). Terminology such as "marital satisfaction," "marital happiness," or "marital adjustment" continues to be used interchangeably with "marital quality" (Andrade & Garcia, 2012; Graham, Diebels, & Barnow, 2011).

Marital quality is defined as a global evaluation of the marriage along several dimensions including positive and negative aspects of marriage including support and strain attitudes, reports of behaviors and interaction patterns, (Bradbury, Fincham, & Beach, 2000; Burman & Margolin, 1992; Fincham, Beach, & Kemp-Fincham, 1997; Slatcher, 2010).

Better marital quality is typically defined by high self-reported satisfaction with the relationship, predominantly positive attitudes toward one's partner, and low levels of hostile and negative behavior. Poor marital quality is characterized by low levels of satisfaction, predominantly negative attitudes toward one's partner, and high levels of hostile, and negative behavior (Robles, Slatcher, Trombello, & McGinn, 2014).

According to Villa and Prette (2013) marital quality in a broader sense consist of three main axes: interaction with the spouse i.e., whether each spouse is satisfied with the frequency of their interaction, the partner's emotional aspects which include whether each spouse is satisfied with the way the other deals with emotions and the practical aspects of marriage i.e., whether each of the spouses is satisfied with the way the other deals with personal organization, priorities, domestic rules, and problem-solving.

Quality of marital life is considered as an important aspect of family life, which play a significant role in the health and well-being of the couple and whole family. Quality of marriage is a mental state that depicts the apparent pros and cons of marriage to a specific person. If the costs of living in a marital relation are more, it will reduce the perceived marital quality, in the same way if the benefits of living in a marital relationship are more, it will increase the perceived marital quality (Shackelford & Buss, 2000). Sociologists refer to marital quality as a significant aspect of adult life. That is why quality of marriage is linked positively with mental as well as physical health of the person (Wickrama, Lorenz, Conger, & Elder 1997). A number of researchers have identified that maintaining and developing a good quality marriage is associated with a number of benefits for individuals i.e., leading to overall happiness, more well-being, less chances of depression, better self rated health and less physical illness (Beach et al., 2003; Hawkins & Booth, 2005; Proulx, Helms, & Buehler, 2007; Wickrama, et al., 1997; Williams, 2003).

People who are more satisfied with their romantic relationship commonly experience situations in other life contexts (work, group of friends etc.) more positively and satisfaction in the relationship is an important predictor of psychological well-being (Haack & Falcke, 2014). It has also been reported that the rate of happiness is higher in married individuals as compare to un-married people (Grandon, Myers, & Hattie, 2004). There is widespread agreement that marital quality is shorthand for the presence of "good" aspects of a marriage and the accompanying absence of "bad" aspects. However, there is less agreement on which aspects of a marriage are relevant exemplars of good and bad aspects (Bradbury et al., 2000). Marital quality is positively associated with subjective well-being, and this association is typically stronger among women than men (Bookwala, 2012; Jackson, Miller, Oka, & Henry, 2014; Proulx et al., 2007). Different levels of marital quality are found in men and women. Men are considered to be more satisfied as compare to women in their married life (Gagnon, Hersen, Kabacoff, & Van Hasselt, 1999; Shek & Tsang, 1993).

According to Loscocco and Walzer (2013) marriage and intimate relationships are more central to women's identities and more consequential for their overall well-being as compare to men. The reason behind this is typical roles of women i.e., nurturing roles such as spouse and parent, whereas their husbands specialize in paid employment outside the home. Women may feel responsible for resolving marital problems and ensuring that the couple maintains a good marriage for the sake of the children (Beach, Katz, Kim, & Brody, 2003; Davila, Karney, Hall, & Bradbury, 2003). Moreover, it is argued that traditionally women has been given low status and less power in married life as compare to men therefore, they have a greater emotional investment in maintaining a healthy relationship (Bulanda, 2011).

Factors Affecting Marital Quality

A major component of an individuals overall happiness is good marital quality which impacts positively on the well-being of the person. Similarly an unhappy marital relationship is likely to have negative impact on the well-being of the person (Ahmadi & Saadat, 2015). Keeping in mind the significance of marital quality, a number of researchers have studied the determinants or factors which affect the marital relationships (Amato, Johnson, Booth, & Rogers, 2003; Bulanda & Brown, 2007). It is found that various cultural and individual variations exists in literature regarding the

determinants of marital quality. Some factors which are considered as essential for maintaining marital quality in one couple may not be considered as essential by another couple (Zainah, Nasir, Hashim, & Yusof, 2012). A study highlighted various factors which contribute towards building stable and satisfied marital relationship, these factors included presences of love, intimacy, compatibility of personalities, mutual interests, good communication style, and having mutual understanding regarding sexual activities (Billingsley, Lim, Caron, Harris, & Canada, 2005).

Another study examined the risk factors in marital quality leading to separation, and found out that poor communication style, infidelity, financial issues, low education, and violence in marital relationship were the prominent risk factors for separation. (Hawkins, Willoughby, & Doherty, 2012). A study found out that gender, education, spouse choice, and marital duration are the most significant determinants of marital quality and highly educated men, those who select their life partner and those who are married for long duration have high levels of marital quality (Allendorf & Ghimire, 2013). A study showed that greater marital quality was related to better health, including lower risk of mortality and lower cardiovascular reactivity during marital conflict (Robles, Satcher, Trombello, & McGinn, 2014). A study conducted by Bayle, Ayalew, and Yimer (2017) highlighted the major socio-demographic factors that influence the marital quality. It showed that variables such as level of education, number of children, spousal infidelity, marriage type, leisure spending, interest difference, openness among couples, and poverty can bring statistically significant difference in marital quality.

Gender has been identified as an important factor in determining the marital quality of men and women. A number of studies show that generally women have low marital quality as compare to men (Amato, et al., 2003, Ng, Loy, Gudmunson, & Cheong, 2009; Pimentel 2000; Umberson, Williams, Powers, Chen, & Campbell, 2005, VanLaningham, Johnson, & Amato, 2001; Xu & Lai, 2004). According to Kurdek (2005) no major gender differences exist in marital quality of both men and women and men do not always report higher marital quality than women. Studies have indicated that women are expected to perform traditional gender roles in which they have to provide emotional support to husband and to make efforts for marinating marital relationship whereas husband do not have such responsibility. In this way women own martial quality is decreased in an effort to maintaining harmony in relationship (Ng et

al., 2009; Wilcox, & Nock, 2006). Muneer (2014) found out that husband marital quality was more significant than wife's marital quality to increase the overall couple's marital quality, when forgiveness, attachment, commitment, conflict handling and demographic variables were predictors. Alternatively wife's marital quality was more significant as compare to husband in increasing the overall couple's marital quality when, love, marital emotion, work or communication patterns were used as predictors.

Age has also been regarded as important factors in determining the quality of marital relationship (Jose & Alfons, 2007; Shakerian, 2008). Increase in age has been linked with poor marital quality in middle age (Teimourpour, Bidokhti, & Pourshahbaz, 2010) and people in older age experience less marital problems as compare to middle age people (Gorchoff, John, & Helson, 2008). Increase in duration of marriage is likely to increase the marital satisfaction (Duncan, 2008; Dush, Taylor, & Kroger, 2008; Zainah et al., 2012). Age at marriage is also an important factor for marital quality. According to Glenn, Uecker, and Love (2010) marrying at young age is linked with low marital satisfaction and increased risk of divorce is present. According to few researchers the age range of 18-30 years is considered suitable to get married and getting married before 18 years is considered as a risk factor for failure in marriage and less harmony in married life (Haghighizadeh, Kararmi, & Soltani, 2010; RezaeanLangeroodi, Azizinazhad, & Hashemi, 2011).

Financial resources and economic status have also been identified as important factors to determine the marital quality (Pepping & Halford, 2012; Shopiro, Gottman, & Carrere, 2000). It is highlighted in researches that insecurity of job and less monthly income are associated with poor marital quality for men (Zainah et al., 2012). According to Tavakol, Nikbakht, Bahboodi, Salehiniya, and Rezaei (2017) high monthly income couples experience more marital satisfactions as compare to low income couples. Economic stress has been linked with marital distress and low quality of marital relationship (Blekesaune, 2008; Gudmunson, Beutler, Israelsen, McCoy, & Hill, 2007; Kinnunen & Feldt, 2004).

Level of education has also been identified as a factor affecting marital quality. Few studies found out that high level of education is positively related to marital satisfaction (Pepping & Halford, 2012; Shakerain, 2010; Wagheiy, Miri, & Ghasemipour, 2009). According to Madanian and Mansor (2013), when both the

partners are well educated they are able to deal with daily life issues effectively due to realistic approach towards life as compare to less educated couples. On the other hand low level of education or illiteracy can be a risk factor for conflict in marriage (Jadiri, 2009). However, few studies have also identified no relationship between education level and marital satisfaction (Rahmani, Khoei, & Gholi, 2009).

Another important factor in determining marital quality is presence of children. Studies have found mixed finding regarding the positive and negative impact of children on quality of marriage. Some studies found that presence of children is positively related with marital quality (Marci et al., 2012; Reis, Xavier, Coelho, & Montenegro, 2013). Whereas, some studies found negative or no relationship between presence of children and marital quality (Allendorf & Ghimire, 2013; Ashraf, 2001; Jose & Alfons, 2007; Hirschberger, Srivastava, Marsh, Cowan, & Cowan, 2009). A study was carried out to assess whether doing job after marriage affects the marital adjustment and mental health of women. The study findings showed that there was no significant difference in marital adjustment and mental health of both the groups i.e. working and non-working married women (Khurshid, 2013).

As marriage is cohabitation of two individuals, their personality characteristics are also likely to affect the marital quality. Studies have found that personality trait like neuroticism has been frequently linked with poor marital quality (Shackelford, Besser, & Goetz, 2007; Shiota & Levenson, 2007). Personality traits like agreeableness, extroversion, openness, willingness to accept have been linked with good marital quality (Bradbury, Campbell, & Finchman, 1995; Rogge, Bradbury, Hahlweg, Engl, & Thurmaier, 2006). Attachment style has also been linked with marital quality. Iqbal (2013) conducted a study to explore adult attachment style and its association with marital satisfaction between Pakistani couples. Results showed that couples having anxious and avoidant attachment style reported less marital satisfaction. Conflict resolution, communication competence and social support were found to play significant role in enhancing the marital satisfaction.

Type of marriage is also an important factor in predicting marital quality. A study found a significant difference in the marital adjustment in arranged marriage and love marriage between couples when the demographic variables of duration of marriage and age were examined. However, no significant difference were found when gender,

education, occupation, socioeconomic status, and number of children were tested to determine difference among marital adjustment of couples having arranged or love marriage (Ashraf, 2001). Another study conducted by Arif and Fatima (2015) compared the marital satisfaction of men and women in different types of marriages. Results showed that both men and women had more marital satisfaction in arranged marriage and marriage of choice with parental acceptance as compare to individuals in marriage by choice without parental acceptance.

Any form of violence in an intimate relationship is linked with negative consequences for the couple and their quality of relationship. A number of researchers have highlighted the adverse consequences of IPV in marital relationship. Violent relationships have more detrimental impact on women's psychological and physical well-being, as compared to men (Hamberger, 2005). Williams and Frieze (2005) found that female experiencing intimate partner aggression shows significantly higher distress and lower marital quality. Similar finding was seen with college going girls who reported lower relationship quality because of IPV (Katz, Kuffel, & Coblentz, 2002). Male violence is a predictor of breakups and relationship dissatisfaction (DeMaris, 2000). Violence in marital relationship leads to depression, drug and alcohol problems, and women are more likely to take time off from their work and use more mental health and criminal's justice services (Anderson, 2002; Ehrensaft, Moffitt, & Caspi, 2006; Tjaden & Thoennes, 2000).

Women experiencing IPV show lower level of marital quality and higher level of distress by their first anniversary and IPV negatively impacts their marital functioning and psychological well-being (Schumacher & Leonard 2005; Testa & Leonard, 2001). Any kind of marital distress has associations with psychological distress (Proulx et al., 2007). Marital dissatisfaction predict the onset of psychopathology, including mood, anxiety, and substance use disorders (Whisman & Baucom, 2012). Depression is the most widely studied problem associated with marital discord (Beach, Fincham, & Katz, 1998; Fincham & Beach, 1999). According to Erci and Ergin (2005) marital quality is less in women experiencing insults, physical violence, fulfilling the wishes and demands of their husbands as compare to those who were not experiencing any such situation. Lower level of marital quality or marital strain is linked with decline in self-rated health. It was found that marital strain seems to have a cumulative effect on health over time (Umberson, Williams, Powers, Liu, &

Needham, 2006). A meta-analysis was carried out to investigate the link between martial satisfaction and IPV. Results showed that a significant and negative relationship exist between marital satisfaction and IPV. The data suggested that gender is an especially important moderator variable in understanding the relationship between marital satisfaction and IPV (Stith et al., 2008). A study was carried out to examine the association between IPV and relationship satisfaction, results of the study showed that aggression harms the quality of the intimate relationships of females much more as compare to quality of intimate relationships of males (Field, 2011). Psychological abuse has been found to be the most consistent negative predictor of marital quality (Panuzio & DiLillo, 2010; Razera et al., 2016).

Coercive control is likely to have negative impact on the individual and relational functioning of married individual. Past studies have highlighted that mental health and marital quality is highly affected by the presence of coercive control. However, the negative relationship between coercive control, mental health, and marital quality is not deterministic, there are some factors whose presence can help in reducing the adverse effects of coercive control. A number of factors have been identified in past literature but in present study self-silencing and coping self-efficacy will be studied.

Self-Silencing

Women are thought to give more importance to close relationships and this is consistent with social psychology research (Josephs et al., 1992). Keeping in mind this trait of women construct of silencing the self was introduced by Jack (1991). He was of the view that there is more motivation in women to maintain a conflict free, balance and healthy relationship with others, specially her husband and family. Moreover, in order to maintain balance in their married and family life, some women use such tactics which impacts their mental health negatively. Mostly women start hiding and silencing their true feelings and emotions, when the situation of conflict arise (Whiffen et al., 2007).

Self-silencing is defined as a tactic usually thought to be used by women to keep positive relations with others. This is done by taking special care for not expressing or discussing negative thoughts and emotions. Moreover, by not becoming a part of an activity or action that maybe upsetting for others. Some women even report of not expressing rather suppressing their thoughts, desires or wishes that they think will be

contrary with their husband's thoughts (Jack, 1991; Jack & Ali, 2010). In the context of interpersonal relationships self-silencing is regarded as loss of self (Jack, 1991; Jack & Dill, 1992).

Ross and Wade (2004) described self-silencing as an interpersonal schema that is defined by four core aspects that ultimately leads to disconnection of one's emotions over time: (1) emotional suppression, (2) externalized self-judgments, (3) insecure attachment to others due to denial of personal needs, and (4) a caring, nurturing, and yielding persona.

When self-silencing is placed in the context of romantic marital relations, it is expected to have major impact on the person who is trying hard to keep the relation. Women are more likely to self-silence themselves as compared to men as this construct is based on the values, norms, and ideal image of women i.e. how they are expected to act: unselfish, loving, approachable and pleasing (Jack & Ali, 2010). The mechanism of self-silencing is thought to act as a coping technique in order to deal with marital conflict, which makes the women more prone to poor mental health i.e., depression. (Whiffen et al., 2007).

This concept is based on the attachment theory and self-in-relation theory, it states that those individuals whose sense of self is relationally-based and who maintain their relations by self-scarifying ways are more prone to depression. The act of self-silencing is helpful in short-run as it is effective and allows women to avoid conflict, maintain relationships, and feel safe. However in the long-run women relying on the strategy of self-silencing start to lose their voice, their sense of self therefore, they start to feel ashamed of themselves because of the self-betrayal they experience (Jack & Ali, 2010). A number of personal and relation problems have been documented in the literature when self-silencing is used in intimate relationships. Girls and women who self-silence themselves reported the problems of anger suppression, decreased marital satisfaction, decreased feelings of mutuality in relationships, lower self-esteem, depression, body surveillance, self-objectification, eating disorders, self-alienation, premenstrual distress, poor adjustment in college settings, rejection sensitivity and loneliness (Ali & Toner, 2001; Besser, Flett, & Hewitt, 2010; Davis, Flett, & Besser, 2003; Frank & Thomas, 2003; Harper, Dickson, & Welsh, 2006; Harper & Welsch, 2007; Haemmerlie, Montgomery, Williams, &

Winborn, 2001; Mauthner, 2010; Morrison & Sheahan, 2009; Page, Steven, & Galvin, 1996; Piran & Cormier, 2005; Wechsler, Riggs, Stabb, Marshall, 2006; Whiffen et al., 2006; Zaitsoff, Geller, & Srikameswaran, 2002). Self-silencing has been shown to be associated with abusive relationships as well (Woods, 2010).

Researchers have suggested that the construct of self-silencing and its outcomes maybe different and difficult to explain for men as compared to women (Smolak & Munstertieger, 2002; Smolak, 2010). Previous studies have found gender acted as a moderator between self-silencing and depression (Lutz-Zois et al., 2013; Tippett, 2014). For men the act of self-silencing has been associated with attachment avoidance, means to control relationships, emotional restraint, desire to avoid intimacy and conflict, and situations that limit independence (Harper & Welsh, 2007; Remen et al., 2002). Whereas for women, the construct of self-silencing has been linked with cultural values, powerlessness, desire to maintain harmony and happiness, pleasing everyone or save face and anxious attachment (Dziedzic, 2014; Remen et al., 2002; Smolak, 2010).

It is quite common for women to resort to silence in order to avoid rejection, isolation or argumentation that they might have to face if they speak out (Thompson, Whiffen, & Aube, 2001). One possible psychological cause for silencing is shaming. Shame is a painful feeling of being flawed, inadequate, or worthless as a person and is often imposed through ridicule, criticism, control, judgment, rage, and power-over behaviors by significant others. Shaming, initially, may be caused by some external sources but it is something, which can become internalized over a period. Shaming is a powerful tool for subordinating, stopping people from expressing their actual feelings, and it leads to disconnection, isolation, and silencing of individuals (Hartling, Rosen, Walker, & Jordan, 2000). Miller (2006) suggested that when a woman's feelings and thoughts are deemed unacceptable in a relationship, it leads to a terrible sense of isolation. Women disconnect from their inner selves and their surrounding for protection or to make sure that they are safe from the thoughts that are unacceptable in the relationship or society (Briere, 2002; Jack, 1991; Jordan, 2003).

A study carried out on African American women showed that the need to "show strength" is associated with self-silencing over emotional problems in an abusive relationship and leads to forgiveness thus continuing to remain in abusive relationships (Beauboeuf-Lafontant, 2007; Wallace & Parks, 2004). A study was carried out with the

aim of identifying the factors that may play a role in making a women more forgiving the IPV in intimate relationships. The results of the study showed that commitment, specifically personal dedication and constraint commitment predicted forgiveness. Moreover, denial of injury mediated the relation between commitment and forgiveness, as women may be more likely to deny the severity of the abuse in order to reduce the experienced dissonance that arises from being committed to an unhealthy relationship. Finally, it was found that self-silencing was not a moderator in the relation between personal dedication and denial of injury (Gilbert & Gordon, 2017).

Personality traits also effect the process of self-silencing. A study was conducted to explore the relation between self-silencing and personality traits. Findings of the study showed that boys self-silenced more than girls. Self-silencing was found to correlate the most with conscientiousness subscale and neuroticism was negatively correlated with self-silencing (Sial, 2008). Besser et al. (2010) found that personality traits like dependency, self-criticism and perfectionism are all positively related with self-silencing.

The specific social-psychological setting under which IPV occurs is important to consider. Men usually use violence against women or threaten them with violence within the context of intimacy, coercion and intimidation and it is a powerful tool used to establish dominance over women and keeping them under control (Dobash, Dobash, Cavanaugh, & Lewis, 1998). Dobash and Dobash (1988) reported that men use violence against women "to silence them, to win arguments, to express dissatisfaction, to deter future behavior and to merely demonstrate dominance". In a society based on gender discrimination, women are encouraged and in some cases forced to remain silent against any discrimination because of which women find it more and more difficult to express their actual feelings. Use of violence by an intimate partner leads to a mental state in which a women is disconnected with her inner self and her surroundings (Pearlman & Courtois, 2005). According to Thompson, Whiffen, and Aube (2001) women who are in a relationship with a partner, who is intolerant and critical, are more likely to silence their thoughts and feelings. Study conducted by Woods (2010) on women's self-silencing within intimate relationships showed that women who had suffered abuse scored high on self-silencing.

Self-silencing might be another coping strategy used by many women faced with IPV. There is a possibility that those individuals who silence their self more, are likely to refute the intensity and severity of abuse. Because they are already trained to censor their thoughts and experiences. Silencing the self as a trait is found to be a predictor for increasing the likelihood of forgiveness in an abusive relationship (Gilbert & Gordon, 2017). Woods and Isenberg (2001) studied the methods of sustaining and maintaining intimate relationships as defined by the self-silencing. Results of the study showed that relationship between IPV and PTSD was partially mediated by self-silencing. This study revealed that women who spoke up more and were connected with their inner self, and with their surroundings, experienced less severe PTSD symptomatology as compared to women who had higher levels of self-silencing and were disconnected with self and surroundings. A study was carried out by Ali and Tonner (2001) to assess whether self-silencing is a pro-social behavior or not. Results of the study showed that self-silencing was a prosocial behavior. It was also found that those who score more on silencing the self scale try to avoid arguments and fights. Therefore, they face less problems in their personal relationships.

There is a clear correlation between self-silencing and depression in both women and men (Duarte & Thompson, 1999; Hart & Thompson, 1996). Cramer, Gallant, and Langlois (2005) reported that depression in female undergraduates was predicted by higher self-silencing, higher self-concealment, and lower self-esteem (depression in male undergraduates was predicted by higher self-silencing and self-concealment only). In a study conducted on female college students, self-silencing was found to be partially the reason behind attachment anxiety and disordered eating and fully mediated the association between attachment avoidance and disordered eating behaviors (Young, 2006). Self-silencing and submissiveness in women appears strongly related to early character adaptations to an emotionally unavailable mother and it leads to a lack of mutual, authentic relationships, an inability to follow personal career goals, and ultimately depression (Condylis, 2012). Besser et al., (2003) reported that there is a strong association between self-silencing and both depression and loneliness in men and women and that a high level of self-criticism was related to more self-silencing. Although, self-silencing is used as a strategy of self-protection and as a way to sustain relationships, it comes with a price. Women who use self-silencing will never get to experience how it feels to share their actual feelings and their opinions. They

cannot share their happiness and successes nor their sorrows and suffering. And they will not experience the acceptance and compassion that can accompany authenticity in relationship with self and others.

A study was conducted to explore the associations between marital dissatisfaction, depression symptoms, and perceptions of marital communication styles (i.e., self-silencing and the demand withdraw communication pattern). Results of the study showed that depression symptoms of men and women were correlated with self-silencing and wife-demand and husband-withdraw communication. Moreover, for women self-silencing acted as a mediator between the relationship of marital dissatisfaction and depression symptoms. This showed that marital dissatisfaction in women can lead to self-silencing in order to maintain the relationship. In the study men's self-silencing was not significantly correlated with their marital satisfaction, so mediation model could not be tested (Uebelacker, Courtnage, & Whisman, 2003). Zehra (2012) explored the relation between love styles, self-silencing and marital adjustment among married individuals and results showed a significant negative correlation between self-silencing and marital satisfaction. Marital satisfaction was used as a moderator between love styles and self-silencing. Moreover, women were found to be more prone to self-silencing.

Harper et al. (2006) conducted a study to examine the relationship between rejection sensitivity, self-silencing behaviors, and depressive symptomatology among adolescent dating couples. The findings of the study showed that dating adolescents who were sensitive to rejection reported more depressive symptomatology and higher levels of self-silencing behaviors within their romantic relationship compared to dating adolescents who were not so sensitive to rejection. Self-silencing was identified as a partial mediator of the association between rejection sensitivity and depressive symptomatology among dating adolescents. Harper and Welsh (2007) showed that high self-silencers reported conceding more to their partner during a conflict, poorer global communication within their romantic relationships, and greater experiences of depressive symptomatology. Partners of self-silencers reported more frustration and discomfort when interacting with the self-silencing member. Results of correlation analysis showed a significant negative correlation between self-silencing and relationship satisfaction among adolescent girls.

A study was carried out to examine the mediating role of self-silencing between marital conflict and depressive symptoms. The study findings indicated that both men and women who perceived their marriages as conflicted tended to hide their anger and pretended to go along with their partner's wishes. The silencing model appears to describe the development of both men's and women's depression in conflicted marriages (Whiffen et al., 2007). A study was conducted to check the gender differences in the construct validity of the silencing the self scale (STSS). Findings of the study showed that women on average scored higher than men on the externalized self-perception subscale, whereas men scored higher on the care as self-sacrifice subscale (Lutz-Zois et al., 2013).

Self-silencing is likely to be present when coercive control exist within an intimate relationship. Many people use it as one of the strategy to keep harmony in their marital life and to avoid humiliation from relatives and friends. However, previous literature has identified a number of other mechanism through which negative impact of coercive control is reduced. One of the mechanism is coping self-efficacy which will be studied in the present study.

Copping Self Efficacy

Intimate partner violence researchers have documented a plethora of negative outcomes of an abusive and violent intimate relationship. These outcomes include issues of mental health i.e., depression, anxiety, PTSD, phobias, disturbances in cognition, lower levels of self-esteem and thoughts of suicide (Black et al., 2011; Briere & Jordan, 2004; Hien & Ruglass, 2009; Macy, Ferron, & Crosby, 2009). Luckily the relationship between intimate partner violence and its adverse impacts is not deterministic. There are a number of variables which can affect the path of IPV and its negative outcomes. To provide protection against the negative outcomes of IPV, a coping mechanism should be used which can mitigate the negative effects for the well-being of the survivor (Mengo, Small, & Black, 2017; Rizo, Givens, & Lombardi, 2017).

Folkman and Lazarus (1984) explained coping within IPV as a mediator, which tries to mediate the negative impact of IPV with the aim of reducing the psychological stress caused by it. According to Mohino, Kirchner, and Forns (2004) coping is defined as efforts which are individual, context dependent and social in nature, and people adopt these as a mean to fulfill the demands of situations which are perceived as stressful

psychologically. Coping strategies are defined as an individuals cognitive and behavioral efforts for managing, minimizing, reducing, mastering, or tolerating internal and external environmental expectations that are perceived as taxing or exceeding one's resources and have the potential to have a negative effect on one's well-being (Folkman & Lazarus, 1988). According to Sabina and Tindale (2008) coping is a process which can help in reducing the negative impact of stressors. According to Pollack (1988) the mental health researchers had given much importance to the construct of coping in the past years.

Forms of Coping

According to Rizo et al., (2017) one of the most commonly used categorization of coping is based on the stress and coping theory of Lazarus and Folkman's (1984). According to their categorization two forms of were, problem-focused or emotion-focused coping.

Problem-focused coping. It refers to efforts to deal with the problem by actively approaching and attempting to alter the stressful situation (e.g., problem-solving). This type of coping is action-oriented and works by eliminating or reducing the source of threat. This approach helps in dealing with the difficult situations and helps in attainment of goals which may be hindered by the stressor (Rubin, 2001).

Emotion-focused coping. It refers to cognitive and behavioral strategies aimed at ameliorating or managing the emotional response (i.e., distress) associated with the stressful situation (e.g., venting of emotions through crying or yelling, restructuring one's perception of the problem; Folkman and Lazarus 1984). Emotion-focused coping may include strategies like avoiding the stressor, reevaluating the stressor cognitively, or seeing the positive aspects of the stressful event (Mohino et al., 2004). This form of coping may be used in situations where the individual beliefs that nothing can be done by him to change the situation (Rubin, 2001).

Self-Efficacy

In relation with coping, another construct of self-efficacy is also discussed. Self-efficacy is defined as an individuals belief about his/her own abilities to fulfill a certain task. Self-efficacy beliefs determine how an individual thinks, motivate him/herself and behave (Bandura, 1994). Self-efficacy is an important component in shaping an

individuals cognitions, affect and motivation. If a person has high level of self-efficacy beliefs, he/she is more likely to get difficult goals for themselves and are more committed to attain those goals (Catalano, Berglund, Loncsak, & Hawkins, 2004).

The theory of social cognition states that domain specific beliefs of self-efficacy play an important role by acting as cognitive variables which helps in successful adjustment to negative life events. According to Sumer, Karanci, Bevument, and Gunes (2005) self-efficacy beliefs act as buffers in stressful life events because these thoughts are believed to enhance the motivation of an individual to use all the available resources in challenging situations. A higher sense of self-efficacy has been linked with higher levels of subjective well-being (McGregor & Little, 1998). Benight and Bandura (2004) used social cognitive theory to describe the role of self-efficacy beliefs in relation to trauma and coping. Self-efficacy beliefs are understood in terms of general self-efficacy (Luszczynska, Gutierrez-Dona, & Schwarzer, 2005), as well as domain-specific self-efficacy (Bandura, 1986). In current study, focus is on coping self-efficacy beliefs, because domain specific beliefs play a crucial role in adjustment to stressful life events (Bandura, 1991). Beliefs of self-efficacy covers a variety of domains, and one of the domain is coping. Coping self-efficacy is thought to be influential regarding the outcomes of interventions designed to improve coping.

According to Chesney, Neilands, Chambers, Taylor, & Folkman (2006) the beliefs of coping self-efficacy do not represent general disposition, in other words it means that if a person has high level of efficacy in one domain, it does not necessitate high levels of efficacy in another domain. Coping efficacy is basically a part of broader construct of self-efficacy and this aspect of self-efficacy is concerned with the self-regulation of emotional states during the stressful events (Bandura, 1997).

The belief that one has the ability to face stressful and challenging life events is referred as coping efficacy (Bandura, 1997) or coping self-efficacy (Chesney et al., 2006). Coping self-efficacy is referred as what a person feels he can do in stressful event and how much control he feels he has on the situation, which in turn has impact on coping process (Chesney et al., 2006). According to Lusszczynska, Benight, and Ceislak (2009) coping self-efficacy is defined as an individuals perceived ability to efficiently deal with the demands of recovery in the post trauma phase.

Impact of Coping Self-Efficacy on Individual and Relational Functioning

Coping self-efficacy beliefs, or the ability to meet the requirements of coping with traumatic life events, are thought to be of prime importance for the human response to traumatic experiences (Benight & Bandura, 2004) and provide a construct for understanding the impact of resilience in the context of trauma as well (Benight & Cieslak, 2011). Coping self-efficacy has been found to have positive impact on the short and long term stress levels which an individual faces by exposure to a number of traumatic events such as natural disasters, terrorism attacks, accidents and domestic violence (Bosmans, Hofland, Jong, & Loey, 2015).

Research is still limited, however there are some empirical evidences which showed that coping self-efficacy is related to positive psychological functioning. A study conducted by Pisanti Lombardo, Lucidi, Lazzari, and Bertini (2007) found that strong perceptions of coping self-efficacy leads to more proactive and continuous efforts by the individual. This study also found that coping self-efficacy can exert a direct and an indirect impact on the emotional well-being of that person. According to Bandura (1997) the level of efficacy beliefs in a person can determine how much effort that person can put while dealing with difficult or stressful events. Studies have shown that high levels of coping self-efficacy is related to better psychological adjustment after facing a stressful event (Pisanti et al., 2007).

The relationship between coping self-efficacy and psychological distress has been well documented, although, the focus has more often been on the role of coping self-efficacy in predicting mental health outcomes (Benight, Swift, Sanger, Smith, & Zeppelin, 1999; Maciejewski, Prigerson, & Mazure, 2000). In spite of the plethora of research involving self-efficacy, little research has examined its role in mediating the relationship between PTSD and associated health behaviors. Coping self-efficacy has emerged as a focal mediator of posttraumatic recovery (Benight & Bandura, 2004). Thus, coping self-efficacy may offer a potentially powerful and modifiable explanation for linking the negative psychological sequelae of violence, especially PTSD, to health behaviors.

Coping self-efficacy has an effect on the stressfulness of traumatic events in three ways. First, coping self-efficacy perceptions have an effect on the extent to which an event is thought of as threatening, as a result of the perceived balance between coping

abilities, coping demands, and the potential harmfulness of the event (Bandura, 1997). Second, coping self-efficacy perceptions may also affect the level of motivation to use coping strategies because of its influence on the expected outcome of behavior (Bandura, Taylor, Williams, Mefford, & Barchas, 1985). And third, coping self-efficacy affects the extent to which (initial) PTSD symptoms are perceived as stressful; it determines the perception of control over disturbing thoughts and emotions (Kent & Gibbons, 1987). Coping self-efficacy can also be seen as a very important step in Lazarus and Folkman's transactional model of stress and coping (Lazarus & Folkman, 1984): it determines secondary appraisal (evaluation of coping options) and thereby the actual coping efforts employed, since the only viable coping options are those that the individual thinks he is capable of. Previous studies have shown that coping self-efficacy has a positive effect on the use of effective coping strategies (Benight et al., 1999).

Coping Self-Efficacy in Intimate Partner Violence

Coping is one of the most frequently linked concept with the individuals experiencing IPV (Arriaga & Capezza, 2005; Macy, 2007). The increased interest in exploring various coping strategies is due to the findings of studies which indicated that use of coping strategies can mediate the impact of IPV on the victim (Arias & Pape, 1999; Dempsey, 2002; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). The research related to trauma has been linked with the coping self-efficacy, which is an individuals perceived capability to deal with demands of recovery after experiencing any trauma (Mengo et al., 2017). A number of studies had indicated that coping is an essential component in understanding the relationship between mental health and IPV (Calvete et al., 2008; Krause et al., 2008; Lee et al., 2007). In a meta-analysis conducted by Rizo et al., (2017), it was found that generally higher levels of psychological distress is present when coping strategies such as emotion-focused coping, disengaged, and avoidant coping are used. When more strategies of emotion-focused coping is used to deal with stress as compare to problem focused coping, it results in higher levels of PTSD symptoms (Arias & Pape, 1999). Moreover, emotion-focused coping was found to act as a moderator in the relationship between IPV and PTSD (Lilly & Graham-Bermann, 2010). Researchers have documented the impacts of another type of coping i.e., disengaged coping which is found to result in increased PTSD symptoms, more severe depression, anxiety, hopelessness and lower levels of self-esteem (Flicker, Cerulli, Swogger, & Talbot, 2012; Kemp Green, Hovanitz, & Rawlings, 1995; Lewis

et al., 2006; Taft, Resick, Panuzio, Vogt & Mechanic, 2007a). Avoidance coping was found to act as a mediator in the association between trauma-related guilt and PTSD, such that guilt of trauma related event leads to use of avoidance coping strategies which results in higher levels pf PTSD symptoms (Street, Gibson, & Holohan, 2005). Passive coping was also found to act as a mediator in the relationship between IPV and psychological outcomes i.e., depression and PTSD, such that the higher intensity of IPV results in frequent use of avoidance coping strategies which results in negative mental health (Lee et al., 2007). Mixed findings were found in the literature regarding the use of active coping and its mental health outcomes (Rizo et al., 2017). Repeated use of engagement coping style was found to be a predictor of less hopelessness and lower levels of anxiety (Taft et al., 2007a). Contrarily repeated use of problem-focused coping was found to result in higher levels of depression and PTSD (Kocot & Goodman, 2003).

Presence of coping self-efficacy is a strong predictor of lower levels of PTSD even after 10 years of the event (Benight & Harper, 2002; Bosmans, Benight, Knaap, Winkel, & van der Velden, 2013). Coping self-efficacy acts as a mediator in the relationship between experience of trauma and its negative impact (Cieslak, Benight, & Lehman, 2008; Waldrop & Resick, 2004). Waldrop and Resick (2004) noticed that although, IPV usually results in poor mental health, many women are able to survive IPV with limited to no negative mental health consequences. A research studying the effect of both, individual and dyadic coping styles, in relation to stress on verbal aggression found that coping styles had a high effect on bringing moderation in the relationship between stress and incidences of verbal aggression (Bodenmann, Meuwly, Bradbury, Gmelch, & Ledermann, 2010). The past literature on coping with IPV indicate that coping abilities not only effect the victim, but coping resources itself are affected by the presence of IPV (Calvete et al., 2008; Clements & Sawhney, 2000; Krause et al., 2008; Kocot & Goodman, 2003; Lee et al., 2007).

Coping variables including spiritual well-being and social support have been found to mediate the link between IPV and depressive symptoms and stressful parenting (Mitchell et al., 2006). Effective coping styles comprising of problem-focused and positive emotional-focused strategies had been linked with more marital satisfaction and psychological well-being, and less psychological distress. The negative emotional-focused coping style as an ineffective strategy had negative relationship with marital

satisfaction and psychological well-being, and positive relation with psychological distress (Besharat, Tashk, & Rezazadeh, 2006).

Ting (2010) conducted a study and found that strategies like beliefs in spirituality, a future orientation, a sense of self-efficacy, accepting abuse as normal; refuting the severity of abuse; avoidant behaviors and thoughts were used by African survivors of IPV. Kanagaratnam et al., 2012 found out that perceptions regarding coping with IPV are influenced by sociocultural context, gender-role expectations from the community and women reported more use of passive modes of coping. A study was conducted to see the moderating effect of domestic violence coping self-efficacy between the relationship of recent partner violence and PTSD. Results of the study showed that partner violence was significantly associated with current PTSD symptoms, and this relationship was moderated by domestic violence coping self-efficacy. These findings highlighted the importance of assessing domestic violence coping self-efficacy in incarcerated women with recent IPV, given that domestic violence coping self-efficacy appeared to be protective against symptoms of PTSD (DeCou, Lynch, Cole, & Kaplan, 2015).

A study was conducted to examine the psychological well-being of women who report abuse to police-departments. Results showed that women who had high social support reported more mental health symptoms. Coping strategies were found to mediate the relationship between IPV and mental health symptoms. The findings suggested that availability of coping resources may help in mitigating repeated IPV and modify the impact of mental health (Mengo et al., 2017). Torres (2017) conducted a study and found that regardless of type of IPV, high amount of IPV and use of disengaged coping type were the strongest predictors of PTSD.

Mazher (2017) conducted a study and found that coercive control was negatively related to coping self-efficacy and mental health was positively related to coping self-efficacy. Mediating role of coping self-efficacy was also seen. Coping self-efficacy was found to mediate the negative relationship between coercive control and mental health.

RATIONALE AND RESEARCH DESIGN

Chapter II

RATIONALE OF THE STUDY AND RESEARCH DESIGN

Rationale of the Study

The present study aimed at having an in-depth knowledge of impacts of coercive control on individual and relational functioning of married men and women, and the role of self silencing and coping self-efficacy. IPV and its impact on women and children has long been the center of interest. However, researchers have mainly focused on physical form of IPV. Coercive Control has sparked great interest among domestic violence researchers lately but its impacts on primary victims needs a more clear explanation. The increased interest in coercive control is due to the fact that it may not always include physical form of violence i.e., it may be solely based on psychological form of violence. A number of studies have indicated that when violence is used in the context of coercive control, it can result in more severe consequences for women (Ansara & Hindin, 2010; Campbell et al., 2003; Johnson & Leone, 2005; Johnson et al., 2014).

Adjusting in a marital relationship can be challenging but adding the additional stressor of a controlling partner can significantly impact numerous areas of married individuals life, including mental and physical health, work, self-esteem, social and family relationships. Coercive control, as a severe form of psychological abuse and control, in many cases occurs alongside other forms of violence although, this may not always be the case. If a woman sees her husband as a stressor which impacts her self-identity, self-esteem and self-confidence, she may not be able to raise and give nurturance to her children and give the family best possible care.

Pakistan is predominantly a patriarchal society in which girls are taught from birth to follow and obey men (Niaz, 2004). Abuse and control against women by men mostly occurs within the framework of intimacy, coercion, and intimidation. Exerting control or abusing women is considered a strong source of subordinating women and keeping a social control on them. A society structured along gender lines, with its unequal distribution of power in relationships, promotes self-silencing, which in turn leads to discrepancy between women's original thoughts and feelings and what is shown publically. In most Asian countries women often silence themselves in marital

relations rather than risk negative interpersonal outcomes such as isolation, rejection, conflict, or violence. From childhood, a girl is socialized to be silent, patient, and submissive, to become a selfless person who is pleased to keep her husband and her in-laws happy (Hamid et al., 2010; Winkvist & Akhtar, 2000). However, recent advancement in self-silencing researches have indicated that men also use self-silencing but the reasons and motives behind using it are difficult to identify as compared to women (Smolak & Munstertieger, 2002; Smolak, 2010). Self-silencing phenomenon has rarely been studied in men among Asian population. This gap in literature has restricted the studies to draw any empirical conclusion on use of self-silencing among men. It is yet to be known that whether this phenomenon is expressed by men as well and do they also use self-silencing in response to this experience.

Despite the potentially severe impact of coercive control, IPV studies mostly focus on the physical form of abuse rather than exploring the non-physical type of abuse in marriages. Abuse of such kind against women can have serious consequences on their emotional and physical health, and it can lead to social isolation and even result in job loss and severe consequences (Ellsberg, Jansen, Heise, Watts, Moreno, 2008; Watts & Zimmerman, 2002). However, the negative impact of coercive control on individual and relational functioning is not direct and researchers have identified that coping self-efficacy within an individual can act as source to reduce the adverse effects of abuse (Arias & Pape, 1999; Dempsey, 2002; Merrill et al., 2001). The usefulness of studying coping in the context of IPV to advance the field for making suitable prevention and intervention plans has been highlighted (Waldrop & Resick, 2004). A study conducted by Ahmed (2017) in Pakistani context identified the need for future researchers to conduct qualitative studies to get more in-depth understanding of the phenomenon of coercive control.

The current study is crucial to conduct in order to correctly assess the safety and consequences for women and children living with domestic violence, especially if there are no indicators of physical violence, sexual assault or other chargeable offences. This study is important to conduct in Pakistan because gender is structured by patriarchal and religious norms echoed in deep structural inequality. Together, these cultural factors create a subordinate position for women in both the household and society at large. IPV is a significant public health problem affecting the lives of men and women around the world. Most of the researches conducted in Pakistan haves been quantitative

and no attempt has been made to explore the perspectives of Pakistani population about coercive control, its definitions, and the processes through which it occurs. The definition of coercive control in other countries and cultures is being used in questionnaire surveys among Pakistani sample, with an assumption that this definition is understood by them. Therefore, instead of imposing the definition of coercive control from other cultures and contexts on to Pakistani people, it is needed to understand what their definition of coercive control is before further exploration of this construct. This indicates the need to conduct more qualitative phenomenological studies to understand the perceptions, subjective feelings, attitudes and experiences of coercive control by Pakistani population. This will help in developing culture specific measures of coercive control which will be used in quantitative studies to get more valid and reliable results using the indigenously developed scales. It can help the clinicians to include interventions for non-physical form of abuse. Moreover, it will create awareness in law making agencies towards the non-physical type of abuse which has more lasting effect on the identity of women.

Hypothesized Model

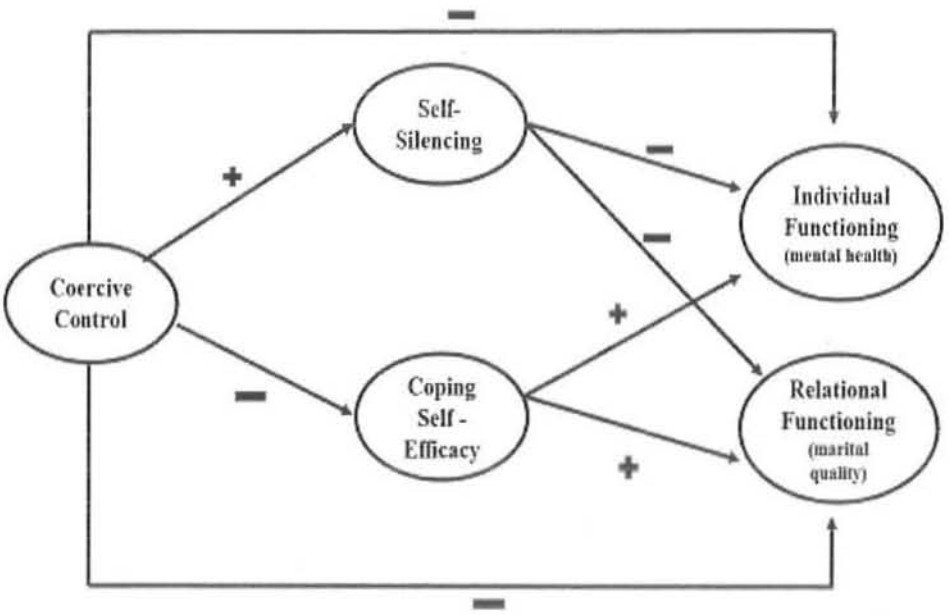

Figure 1: Hypothesized Model of Present Study

Research Design

Present research was based on sequential exploratory form of mix method research design. Exploratory sequential mixed method is a design in which an initial qualitative phase of data collection is followed by quantitative data collection phase to test or generalize the initial qualitative results (Creswell & Clark, 2011). Following were the objectives and design of respective studies.

Study I. It was based on the qualitative exploration of coercive control phenomenon in married individuals. Focus group discussions (FGDs) were conducted to get the perceptions of married individuals regarding controlling tactics and use of coercive control in daily life by their partners. FGD's were then analyzed through thematic analysis.

Objectives. The main objectives of the study I were:

1. To qualitatively explore the phenomenon of coercive control.
2. To get firsthand information regarding the use of controlling tactics used in daily life among married individuals.
3. To get experts review regarding the coercive control phenomenon to get more in depth information.

Study II. This study was based on a cross sectional correlational study. Survey method was used as a mode of data collection.

Study II consisted of following phases:

Phase I - Development of scale for measuring coercive control

Phase II - Pilot Study

Phase III - Main Study

Phase I: Development of scale for measuring coercive control. The main objective of the study was to explore the impact of coercive control on the individual and relational functioning of married individuals; role of self-silencing and coping self-efficacy. Moreover to get in-depth understanding of coercive control phenomenon. The cultural differences and the context dependent nature of this construct was the main reason behind studying it qualitatively. Based on the results of qualitative study, it was decided to develop an indigenous measure of coercive control.

Phase II: Pilot study. To check the psychometric properties and understanding of the scale developed along with other scales used in the study, a pilot study was carried out. For this purpose, a small sample of 60 married individuals participated in the study. They were asked to identify any difficulty regarding the content of the measures or the response options. Time consumed while filling the booklets by participants was noted.

Phase III: Main study. Main study was based on the hypothesis testing. Initial hypotheses were with relationships between variables, then mediation based hypotheses were checked, group differences were checked. Along hypotheses testing, all the objectives that were exploratory in nature were also addressed.

STUDY 1
QUALITATIVE STUDY

Chapter III

STUDY I

UNDERSTANDING OF COERCIVE CONTROL PHENOMENON IN PAKISTANI CONTEXT

This chapter comprise of the qualitative part of the study which was carried out to explore the coercive control phenomenon in Pakistani context. In previous years, a lot of importance has been given by researcher to understand and differentiate among types of intimate partner violence (Hardesty et al., 2015). However, according to Dutton et al., (2005) regardless of the efforts made still there is little understanding about the mechanism through which coercive control works. Due to the little understanding of coercive control in intimate relations and context dependent nature of this construct, qualitative research was important to conduct to get first hand views of the individuals experiencing it. Understanding the perspectives of individuals in our society is important for conceptualization of coercive control in Pakistani culture. Primary aim of this part of research was the collection and assessment of qualitative data, to better understand the construct of coercive control in context of Pakistani culture and to identify its various dimensions.

To explore the construct of coercive control, it was decided to conduct interviews from subject matter experts. Three in-depth interviews with experts in the field (i.e., marital counselors) were conducted. The aim behind conducting interviews with subject matter experts was to get professional knowledge regarding intimate partner violence and the use of coercive control or controlling tactics specifically in married life. Moreover how it effects the individual and relational functioning of the person experiencing it. Moreover, seven focus group discussions were carried out with married individuals. Focus group discussions as a tool for qualitative research has gained popularity in social sciences in previous years. A major hallmark of focus groups is their ability to explicitly use group interactions to produce data and understanding of the topic in discussion that would be not possible without a group interaction (Morgan, 1997). According to Holsman (2002) focus group discussion is a significant method of qualitative data collection as it helps in providing essential insights of the data which helps the researcher to get maximum information from the group by probing. For conducting focus group discussions sample of married individual was taken from

Islamabad and Rawalpindi. For conducting focus groups it is recommended to have 8 to 12 participants, the group size may vary depending on the sensitivity of the topic (Caroline-Tynan & Drayton, 1988). The group discussion revolved around a certain set of questions (see Appendix A) developed for this purpose by reviewing the literature.

Sample

To get in depth knowledge about the coercive control phenomenon and perceptions of married individual regarding control in married life, subject matter experts and married individuals were contacted separately. Following are the details of the sample

1. Interviews from subject matter experts were conducted individually, in order to get initial understanding of the construct. Two marital counselors and one researcher who has worked with the construct of coercive control was contacted for the detailed interview from Islamabad and Rawalpindi.

2. Married men and women (married for at least one year and having at least one kid) were contacted to get first hand views regarding the perception of coercive control or controlling tactics used by ones partner. Seven focus group discussions were conducted (i.e., three with married men and four with married women). Overall, 57 married individuals participated in the discussions. Each group consisted of at least 8 participants. Participants of focus group discussion had an age range of 34-50 years. Following are the details of participants in Table 1.

Table 1

Demographic Profile of Focus Group Participants (N = 57)

S.no	Place	Gender	Total	Ages	
				M	*S.D*
1	Accountant General Pakistan Revenues, Islamabad	Men	11	36.18	6.52
2	Fauji foundation office RWP	Men	7	40.71	9.97
3	The Work Bahria town RWP	Men	10	35.30	5.55
4	PWD	Women	8	47.00	10.17
5	G-7/2 Islamabad	Women	6	44.50	6.08
6	G-8/1	Women	7	50.71	8.44
7	Roots international PWD branch	Women	8	34.00	11.07

Note. *M* = Mean; *SD* = Standard Deviation.

Table 1 is representing the demographic profile of focus group discussion participants including age and gender. The participants included in focus group discussion were the residents of Islamabad and Rawalpindi.

Focus Group Guide

For the purpose of conducting focus group discussions (FGDs), a focus group guide was prepared. The guide for FGDs was developed after a thorough and detailed review of past literature. Based on the extensive review of literature, significant themes and elements were highlighted which helped in developing specific questions for focus group. It is important to develop the questions simple and clear with extra caution to the wording used which might influence the responses, avoid using evocative or judgmental wording (Turner, 2010). Questions were developed in a way so that they covered all the dimensions identified in the literature. During the development of focus group guide, it was kept in mind to cover all the relevant sub-topics. It was decided to keep the arrangement of questions from general to specific (see Appendix A).

Procedure

First of all in depth interviews with subject matter experts were conducted. All the ethical concerns were kept in mind while conducting the interviews. Before starting the interview the researcher did rapport building so that the interviewee feel relaxed and comfortable while sharing his/her views and experiences.

For conducting the FGDs, all participants who agreed to participate were briefed about the purpose of conducting the focus group discussion. In the whole process of focus group discussions ethical considerations were specially kept in mind. Participants were asked to sign a consent form in which they agreed about their voluntary participation, they were also given a demographic sheet to keep a record of their personal information. Permission was taken to record the focus group discussion, which was used later for transcribing the data. Each session took 55 minutes to 1 ½ hour approximately. The participants were told about their right to quit at any time they want. Focus group discussion were done to the point at which no new information was obtained from participants and redundancy was achieved, referred to as data saturation. Participants were guaranteed about confidentiality of their data. They were assured that their provided information will be utilized for research and it will not be misused.

Results

Qualitative interviews and focus group discussions were analyzed with the help of thematic analysis. According to Braun and Clarke (2006) thematic analysis is an independent qualitative descriptive method which is mainly used as a method of identifying, analyzing and reporting of patterns (themes) across data. It is a technique which uses minimal description to data sets, and interprets various aspects of the research topic (Braun & Clarke, 2006). Thematic analysis was carried out in a number of steps in which first of all familiarization with the data is done by transcribing it and reading it again and again. In the second step initial codes were generated by arranging the relevant data. In the third step themes were searched by organizing the initial codes into potential themes. In the fourth step themes were reviewed by checking whether the themes were relevant to the codes extracted and the entire data set. In the fifth step themes were defined and names were given. Extra caution was taken while transcribing the data so that no data is lost while transcribing. Focus group recordings were replayed several times in order to get meaningful data information and to arrange the data in

codes and themes. After transcribing the data the researcher went through the data over and over again with the aim of discovering emerging patterns, themes and sub-themes. This helped the researcher to categorize the data under different sections. Similar data was merged to reduce into meaningful codes. It was time taking process as the researcher has to go through the data again and again before the themes and sub-themes were finalized. The whole process of reading and rereading of data is known as "immersion" (Green et al., 2007). Following are the data driven themes and sub-themes.

Table 2

Main themes and Sub-Themes of Coercive Control in Intimate Relationships

S.no	Main Themes	Subthemes
1	Meaning of Control	1.1 No freedom to spouse
		1.2 Giving importance to his/her will
		1.3 Control on all kinds of decision making
		1.4 Making spouse's to obey by using various tactics
		1.5 Authority over spouse thoughts and behavior
		1.6 Inducing dependency in spouse
2	Tactics/ Ways of Controlling	2.1 Use of physical violence
		2.2 Conditional regard
		2.3 Restrictions on mobility
		2.4 Use of threats
		2.5 Use of children
		2.6 Control by cultivating self-worth
		2.7 Control on financial resources
		2.8 Monitoring/ surveillance
		2.9 Control on sexual activities
3	Reasons to Control	3.1 Religious interpretations
		3.2 Social cultural norms
		3.3 To maintain superiority
		3.4 Fear of losing power

Meaning of Control. First theme which emerged as result of thematic analysis of FGDs and expert interviews was meaning of control. This theme is basically explaining the understanding or perceptions of coercive control phenomenon in participants. Participants were asked about the general understanding of the term coercive control. Most of the participants took it as overall control of one spouse on other. Participants explained that control is giving no freedom to other spouse, not giving importance to the will of other spouse, control on decision making, making the spouse to obey orders or fulfill demands, maintain authority and inducing dependency. These sub-themes are explained below along with narratives of the participant which have been translated from Urdu to English.

No freedom to spouse. This sub-theme emerged from the focus group conducted. All the participants agreed that control is limiting the freedom of the spouse. Not allowing the spouse to do anything without his/her permission. One of the participants said "*Control is basically to do household work as I tell her, and give priority to my parents and family members. Do not meet those relatives whom I dislike*" (FGD1-P2).

Giving importance to his/her will. Another sub-theme which emerged was giving importance to his/her will. Most of the participants defined control as spouse being self-centered and wanting that only his/her will is followed. He/she is not concerned about the will of the other partner. Few participants said "*control is to keep in mind my likes and dislikes, give importance to my relatives*" (FGD2-P5).

Another participant said "*Control is to obey his orders, doing things according to his will and not going anywhere without his permission*" (FGD3-P6). Similarly another participant said "*Control is basically to keep in mind my will, do things as I tell her*" (FGD1-P5).

Control on all kinds of decision making. Next sub-themes which emerged from data was control on all kinds of decision making. Mostly participants reported that the spouse exert control by keeping the decision making power in his/her hand. In this way the other spouse is relying on the partner to decide matters whether internal (within house) or external (outside house). One of the participant said "*Control is that all small and big decisions related to home and children will be taken by him*" (FGD1-P6). Another participant explained control as "*In our culture husbands have all the authority to decide*

household matters and their wives have no say and they totally rely on their husbands" (FGD3-P3).

A participant while taking about control by decision making added *"In some places husband thinks he is superior and takes all decisions by himself without discussing it with his wife. Girls in our society thinks it's their duty to obey all orders or decisions made by their husbands"* (FGD5-P5). Similarly another participant said *"Taking hold of household matters, deciding where to go for grocery shopping himself, deciding where to buy things himself"* (FGD5-P8).

Making spouse to obey by various tactics. Next sub-theme which emerged was making spouse to obey him/her by using various tactics. This sub-theme indicated the idea that mostly spouse use various tactics to make sure that the other partner obeys or fulfill his/her demands. Various tactics includes monitoring, physical or mental abuse, threats, and maintaining strict environment were highlighted. One of the participant said *"By abusing the wife, the husband keeps his control on her"* (FGD4-P3). Similarly another participant added that *"Maintaining strict environment at home so that the wife stays frighten, this is control"* (FGD5-P1).

Authority over spouse's thoughts and behavior. This sub-theme was emerged from most of the focus group discussions. Both men and women agreed that control is mostly exerted by using authoritative nature. Use of authority is seen in all matters whether it is deciding what to cook, what to wear and when to work. One participant said *"Control is not allowing to do office work at home, making her wear scarf or abbaya at office, telling her what to cook"* (FGD5-P7). Another participant added that *"Control is to deal with household matters as he tells and making it compulsory to take his permission for going out"* (FGD7-P3).

Inducing dependency in spouse. This sub-theme was emerged from the focus group data and it indicated that in married relationships the spouse makes the partner so dependent on them that they cannot think of doing anything without their permission or against their will. One of the participant said *"Control is basically to make the wife totally dependent on her husband by not allowing them to do anything without their permission"* (FGD4-P3). Another participant explained control as *"Control is that wife cannot imagine to do anything without his knowledge"* (FGD5-P8).

Tactics/ ways of controlling. The second main theme which emerged was tactics/ways of controlling. Participants were asked about the ways through which a spouse can impose his/her control on their spouse in our culture. A number of tactics to control emerged from the analysis. Few tactics were gender specific whereas, general tactics used by both genders were also reported. Participants reported various kinds of tactics used in our culture to impose control on the spouse including use of physical violence, emotional manipulation, restrictions on mobility, use of threats, use of children, control by cultivating self-worth, control on financial resources, monitoring/surveillance and control on sexual activities.

Use of physical violence. This sub-theme emerged from all the focus group discussions. All the participants were of the view that most common way of imposing control on spouse is use of physical violence. Keeping in mind the pure patriarchal system followed in Pakistani culture, it is not a rare thing where husband physically abuse his wife to make her follow his demands. Both men and women reported that it is a common practice in people with lower socio economic status and less education. Whereas, few participants also reported that use of violence against women is a common practice in all socio economic status types and educated people are also sometimes involved in using violence to exert control on wife. One participant said "*In our society many men use physical violence to keep their control because they cannot keep so much control by other ways*" (FGD1-P2). Similarly another participant added that "*Mostly man make his wife target of domestic violence when the wife refuse to obey him*" (FGD5-P9).

Conditional regard. Next sub-theme which emerged was emotional manipulation. While talking about the tactics of control participants said that many men and women try to manipulate their spouse emotionally by playing with their emotions so that he/she realizes his/her mistake and apologize for it. One participants said "*Husband stops talking, stay in bad mood and show tantrums to the wife so that she realizes that I did something wrong and apologizes for it. Same goes for the wife as well*" (FGD1-P3). Another participant added "*Husband start showing tantrums or stay in bad mood with wife. Go in other room, wife becomes worried and start asking him reason of such behavior and ultimately she has to accept his demands*" (FGD5-P4).

Restrictions on mobility. This sub-theme emerged from almost all the focus group discussions. All the participants said that restricting the mobility of the spouse is a

very common way of controlling ones spouse. Both men and women were of the view that mostly husband put restrictions on his wife so that she interact with as less people as possible and do not get the exposure to outside world to share her suffering or bad behavior of her husband with any family member or friends. One of the participant said *"Not allowing to go out or on shopping alone, wait for him until he comes back from office"* (FGD4-P4). Another participant added that *"Mostly men restrict their wives from going out, not allowing her to talk to her relatives, meet them or visit her mother's home"* (FGD3-P3).

While explaining tactics of control a participant said *"Some husbands restrict their wives from going in neighbors or allow to go for a specific time"* (FGD4-P6). Similarly another participant added that *"Some try to totally restrict the moment of their wife so they cannot meet anyone and cannot share their situation with anyone"* (FGD5-P4).

Use of threats. Next sub-theme which emerged was also found in all the focus group discussions. Use of threats as a way to control was reported as a common practice by both men and women. Various types of threats were reported out of emotional blackmailing was the most common. According to most of the participants both the partners use this tactics to make their demands get fulfilled in marital relationship. One of the participant said *"Threatens his wife to divorce her if she will not obey or fulfil his demands"* (FGD7-P2). Another participant added while talking about use of threats that *"In some places it is a common practice where husband threaten his wife, that he will keep the children and send her home"* (FGD3-P1). One participant added that *"If the wife decides for separation she is blackmailed by her husband to stop her. Moreover, she is blackmailed about social stigmatization she will have to face as a result of divorce"* (FGD4-P5). Another participant said that *"There are also some families where husband keeps threatening his wife, that if she will not obey his order he will do second marriage"* (FGD7-P5).

Use of children. This sub-theme was also commonly found in all discussions. Both men and women agreed that using children as a tactic to control is a very common practice in our culture. Mostly it is used against women because they are more attached to their children and their lives revolve around them. On the other hand men use the children as a tactic to get his demands fulfilled from his wife. One participants said

"Mostly uneducated men use children as a way of controlling their wives" (FGD2-P5). Another participant added that *"In some places it is a common practice where husband threaten his wife, that he will keep the children and send her home"* (FGD3-P1).

Similarly another participant said that *"Husband knows it well that children are the weakness of my wife, so they do use children to threaten her, like sending her home while keeping the children. In such situation the wife has to return for the sake of her children"* (FGD3-P2). Another participant explained *that "The biggest weakness of women is her children, so it is the easiest way to control her and husband knows it well. In our society it is also seen where husband turn the children against their mother, or proving her wrong in front of children so they will start hating her"* (FGD4-P6).

Control by cultivating self-worth. Next sub-theme which emerged from the data was control by cultivating self-worth. Some participants reported that sometimes control is exerted by inducing positive feelings in the spouse, by making him/her believe that he/she is the most important person in this world, by showing them extra love and care so that the spouse feels blessed to have such a partner and never thinks of disobeying the demands of their partner even when they do not feel like doing a certain thing. One of the participant said *"Some husbands control their wives by praising them often, they impress their wife and she automatically comes under their control"* (FGD6-P1).

Control on financial resources. Next sub-theme which emerged from data was control on financial resources. Mostly participants reported that it is a common practice to control the spouse by limiting her access to money or giving a limited amount to spend. Mostly women in Pakistan are housewives and are totally depended on their husbands. Taking advantage of this thing mostly men exert control on their wives and get their demands fulfilled. It was also reported that working women are also controlled by their husband, their husband is so influential that they cannot think of spending their own pay without the permission of their husbands. One of the participant said *"One way of controlling is to not giving money to the wife for household expenditure, keeping all the control in his hand"* (FGD3-P4). Another participant added that *"In some places mostly in poor Christian community, it is seen that husband takes the pay from his wife forcefully and to keep his control"* (FGD1-P5).

One participant said that *"In some place husband and wife have mutual accounts and the pay comes in that account. In this way both of them have the knowledge about where money is being spent. Although, wife is not allowed to spend without her husband consent"* (FGD4-P2). One participant narrated that *"I have seen many cases of teachers where they do not have their own ATM card. Their husbands keeps it. Even after doing job they are still dependent on their husbands"* (FGD5-P2).

Monitoring/surveillance. Next sub-theme which emerged from all focus group discussions was monitoring/surveillance. Both men and women reported that monitoring the daily activities of the partner is common way of controlling them. Men and women adopt different ways to control by monitoring. Few men were of the view that it is mostly the habit of wife to monitor the activities of her husband as she is insecure. But majority of the men and women were of the view that monitoring is done by both partners to keep check and balance on their partner. One participant reported "*One way of controlling is by keeping eye on the wife (i.e. when and where she is going or with whom she is going)"* (FGD2-P1). Another participant added that "*Control by checking the mobile or reading the text message so the partner stays cautious while texting or calling anyone as his/her partner can check the mobile anytime"* (FGD3-P3). One participant was of the view that "*Both the parties monitor each other but level of monitoring is different"* (FGD1-P7). Another participants added that "*If she is a working lady then he will ask questions like why are soo dressed up for office, why you came late from office. With whom you are talking on call?"* (FGD5-P7). *Another participant said that "Some husbands start questioning from their children that what your mother did all day? Who came home while I was in office? Who called you mother?"* (FGD4-P3).

Control on sexual activities. Another sub-theme which emerged from analysis of FGDs was control on sexual activities. Most of the participants agreed that in matter of sexual activities male dominates and the wife has to concede before her husband whenever he demands it. Participants also reported that women has to do what her husband ask for and husband has the final say in deciding upon gap between children birth. Men totally dominates and controls the decisions of having sexual activities. One participant said that "*In our society male dominance is very prominent. Then obviously sex related things are also decided by husband"* (FGD7-P6). Another participant added that "*Men control their wives by making them perform sexual activities against their*

will and the decision of taking birth control measure is also made by them" (FGD2-P3).

Reasons to control. Next main theme which emerged from the data was reasons/justifications given by participants for using controlling tactics. Participants were asked that why the partners feels the need to control the other partner. Most of the participants were of the view that because it is a male dominated society and men are superior to women so it is their right to control their wives. Most women were also of the view that husband has the right to control his wife. As he is the earning member of the family so he has the right to control her wife. Participants reported various reasons for using controlling tactics which included religion, social cultural norms, to maintain superiority, fear of losing power and to avoid social stigma.

Religious interpretations. This sub-theme emerged in most of the FGDs. Most participants were of the view that controlling wife is their right of men because Allah has made them superior and strong as compare to women. Participants reported that as men is the earning member of the family all decision are in his hands so, it is natural that he will impose control on household matters and in marital relationship. One participant reported that *"According to Islamic values man has been given a leading position, wife should implement husband's orders as it is"* (FGD1-P3). Another participant added that *"Allah has created men and women differently, he is stronger in all aspects as compare to women and this difference is due to some reason. It is commonly seen in our society that men consider themselves the ruling authority due to which he thinks it's his right to control her wife"* (FGD2-P2).

Socio cultural norms. Next sub-theme which emerged indicated the presence of socio cultural norms which promote the idea of male dominance. Most of the participants were of the view that in our culture men is dominating in every field and women are not given their rights whether it is marital life or work life. Women are treated as lower to men and forced to obey their husband. They are taught to give more importance to their husband's demands and wishes and forget about their own wishes. One participant said *"It is a male dominated society, and it is seen mostly that males dominate and it is accepted by the society"* (FGD1-P6). Another participant said *"Mostly males dominate. In our culture girl is taught by her mother, to obey her husband and not speak anything in front of him"* (FGD4-P6).

To maintain superiority. This sub-theme emerged from almost all the focus group discussions. Both men and women were of the view that as it is a common practice in which boys from young age given more privileges, importance and are treated as superior to girls. This learning later on is seen in marital life as well. Where men tries to impose control on his wife. Moreover, it is in the nature of men and they feel the urge to keep control on his wife so he feels superior and his ego gets satisfied. One of the participant said that "*Men are treated as superior in our culture, so they try to maintain this superiority in married life by controlling their wives as a right*" (FGD2-P4). Another participant added that "*In our society boys are always treated like they are special. Men think they are superior from their wives and try to keep them below by controlling them*" (FGD5-P8).

Fear of losing power. Last sub-theme which emerged was fear of losing power. Mostly participants reported that a major reason behind exerting control by men is that they feel the fear that their wife will be more successful (if working) or everyone in family will praise their wife and he will feel inferior in front of others. Both men and women said that sometimes control is exerted due to some inferiority complex and men try to boost their self-esteem by making women dependent on them. One of the participant said "*Husband have this fear of wife going ahead of him if she is working lady or if she becomes independent so he controls her*" (FGD7-P2). *Another participant added "Husband cannot accept his wife becoming equal to him or speaking in front of him so he makes her dependent on him by using various controlling tactics*" (FGD3-P6).

Discussion

Intimate partner violence (IPV) is a phenomenon occurring worldwide from ancient times. It is a phenomenon which is found in developed as well as underdeveloped societies. Therefore, IPV is regarded as a serious health issue (Sarkar, 2008). WHO has declared IPV as serious human right violation and a public health concern. A number of researchers have highlighted the need to explore beyond the characteristics and dimensions of physical violence and to identify the various types or contexts of IPV (Cook & Goodman, 2006; Graham-Kevan & Archer, 2003; Johnson & Leone, 2005).

One of the type of violence which has gained popularity among researchers is coercive control. It is a term which is used to explain the broader areas of IPV. According to Dutton et al., (2005) it is a process involving repetitive and multiple demands across various dimensions that leads towards victim's obedience to comply with the demands, as the victim expects negative consequences for non-compliance and rewards for compliance. An important issue which researchers have highlighted is the difficulty in defining IPV because it varies from culture to culture and it is context dependent (Dutton, 1996, Dutton et al., 2005; Walker, 1999). In order to understand the coercive control phenomenon which is a type of non-violent IPV, it is needed that one should be precise in explaining and defining the acts and behaviors used in coercive control and in what ways it effects the victims.

Keeping in mind the above stated issues of cultural differences and context dependent nature of IPV i.e., coercive control, this study was carried out with an intention to explore the phenomenon of coercive control qualitatively. For this purpose, focus group discussions were conducted with married individuals. Along with Focus group discussion with general population, in-depth interviews from subject matter experts were also conducted. Analyses of the focus group discussions and in-depth interviews showed some dimensions of coercive control already existing in literature including sexual coercion, intimidation, surveillance, limiting resources and outside support, degradation, control and isolation (Stark, 2007).

Some of findings identified in indigenous data were new to the existing literature including inducing dependency in spouse, religion, socio cultural norms, to maintain superiority and fear of losing power. Based on the analyses the data was summarized in themes and sub-themes (see Table 2). The data was summarized on three major themes which had further sub-themes incorporating the various dimensions.

The first theme was based on the basic idea of what is control and how to define control in married life keeping in mind our cultural dynamics. This theme highlighted the traditional patriarchal cultural context of Pakistan where men dominate and no freedom of choice is given to women, male members are considered the leaders and maintain strict environment at home to keep their hold on wife and family members. Moreover, this theme also highlighted the self-centered nature of husbands in which only his will should be considered important. According to Stark (2007) coercive control is most effective in communities where patriarchal system is common which

allow obeying the typical gender roles, serving as proof and endorsement of stereotypical masculinity.

The second theme was on the various ways and tactics used for controlling one's partner. This theme indicated the use of physical violence, emotional manipulation, restrictions on mobility, use of threats, use of children, control by cultivating self-worth, control on financial resources, monitoring /surveillance, control on sexual activities. Use of physical violence is a common practice around the world. When the husband cannot do anything to exert control he adopts the tool of physical violence. Next sub-theme was emotional manipulation of the spouse. It indicated playing with the partner feelings by becoming unresponsive or cutting off communication for few days so that the other partner keeps worrying and ultimately fulfil the demands. Next sub-theme was restrictions on mobility, it indicated that partner limits the contact with friends, family and relatives. This is done so that the partner is not allowed to share her feelings with anyone and cannot get the support from anyone. Next sub-theme was use of threats, which is also a very common tactic used in our culture. Emotional blackmailing is done by both partners in order to get their demands fulfilled. Threats like separation and second marriage are most commonly reported in our culture. Next sub-theme was use of children as a way of controlling the spouse. This sub-theme showed the use of children to emotionally blackmail the partner, threatening the partner to take the children away and investigating from children about the activities of the partner in his/her absence. Previous researches have also reported use of children for exerting control on partners by asking questions from children about who came to house in his/her absence, who their mother/father talked to phone, when he/she returned, threatening the partner to take the children away, not allowing to take decision regarding their children (Dutton et al., 2005; Pence & Paymer, 1993; Stark, 2007). Next sub-theme was control by cultivating self-worth, it indicated the use of positives tactics in which partner start flattering the spouse, make them belief that they are the most important person in their life. Next sub-theme was control on financial resources. This theme indicated that it is a common practice in our society that if the wife is earning or owns property, husband will force her to make a joint account and wife cannot spend without his permission, taking pay forcefully or taking ATM card forcefully were also reported as a common practice. Withholding necessary resources and money was found a controlling tactic in previous literature as well (Dobash & Dobash, 1998; Dutton et

al., 2005). In Pakistani context, property ownership was also found to be a significant predictor of men using controlling tactics against women (Murshid & Critelli, 2017). Next sub-theme was monitoring/surveillance. This sub-theme indicated that male and female both try to observe the activities of each other. However due to the dominant position of male and being the head of the family he is in strong position to keep a hold on household activities and personal matters of his wife. Keeping check and balance on the partner to whom he/she is meeting. Keeping an eye on his/her social activities i.e. observing his/her activities on social media, asking about friends and colleagues at work. In previous literature researchers have used the term isolation to refer to control on social activities like restricting contact with friends, cutting off the person from the world by limiting outside involvement (Pence & Paymar, 1993; Dutton et al., 2005; Stark, 2007). Last sub-theme was control on sexual activities. This sub-theme also indicated the traditional male dominant role in our culture. Male dominance was also found in intimate sexual relationships and the use of birth control method. Women in Pakistani society are taught to obey their husbands no matter what, and due to gender differences male is the leading authority and he exerts his control in sexual activities as well. A study conducted in Pakistani settings found that women, regardless of their own personal experience were aware of sexual coercion in marriage and many women tolerate "*jismani ziyati*" (Hussain & Khan, 2008). Controlling sexual activities in previous literature indicated the use of sexual abuse and sexual coercion (Dutton et al., 2005; Forbes, Adams-Curtis, Pakalka, & White, 2004; Stark, 2007). The previous literature also highlighted such tactics to control one's partner like use of direct and indirect threats, intimidation, physical and sexual violence, surveillance (Kirkwood, 1993; Stark, 2007; Johnson, 2008).

The third main theme was reason/justifications given by the participants for using controlling tactics in marital life. It included the sub-theme of religion, socio cultural norms, to maintain superiority and fear of losing power. A sub-theme of religion indicated that both men and women justify the use of control as a right given to men by Allah. As he has made him superior to women and strong so he has the right to control his wife. Next sub-theme of socio cultural norms also indicated the male dominant societal norms in our culture, in which men are considered to have a right to control their wives due to the authority and superior position they are given in our culture. According to previous research, use of authority, dominance or superiority by

a male partner is a way of manipulating their female partners (Levant & Richmond, 2007). Within Pakistani society, considering it a right to control female partner, can best be understood as a part of patriarchal system that suppress women's through the societal norms and cultural values which dictate and specifies the role of women (Hadi, 2017). Next sub-theme was to maintain superiority in which men use controlling tactics as their right. In our culture it is commonly seen that men cannot stand a more successful wife in terms of job and salary or even in family terms. So in order to maintain his superiority in marital life he start using controlling tactics so that wife stays below him. Last sub-theme was fear of losing power, men use controlling tactics to make the women dependent on them so that she cannot think of disobeying them and in this way their superior power is maintained.

The context dependent nature of coercive control demands the indigenous exploration of the construct, due to which qualitative exploration was conducted. Results of FGDs revealed that dynamics of coercive control are a bit different in Pakistani society as compare to western countries. Few sub-themes which emerged were not found in the western culture. Keeping in mind the cultural differences and the results of FGDs it was decided to develop an indigenous measure of coercive control which will be suitable for Pakistani culture.

STUDY 2
QUANTITATIVE STUDY

Chapter IV

STUDY II

DEVELOPMENT AND VALIDATION OF COERCIVE CONTROL SCALE

IPV is considered a worldwide phenomenon and its negative consequences on the individual and relational functioning of the person experiencing it are indisputable. Currently the focus has been shifted to one type of IPV referred as "coercive control" (Stark, 2007). The attention of researchers has been shifted to this particular type due the fact that it may not include any visible form of physical violence (Allen, 2013; Johnson, 2008). Exploring this construct is crucial to correctly assess the safety and consequences for the person experiencing it, particularly when there is no indicators of physical violence, sexual assault or other chargeable offences. On the basis of previous literature and the qualitative exploration in chapter II, it was found that coercive control had different indigenous expressions in our culture. Development of an indigenous scale for coercive control was decided based on the results from qualitative study. Although, tools to measure coercive control or control in intimate relationships exist internationally (Dutton et al., 2005), however, cultural dynamics and the context under which it occurs in our society is very different from the western society. Therefore, developing an indigenous scale was thought to be helpful in measuring coercive control for more valid and reliable findings in future studies.

Objective

The main objective of the study was to develop a scale for measuring coercive control in intimate relationships and establish its psychometric properties.

Method

Development of Coercive Control Scale was completed in four phases which are as follows:

Phase I: Generating Item Pool.

Phase II: Evaluation of Items by experts and establishment face validity.

Phase III: Selecting final items by exploratory factor analysis (EFA).

Phase IV: Determination of Reliability and Construct Validity of Coercive Control

Phase I: Generating Item Pool

Based on the qualitative study reported in chapter III, an item pool was generated (see Appendix B). It comprised of three in-depth interviews with subject matter experts and seven focus group discussions with married men and women. The item pool was generated based on the thematic analysis of the interviews and focus group discussions. Some of the themes which were identified were inducing dependency in spouse, religion, socio cultural norms, to maintain superiority and fear of losing power. Majority of the items for item pool generation were made from the second theme which was tactics/ways of controlling (see Table 2).

Phase II: Evaluation of Items by Experts and Establishment of Face Validity

Initially, a pool of 78 items was generated by the researcher covering all themes emerged in the phase I. After generation of items, expert opinion was taken regarding the suitability of items. For this purpose, 4 faculty members of psychology with a sound background in psychological testing were approached and requested to critically review each item and give their valuable suggestions for face validity. They were also requested to highlight the items which they thought were repetitive, ambiguous, specific to only one gender or needs to be modified. On the bases of the feedback from the 4 faculty members, a total of 36 items were excluded from the initial scale. In order to give a clear and specific idea, some of the items were rephrased with better Urdu language expression. Finally, an initial form of the scale for measuring coercive control was developed without any predetermined categories and put to exploratory factor analysis in the next phase. After the expert's feedback, it was decided to arrange the items on a four-point Likert type scale. For Coercive Control Scale, response options were *Never* = 1 to *Always* = 4 were selected. No item was identified as negatively worded so there was no need of reverse scoring.

Phase III: Selecting Final Items by Exploratory Factor Analysis (EFA)

Sample. A total sample of 500 married individuals including men (n = 251) and women (n = 249) from Islamabad and Rawalpindi was taken for this research.

Convenient sampling technique was used. Inclusion criteria was a married individual, married for at least one year or having at least one child.

Instrument. Initial form of the scale consisted of 42 items. It was a four-point Likert scale with categories ranging from *Never* = 1 to *Always* = 4. Demographic information sheet was also developed to obtain information from the participants regarding their gender, age, employment status, job sector, socio-economic status, number of children, marriage duration, marriage type and family system.

Procedure. For conducting the study with working women/men their respective organizations (i.e. schools, offices) were contacted to get permission for carrying out the research with their employees. After getting the consent letter from the administration, participants were provided with the information about the study and purpose of conducting the study. Participants were asked to give their consent and then the initial scale was distributed. They were also requested to give their suggestions regarding the items or highlight any item which they think is ambiguous or inappropriate. For conducting the study with non-working women sample was selected randomly. The housewives were contacted in person and were briefed about the study purpose. After that the same procedure was followed as above. Ethical considerations were followed.

Results. The initial form of the scale with 42 items was subjected to EFA and item-to-total correlation for the development of the scale. Before finalizing the items, content validity of the selected items was also checked with the help of faculty members and PhD scholars in the field of psychology. For establishing the psychometric properties of the scale, alpha reliabilities were also calculated.

Table 3

Item- Total Correlation of Coercive Control Scale (CCS) (N = 500)

Item No.	*r*	Item No.	*r*	Item No.	*r*
1	.57**	17	.56**	33	.62**
2	.56**	18	.53**	34	.49**
3	.44**	19	.65**	35	.44**
4	.49**	20	.70**	36	.55**
5	.59**	21	.69**	37	.63**
6	.63**	22	.67**	38	.56**
7	.47**	23	.61**	39	.49**
8	.59**	24	.55**	40	.50**
9	.65**	25	.58**	41	.21**
10	.63**	26	.64**	42	.51**
11	.54**	27	.55**		
12	.59**	28	.56**		
13	.60**	29	.65**		
14	.61**	30	.59**		
15	.52**	31	.64**		
16	.52**	32	.69**		

*$p \leq .05$, **$p \leq .01$.

Table 3 is representing the result of item-to-total correlations for 42 item of CCS. It is evident that all the items of CCS are significantly positively correlated with the total of score showing that all the items are contributing in the measurement of coercive control. On the basis of this result, all the items were considered for EFA.

Exploratory factor analysis (EFA). For validation, structuring and reducing the number of the items in the scale EFA was carried out. EFA is a technique which is used when the researcher has no idea about the underlying phenomenon of the target variable and are not sure about how the variables will relate with each other. It helps in identifying the latent (unobserved) factors, and rebuild the complex data in a meaningful form by retaining all the important information of the original data and removing unnecessary/redundant information (Matsunaga, 2011). EFA is a process for the estimation of the unknown structures in the data set. This is an important point which differentiate it from Principal Component Analysis (PCA), which is mostly

confused with EFA and is widely used as its substitute (Henson & Roberts, 2006). One of the reason for widely using principal components analysis is that it is a default extraction method in SPSS (Costello & Osborne, 2005). The main goal of PCA is to reduce the variables in a smaller set of components, while covering as much information as possible with as few components possible. Whereas the goal of EFA is to explore the latent/underlying forms of the data by uncovering common factors. It is an important differentiation from PCA as it basically means EFA is more appropriate choice when exploring underlying theoretical constructs (Hooper, 2012).

While conducting EFA, a main decision is choosing the type of extraction method. According to Fabrigar Wegener, MacCallum, and Strahan (1999) when the assumption of multivariate normality is violated, the method to use is principal factor which is referred as Principal Axis Factoring in SPSS. Principal Axis Factoring (PAF) is a type of EFA which is considered superior to principal components analysis as it analyses common variance only which is a key requirement when developing and validating a construct. Moreover, it is also a helpful method for recognizing items that are not related to the intended factor or those which are measuring multiple factors at a time (Worthington & Whittaker, 2006). Additionally, this method has some benefits in comparison of other methods of extraction as this method does not assume multivariate normality and is not likely to run into estimation problems like in maximum likelihood extraction (Fabrigar et al., 1999). 42 items of CCS were factor analyzed by using principal axis factoring technique.

In EFA, one of the main decisions is selecting the type of rotation. Rotation makes it easier to interpret the factors. Rotation helps in maximization of a loading on each variable on extracted factors whereas minimizing the loading on other factors. There are two types of rotation in EFA including orthogonal and oblique rotation. If the underlying factors are thought to be related then oblique rotation is the best choice, and if the underlying factors are consider unrelated then orthogonal rotation is used (Field, 2009). Inter item correlations were calculated to check that whether the items were related or not. The result showed significant ($p \leq .01$) inter item correlations among the items. As the items were correlated, oblique rotation was selected to be used. Total sample size was approximately 12 respondents against one item, so Promax was appropriate type of oblique rotation to be used in the study. Promax is generally chosen as it is quicker and simpler (Hooper, 2012).

Before conducting EFA, few tests were carried out to verify that the data is fit for factor analysis. In factor analysis, two such tests are offered including the Kaiser-Meyer-Olkim (KMO) measure of sampling adequacy and Bartlett's test of sphericity. The range of KMO statistic varies from 0 to 1. Any value near 0 depicts that the sum of partial correlations is large as compared to relative sum of correlations, which indicates that factor analysis is not an appropriate choice. A value near 1 depicts that patterns of correlations are quite compact and it is safe to carry factor analysis, which will result in distinct and reliable factors. For this data the value of KMO was .92, so it was evident that the data was appropriate for factor analysis. The value of .92 suggest that the data is superb for factor analysis (Field, 2009). Bartlett's test of sphericity is a test which examines the null hypothesis that the original correlation matrix is an identity matrix. This test should be significant (i.e., it should have a significance value of less than 0.05) (Field, 2009). For this data, significance of ($p < .000$) of Bartlett's test of sphericity x^2 (861) = 11510.326 was found to be highly significant showing that the sample was adequate for EFA.

Initially, 8 factors were suggested with Eigen values greater than 1. The scree plot suggested 6 factor solution (see Figure 2). Different solutions were applied by fixing the number of factors. As the scree plot suggested, a meaningful picture was obtained on 6 factors solution through oblique rotation that converged on 25 iterations with Eigen values greater than 1 which explained 49.46 % of cumulative variance. The next step was to calculate the reliability estimates of the factors by Cronbach Alpha coefficients. Reliabilities of all the factors were satisfactory. The criteria for inclusion in final form of the scale was:

1. Items with factor loading greater than .40 were kept.
2. Cross loaded items were discarded.
3. Face validity/ compatibility of the item with the content of the respective factor was also checked by qualitative assessment.

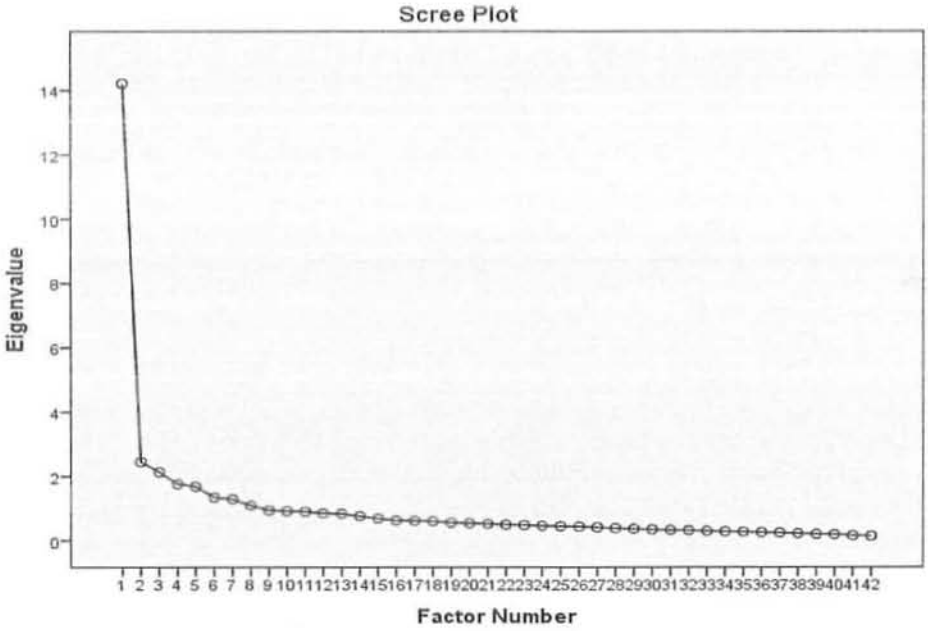

Figure 2. Scree Plot Suggesting Six Factor Solution

Table 4

Factor Loadings for Coercive Control Scale (CCS) through Principal Axis Factoring Analysis by using Promax Rotation (N = 500)

Serial No.	Item No. in Initial Form	Item No. in Final Form	F1	F2	F3	F4	F5	F6	h^2
1	19	14	**.93**	.10	-.20	.06	-.20	.00	.67
2	22	17	**.67**	-.49	-.01	.10	.00	.03	.54
3	28	22	**.68**	-.16	-.02	-.09	.19	.03	.46
4	20	15	**.65**	.04	.03	.03	.12	-.12	.58
5	23	18	**.64**	.11	.03	-.19	.10	-.01	.48
6	24	19	**.64**	.09	.08	-.17	-.16	.15	.44
7	30	23	**.63**	-.04	-.01	.04	.01	.03	.43
8	21	16	**.61**	-.00	.06	.17	.03	-.11	.56
9	14	9	-.07	**.78**	.06	-.03	.12	-.05	.66
10	16	11	.05	**.77**	-.12	-.15	.14	-.01	.57
11	15	10	-.17	**.66**	.11	.08	.06	-.07	.48
12	13	8	-.07	**.62**	.22	-.04	.06	-.01	.51
13	17	12	.15	**.55**	.01	.03	-.03	-.01	.42
14	18	13	.30	**.44**	-.05	.02	-.17	.09	.36
15	32	25	.03	.04	**.82**	-.06	-.06	.11	.72
16	31	24	.09	.02	**.79**	-.08	-.02	-.04	.61
17	11	6	.02	.02	**.63**	.09	-.08	-.05	.44
18	12	7	.02	.10	**.59**	.19	-.15	-.07	.51
19	27	21	.01	-.03	**.58**	.05	.09	-.02	.41
20	10	5	-.02	.12	**.56**	.25	-.13	.01	.56
21	8	4	.00	.02	.09	**.80**	-.15	-.01	.67
22	6	2	-.07	.08	.02	**.76**	-.01	.11	.66
23	7	3	-.06	-.10	-.01	**.73**	.05	.04	.47
24	5	1	-.07	.05	.02	**.62**	.17	-.00	.53
25	26	20	.25	-.09	.08	**.41**	.14	-.02	.48
26	40	31	.11	.07	-.16	-.04	**.70**	-.00	.50

(Continued)

27	39	30	-.05	.04	.02	-.02	**.67**	.02	.45
28	37	29	-.00	.05	.27	.01	**.58**	-.09	.56
29	42	32	.01	.22	-.37	.25	**.53**	.11	.48
30	34	26	.06	.06	.05	-.03	-.09	**.88**	.83
31	35	27	-.03	-.09	-.05	.22	.17	**.56**	.45
32	36	28	.14	-.08	.28	-.08	.12	**.43**	.48
Eigen values			13.73	1.982	1.661	1.302	1.213	1.344	
% of variance			32.69	4.718	3.956	3.099	2.887	2.111	
Cumulative %			32.69	37.40	41.36	44.46	47.35	49.46	

Note. Factor Loading > 0.40 have been listed in each factor, h^2 = Communalities.

Table 4 is showing the results deduced from applying Principal Axis Factor analysis by using oblique rotation (i.e., Promax) to explore the factor structure and validity of the CCS. The results showed clearly that items were falling on six factors, communalities were also reported. Communalities indicate the proportion of common variance in a variable. A variable having no specific value of variance have a communality value of 1, whereas a variable sharing no variance with other variables have a communality value of 0 (Thongrattana, 2012). Although, there is no cutting-off point for dropping any variable based on communalities value.

Communalities have also been reported in Table 4 denoted by h^2. The value of communalities of most items is more than .4, which indicates less specific variance among variables. Results also indicate that factor 1 has an Eigen value of 13.37 and explains 32.69% of variance. Factor 2 has an Eigen value of 1.982 and explains 4.718% of variance. Factor 3 has an Eigen value of 1.661 and explains 3.956% of variance. Factor 4 has an Eigen value of 1.302 and explains 3.099% of variance. Factor 5 has Eigen value of 1.213 and explains 2.887% of variance. Factor 6 has an Eigen value of 1.344 and it is explaining 2.111% of the total variance. Table 4 is also showing the cumulative variance which explained by six factors that is 49.46%. According to William, Onsman, and Brown (2010) when values of cumulative variance are high it is an indicator of good factor solution however, in social sciences value of cumulative variance can get below 50% and it is still considered acceptable. Furthermore, there is no pre-determined criteria or limit for cumulative variance. Finally, out of 42 items, 32

items were selected to be included in the final form of the CCS (see Appendix E). None of the items were reverse coded.

Final Coercive Control Scale

Final form of the scale was developed after conducting EFA. Factor analysis showed that six subscales provided better assessment of the construct of coercive control among married individuals. Based on the results of factor analysis, 32 items were finalized in CCS (see Appendix E). The response options ranged from *Never* = 1 to *Always* = 4. The score ranged from 32 to 128 where high scores shows high experience of coercive control by spouse.

Content Validity. Items selected through factor analysis were given to 3 faculty members and 3 PhD students in psychology taken as SMEs to ensure the content validity of every item within its subscale and to label the factors based on their content. They were requested to name the factors accurately based on the content of each factor. After their judgements, Factor 1 was named as Use of Authority, Factor 2 was named as Surveillance, Factor 3 was named as Threat and Intimidation, Factor 4 was named as Restricting Contact with Relatives, Factor 5 was named as Control on Social Contacts and Factor 6 was named as Sexual Coercion. The six underlying subscales with their respective item numbers are as follows

F1: Use of Authority. Overall, 8 items (14, 17, 22, 15, 18, 19, 23, & 16) were loaded on this factor. The items included in this factor indicated the use of dominance, authority, keeping hold of household decisions, showing superiority in everyday matters, ruling capacity on one's partner. The score on this subscale ranges from 8-32. High score shows high use of authority and vice versa (see Table 4).

F2: Surveillance. Overall 6 items (9, 11, 10, 8, 12 & 13) were loaded on this factor. Items loaded on this factor indicated monitoring and keeping an eye on the partner's activities, examples includes to whom he/she is talking on call, mobile checking, asking who came in his/her absence, where he/she was and what he/she has been up to, involving children to investigate. The scores on this subscale range from 6-24 where high score means high use of surveillance by spouse (see Table 4).

F3: Intimidation. Overall 6 items (25, 24, 6, 5, 7 & 21) were loaded on this factor. Items loaded on this factor showed use of threats, intimidating the partner, threating the partner of negative consequences if he/she will not do things according to

his/her will. The score range on this subscale ranges from 6-24. High score means high use of threats and intimidation and vice versa (see Table 4).

F4: Restricting Contact with Relatives. Overall 5 items (4, 2, 3, 1 & 20) were loaded on this factor. Items loaded on this factor indicated putting restrictions on partner regarding meeting his/her relatives, visiting his/her parents and relatives, and criticizing his/her family. The score range on this subscale ranges from 5-20. High score shows high use of restrictions and vice versa (see Table 4).

F5: Control on Social Contacts. Overall 4 items (31, 30, 29 & 32) were loaded on this factor. Items loaded on this factor showed controlling or limiting contacts with friends, or meeting or interacting with opposite gender and showing unnecessary possessiveness. The score range on this subscale ranges from 4-16. High score shows high control and vice versa (see Table 4).

F6: Sexual Coercion. Overall 3 items (26, 27 & 28) were loaded on this factor. Items loaded on this factor indicated use of dominance in sexual activities and doing the sexual activities without the consensus of other partner. The score range on this subscale ranges from 3-12. High score shows high use of sexual coercion and vice versa (see Table 4).

Phase IV: Determination of Reliability and Construct Validity of Coercive Control Scale

For establishing psychometric properties of the scale, reliability was checked by Cronbach Alpha Coefficients and for checking construct validity inter-subscale correlations and correlations with the total score was calculated (N = 500) through Pearson Product Moment Correlations.

Table 5

Means, Standard Deviations, Alpha Reliabilities, and Correlations between CCS and its Subscales (N = 500)

Scale	No. of Items	*M*	*SD*	*a*	UOA	SUR	INT	RCR	CSC	SC	CCS
UOA	8	13.43	5.77	.93	-	.55**	.39**	.28**	.49**	.45**	.86**
SUR	6	9.69	3.87	.88		-	.32**	.35**	.48**	.32**	.78**
INT	6	7.47	2.83	.83			-	.30**	.19**	.33*	.49**
RCR	5	6.50	2.54	.86				-	.34**	.24**	.44**
CSC	4	6.97	2.89	.76					-	.35**	.69**
SC	3	4.32	1.98	.76						-	.60**
CCS	32	48.73	15.47	.93							-

Note. UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; CCS = Coercive Control Scale *$p < .05$ **$p < .01$.

Table 5 is showing the alpha coefficients for the 32 items of CCS along with its six subscales. The Cronbach alpha coefficient for CCS was .93. High values of alpha coefficient is indicating that the scale is internally consistent and is a reliable measure to assess the underlying construct. Inter-scale correlations are also significant that ranged from .32 - .86 at $p < .000$. It is clear from the results that all the subscales show significant relationship with the total confirming construct validity. Item to subscale correlations were also checked which also indicated that all the items were correlated with their respective subscale.

Discussion

The main aim of this study was to develop and validate a reliable measure for assessing experiences of coercive control by married individuals. Intimate partner violence is considered as a context depended phenomena and it varies from culture to culture. Variations in the findings of cross cultural studies regarding IPV are due to the various contextual differences of questions being asked and the populations from whom samples are selected (Archer, 2000; Bachman, 1998; Straus, 1999). To understand the use of IPV and responses to IPV in intimate relationships, it is essential to understand the contextual, cultural, social, and institutional systems under which a person is living (Dutton, 1996; Edleson & Tolman, 1992). With respect to IPV the most critical element

is the extent of non-violent coercion and control in the relationship. Coercion and control has been identified to play a central role in violent relationships. Irrespective of the importance of non-violent acts of coercion, the measurement of IPV in research has focused largely on violent and aggressive acts, and not on the non-violent coercive acts (Dutton et al., 2005). So far to our knowledge, there is no adequate measure of the construct of "non-violent coercive control" in Pakistani perspective. A study conducted by Ahmed (2017) also highlighted the need for the development of an indigenous measure of coercive control for Pakistani population. Based on the indigenous qualitative findings from study I, researcher decided to go for the empirical testing of coercive control in married individuals. For this purpose a Likert type scale was developed. In social sciences rating scales are commonly used, such instruments often use Likert type scales (Croasmun & Ostrom, 2011).

For the purpose of item pool generation an empirical approach was adopted (Worthington & Whittaker, 2006). FGDs with both married men and women were carried out to explore the construct indigenously. On the basis of results of the content analysis of focus group discussions an item pool was generated (See Appendix B). Overall, 78 items were generated which were reduced to 42 items after assessing the face validity of generated items. The item pool was administered on the sample of 500 married men and women in Islamabad/Rawalpindi. For the validation and establishment of construct validity of the scale EFA was conducted.

EFA was carried out on a sample of ($N = 500$). As the purpose for conducting EFA was to explore and reveal the underlying factors, so Principal Axis Factoring was selected as a method of extraction. This method of extraction is recommended when the data does not meet the assumption of normality (Costello & Osborne, 2005). Selection of rotation was done after examining the inter item correlations among items, which were significant at $p \leq .01$ level. As the items were correlated, Oblique (Promax) rotation was used. Results of exploratory factor analysis showed that from a total of 42 items, 32 items were grouped on six factors which explained 49.46% of variance (see Table 4). The selection of items for the final scales were based on following selection criteria i.e., items with factor loading greater than .40 were kept, cross loaded items were discarded, face validity/compatibility of the item with the content of the respective factor was also checked by qualitative assessment. Six meaningful factors were finalized with 32 items and it was concluded that coercive control is a multidimensional

construct. The multifactor solution was consistent with previous literature (Dutton et al., 2005). Overall six factors were emerged in factor analysis.

For coercive control scale (CCS) Eigen values were reported (see Table 4) indicating the contribution of each factor to the measure. Large Eigen values indicate a meaningful factor (Field, 2009). A scree plot makes the relative importance of each factor evident (see Figure 2). Usually there will be few factors with quite high eigenvalues, and many with relatively low eigenvalues, and so this graph has a very characteristic shape. There is a sharp descent in the curve followed by a tailing off (see Figure 2). Cut-off point for selecting factors should be at the point of inflexion of this curve (Field, 2009). According to Pituch and Stevens (2015) a sample of 200 individuals can be considered ample for providing reliable criteria for the selection of factors. The scree plot also indicated six factors. Factor 1 was named as "Use of Authority" which indicated the dominating role of one's partner, keeping hold of household matters, ruling the partner and feelings of superiority. Factor 2 was named as "Surveillance" which indicated the monitoring of daily life activities of the partner, spying, mobile checking, asking to whom he/she was talking on call or what he/she did in his/her absence and investigation from children. Factor 3 was named as "Intimidation" which showed the use of threats and terrorization about the negative consequences if his/her demands will not be met. Bullying in front of children, and threating about the future of children in case of separation/divorce. Factor 4 was named "Restricting Contact with Relatives" which showed limiting contact with parents, relatives, not allowing to meet them and criticizing his/her family. Factor 5 was named "Control on Social Contacts" which showed controlling and limiting contacts with friends, not allowing to interact with opposite gender, and in case of going out of home insisting on coming back home at a fixed time. Factor 6 was named as "Sexual Coercion" which showed indulging in sexual activities without the will of other partner and not discussing the use of birth control methods.

While developing a scale, it is very important to check the psychometric properties of the developed measure. For this purpose, Cronbach's Alpha reliabilities and Person Product Moment Correlations were computed for the scale and its subscales. The results showed high reliabilities for the scale .93 and its subscales respectively (See Table 5). Satisfactory reliability coefficients indicate that the measure is reliable and high correlational values of each subscale with the total indicated that each subscale is

contributing in the measurement of same construct. Hence construct validity was established.

Conclusion

Findings reported in this chapter indicated that a psychometrically sound indigenous scale 'Coercive Control Scale' (CCS) was developed (see Appendix E). Coercive Control Scale is a multidimensional measure consisting of six subscales i.e., use of authority, surveillance, intimidation, restricting contact with relatives, control on social contacts and sexual coercion. Moreover, the psychometric properties reported in this chapter showed that the scale is reliable and indigenous scales are more useful in terms of testing hypothesis and model.

METHOD

Chapter V

METHOD

Objectives

Following were the objectives of the study:

1. To study the impact of coercive control on mental health and marital quality of married men and women.
2. To investigate the mediating role of self-silencing and coping self-efficacy on individual and relational functioning of married men and women.
3. To see the differences based on demographic variables (i.e., gender, age, education, job status, family structure, marriage type, socio economic status, number of children, and duration of marriage) in relation to the study variables.

Hypotheses

1. Coercive control will be negatively related to mental health of married individuals.
2. Coercive control will have positive relation with self-silencing.
3. Coercive control will be negatively related to marital quality.
4. Coercive control will be negatively related to coping self-efficacy of married women.
5. Mental health will be positively related to marital quality.
6. Mental health will be negatively related to self-silencing.
7. Mental health will be positively related to coping self-efficacy.
8. Marital quality will be positively related to coping self-efficacy.
9. Self-silencing will be negatively related to marital quality.
10. Coping self-efficacy would mediate the relationship between coercive control mental wellbeing of married men and women.
11. Coping self-efficacy would mediate the relationship between coercive control and marital quality of married men and women.
12. Self-silencing would mediate the relationship between coercive control and mental health of married men and women.
13. Self-silencing would mediate the relationship between coercive control and marital quality of married men and women.

14. Women will experience more coercive control as compared to men.
15. Men will have higher mental health as compared to women.
16. Self silencing will be higher in women as compared to men.
17. Working women will experience less coercive control as compared to non-working women.

Operational Definitions

Coercive control. It can be defined as a condition in which a partner influences control on the other partner with the possible harm or punishment for non-compliance. This can encompass individuals social life, his or her freedom to move, and personal daily activities, and autonomy in various life decisions. Coercive control in this study was assessed by Coercive Control Scale (indigenously developed) which is a self-report measure for assessing the level of coercive control. High score on this scale indicated more coercive control on the reporter's life (See Appendix E).

Mental health. Positive mental health is defined as a combination of hedonic well-being and the eudaimonic well-being including psychological and social aspects (Keyes 2002, 2005). Mental health in present was assessed by Mental Health Continuum Short Form (Keyes, 2009; translated by Faran & Malik, 2015). High score show better mental health whereas low scores show poor mental health (see Appendix G).

Marital quality. Marital quality is a subjected appraisal of a married couple's relationship where the range of evaluations comprises a continuum manifesting numerous features of marital interaction and marital functioning. High marital quality, therefore, is identified with good judgment, reliable interpersonal communication, a high degree of marital happiness, cohesion, integration, and a high tenor of mutual satisfaction with the relationship (Spanier, 1976). In the present study it was assessed by the ENRICH Couple Satisfaction Scale (Olson Sigg, & Larson, 2008 translated by Fatima, 2017). Higher scores on the scale indicate better marital quality (see Appendix I).

Self-silencing. It can be defined as restriction on expression of oneself and refrain from doing such actions which can become the cause of conflict in relationship (Jack, 1991). Self-silencing in this study was assessed by Silencing the Self Scale (Jack,

1992; translated by Munir, 2014). High score on the scale means a higher tendency towards self-silencing (see Appendix K).

Coping self-efficacy. It is defined as perceived self-efficacy for coping with challenges and threats on one's confidence in performing coping behavior when faced with life challenges (Chesney et al., 2006). Coping self-efficacy in the present study was assessed by Coping Self-Efficacy Scale developed by Chesney et al., (2006; translated by Younis, 2017). High scores on the respective scale indicate high coping self-efficacy and low scores indicate near to the ground coping self-efficacy of an individual (see Appendix M).

Instruments

Coercive Control Scale (CCS). Coercive control was measured by the Coercive Control Scale (indigenously developed in present study). It is a self-report instrument to measure the experience of control in marital relationships. This consists of six subscales that measure coercion by the intimate partner on six different domains. The subscales of the Coercive Control Scale include Use of Authority (items 14, 17, 22, 15, 18, 19, 23, & 16), Surveillance (items 9, 11, 10, 8, 12, & 13), Intimidation (items 25, 24, 6, 5, 7, & 21), Restricting Contact with Relatives (items 4, 2, 3, 1, & 20), Control on Social Contacts (items 31, 30, 29, & 32) and Sexual Coercion (items 26, 27, & 28). The scale measures the responses on four point Likert scale with response options ranging from 0 = *Never* to 4 = *Always* (see Appendix E). In the present study, the scale showed high reliability of .93. High score shows high coercive control whereas low score shows low level of coercive control.

Mental Health Continuum Short Form (MH). For measuring mental health, Mental Health Continuum Short Form (Keyes, 2009; translated by Faran & Malik, 2015) was used. This consists of 14 items. It has 3 domains including Emotional Well-Being (items 1-3), Social Well-Being (items 4-8) and Psychological Well-Being (items 9-14). High score show better mental health whereas low scores show poor mental health (see Appendix G).

ENRICH Couple Satisfaction Scale. For measuring the quality of marital relationships, the ENRICH Couple Satisfaction Scale (Olson et al., 2008; translated by Fatima, 2017) was used. The scale was originally developed by Fowers and Olson (1993), consisting of 15 items; afterwards the revisions of the scale were also put forth,

and the latest revision of this scale was given by Olson et al. (2008). In the current study, the latest revision of the instrument (10 item version of the scale) was used. This scale consists of 5 positive items (items 1, 3, 4, 7, & 9) and 5 negative items (items 2, 5, 6, 8, & 10). The responses are based on 5 point Likert scale ranging from 1 to 5 i.e., 1 = *Strongly Disagree* to 5 = *Strongly Agree* (see Appendix I). For measuring marital quality, the negative items will be reverse coded and then a composite score will be obtained. The alpha reliability of the original scale was reported .88.

Silencing the Self Scale (STSS). Self-Silencing was measured by Silencing the Self Scale developed by Jack (1992; translated by Munir, 2014). It was developed specifically to measure this construct. It consist of 31 statements describing behavior and beliefs about one self in relationship to others. The scale consist of four subscales which measures the different aspects involved in self-silencing. The subscales include Externalized Self Perception (items 6, 7, 23, 27, 28, & 31), Care as Self-Silencing (items 1, 3, 4, 9, 10, 11, 12, 22, & 29), Silencing the Self (2, 8, 24, 15, 18, 20, 24, 26, & 30) and Divided Self (items 5, 13, 16, 17, 19, 21, 25). Participants rate how strongly they agree with each statement on a five point Likert scale ranging from 1 = *Strongly Agree* to 5 = *Strongly Disagree*. Five items are reverse coded namely 1, 8, 1, 15, and 21 (see Appendix K). Maximum score on STSS is 155 and minimum score is 31. A high score shows individual has a tendency towards self-silencing, whereas a low score denotes no tendency towards self-silencing. High reliability .91 for the scale has been reported (Thompson, 1995).

Coping Self-Efficacy Scale (CSE). Coping self-efficacy was measured by Coping Self-Efficacy Scale developed by Chesney et al., (2006; translated by Younis, 2017) to measure the perceived ability of a person for coping with challenges and threats. On this scale, respondents are asked to tell the extent to which they believe they could perform behaviors important to adaptive coping. This scale consisted of 3 subscales including Use Problem-Focused Coping (items 2, 3, 6, 7, 8, 9, 13, 14, 20, 25, & 26), Stop Unpleasant Emotions and Thoughts (items 1, 10, 12, 15, 19, 21, 22, & 23), and Get Support from Friends and Family (items 4, 16, 17, 18, & 24). Responses were measured along 7 response categories in which 0 (cannot do at all) 3 (moderately certain can do) and 6 (certain can do). Scores range from 0-260 where high score indicates high coping self-efficacy (see Appendix M). The authors reported .95 reliability of the scale (Chesney et al., 2006).

Child Exposure to Domestic Violence Scale (CEDV). Exposure to physical form of violence was measured by 3 items of Physical Violence dimension of CEDV scale developed by Edelson, Shin, and Armendariz (2008). For present study modified and translated version (Masood, 2013) was used. It is a 4-point Likert type scale with options ranging from 0 = *never* and 3 = *Almost Always*. High scores indicate high exposure to physical violence and vice versa.

Demographic sheet. A demographic sheet was used for gaining personal data about the sample. Data was taken regarding the gender, age, education, job sector, family structure, family members, marriage type, duration of marriage, number of children (see Appendix D).

Research Design

Present study used correlational and cross-sectional research and was conducted in two parts. First pilot study was carried on 60 married men and women to check the research protocol and psychometric properties of scales. Then Main study was performed on 500 married men and women. The data was collected through survey method.

Phase-II pilot study. The aim of Pilot Study was to assess the psychometric properties and understanding level of the scales used in sample. Urdu version of all instruments will be used.

Sample. A sample of 60 married men ($n = 30$) and women ($n = 30$) was selected through convenience sampling from Islamabad and Rawalpindi. The inclusion criterion was a married men and women (working/non-working) who was married for at least 1 year of duration, having at least one child and having no exposure of physical violence. Table 6 is showing the information about the demographic characteristics of the study participants.

Table 6

Demographic Profile of Pilot Study (N = 60)

Variables	*Categories*	*f*	*%*	*M*	*SD*
Gender					
	Men	30	50		
	Women	30	50		
Age(in years)				38.70	10.52
Education(in years)				14.30	2.49
Employment status (Men)					
	Government	11	36.7		
	Private	19	63.3		
Employment status (Women)					
	Employed	16	53.3		
	Unemployed	14	46.7		
Family System					
	Nuclear	31	51.7		
	Joint	29	48.3		
Family size				5.37	1.83
Marriage type					
	Love	19	31.7		
	Arrange	41	68.3		
Duration of marriage(in years)				11.58	10.14
Number of children				2	1.02
Monthly income(in rupees)				57818	31771.91

Note. f = frequency, % = Percentage, M = Mean, SD = Standard Deviation

Table 6 shows the demographic profile of the sample of pilot study. As indicated in table the sample consist of equal number of men and women. The age range of the sample is from 23-70 (M = 38.70; SD = 10.52). The education of the sample ranges from primary to graduate level (M = 14.30; SD = 2.49). Employment status wise the sample of male consists of majority of private employees (n = 19; f = 63.3) and for

women (n = 16; f = 53.3) are employed and (n = 14; f = 46.7) are unemployed. Majority of the participants belongs to the nuclear family system and have arrange marriages.

Instruments. Following instruments were used in pilot study:

1. Coercive Control Scale (CSS)
2. Mental Health Continuum Short Form (MH)
3. ENRICH Couple Satisfaction Scale
4. Silencing the Self Scale (STSS)
5. Coping Self-Efficacy Scale (CSE)
6. Demographic Sheet

Procedure. For conducting the study with married men and women their respective organizations (i.e. schools, offices) were contacted to get permission for carrying out the research with their employees. After having the consent letter of the administration, questionnaire booklets were distributed. Participants were asked to give their consent (see Appendix C). After that participants were provided with the information about the study and purpose of conducting the study. For conducting the study with housewives, sample was selected conveniently. The housewives were contacted in person and were briefed about the study purpose. After that the same procedure was followed as above. Ethical considerations were followed. A demographic sheet of personal information such as gender, age, education, job status, family size, family type, marriage type, duration of marriage, number of children, monthly income and socio-economic status (see Appendix D). For fulfilling the inclusion criteria of the study, participants were also asked to answer three questions regarding exposure to physical violence. These items were used solely for the purpose of controlling for physical violence and were not the part of any analysis. The data was analyzed using Statistical Package for Social Sciences-20 (SPSS-20).

Results. For analyzing the data of pilot study and check the psychometric properties of the instruments used, statistical package for social sciences (SPPSS-IBM version 21) was used. Several statistical analysis were applied to check the general trend of data including calculation of mean, transformed mean, standard deviations, actual and potential ranges and values of Skewness and Kurtosis. To determine the reliability of the scales used in study Cronbach's alpha coefficients were also calculated.

Table 7

Descriptive Statistics for the Scales used in Pilot Study (N = 60)

			Scores					
			Raw	Transformed	Range			
Measures	*Items*	*a*	*M(SD)*	*M(SD)*	*Actual*	*Potential*	*Skew*	*Kurt*
CCS	32	.96	50.7(20.4)	1.5(.63)	32-109	32-128	1.4	.98
UOA	8	.93	17.0(8.3)	2.1(1.0)	8-30	8-32	0.35	-1.4
SUR	6	.89	9.6(4.1)	1.6(.68)	6-19	6-24	1.2	.29
INT	6	.92	7.9(3.3)	1.3(.55)	6-16	6-24	1.7	1.4
RCR	5	.90	6.3(1.8)	1.2(.36)	5-10	5-20	1.1	-.26
CSC	4	.83	6.9(3.0)	1.79(.77)	4-16	4-16	1.1	.65
SC	3	.77	4.3(1.6)	1.4(.53)	3-8	3-12	1.1	.24
MH	14	.81	39.3(11.1)	2.8(.79)	16-62	14-84	-0.03	-.41
MQ	10	.67	29.2(5.0)	2.9(.50)	18-40	10-50	0.29	-.38
SS	31	.84	103.0(16.2)	3.3(.52)	59-130	31-155	-0.24	.03
CSE	26	.92	51.2(13.5)	1.9(.52)	26-78	26-182	0.16	-.99

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH = Mental Health; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy; Skew = Skewness; Kurt = Kurtosis.

Table 7 is showing detail statistics including mean, median, standard deviation, skewness and kurtosis. Table 7 shows the reliability coefficients, of all scales and subscales respectively. As indicated in Table 7 all the scales have good reliabilities, showing acceptable to high internal reliabilities. As per the criteria of Field (2009) the acceptable range of skewness and kurtosis is between -2.96 to +2.96. Result is showing that in pilot study all the scales are showing the values of skewness and kurtosis in acceptable range. Mean and SD are also present in Table 7. Values of SD ranges from low to high which reveals that responses are scattered from mean of each variable.

Item total correlation of scales. Item total correlations were calculated in order to examine the consistency among items with their scales and subscales. One of the most commonly used method to examine internal consistency is to calculate item total correlation. Following are the results showing correlation of every scale with its subscale for all variables of study.

Table 8

Item -Total Correlation of Use of Authority Subscale of Coercive Control Scale (N = 60)

Item No.	*r*
14	.78**
17	.82**
22	.72**
15	.81**
18	.78**
19	.74**
23	.73**
16	.78**

Table 8 is showing item-total correlation of use of authority subscale of coercive control scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 9

Item -Total Correlation of Surveillance Subscale of Coercive Control Scale (N = 60)

Item No.	*r*
9	.84**
11	.84**
10	.75**
8	.84**
12	.84**
13	.67**

Table 9 is showing item-total correlation of surveillance subscale of coercive control scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 10

Item -Total Correlation of Intimidation Subscale of Coercive Control Scale (N = 60)

Item No.	*r*
25	.91**
24	.94**
6	.73**
7	.83**
21	.78**
5	.84**

Table 10 is showing item-total correlation of intimidation subscale of coercive control scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 11

Item -Total Correlation of Restricting Contact with Relatives Subscale of Coercive Control Scale (N = 60)

Item No.	*r*
4	.74**
2	.85**
3	.57**
1	.69**
20	.83**

Table 11 is showing item-total correlation of restricting contact with relative's subscale of coercive control scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 12

Item -Total Correlation of Control on Social Contacts Subscale of Coercive Control Scale (N = 60)

Item No.	*r*
31	.84**
30	.82**
29	.86**
32	.72**

Table 12 is showing item-total correlation of control on social contacts subscale of coercive control scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 13

Item -Total Correlation of Sexual Coercion Subscale of Coercive Control Scale (N = 60)

Item No.	*r*
26	.86**
27	.74**
28	.81**

Table 13 is showing item-total correlation of sexual coercion subscale of coercive control scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 14

Item -Total Correlation of Emotional Well-Being Subscale of Mental Health Scale (N = 60)

Item No.	*r*
1	.83**
2	.87**
3	.89**

Table 14 is showing item-total correlation of emotional well-being subscale of mental health. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 15

Item -Total Correlation of Social Well-Being Subscale of Mental Health Scale (N = 60)

Item No.	*r*
4	.64**
5	.43**
6	.62**
7	.69**
8	.58**

Table 15 is showing item-total correlation of social well-being subscale of mental health. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 16

Item -Total Correlation of Psychological Well-Being Subscale OF Mental Health Scale (N = 60)

Item No.	*r*
9	.47**
10	.62**
11	.68**
12	.52**
13	.58**
14	.50**

Table 16 is showing item-total correlation of psychological well-being subscale of mental health scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 17

Item -Total Correlation of ENRICH Marital Satisfaction Scale (N = 60)

Item No.	*r*
1	.56**
2	.63**
3	.53**
4	.66**
5	.44**
6	.76**
7	.40**
8	.63**
9	.48**
10	.54**

Table 17 is showing item-total correlation of ENRICH marital satisfaction scale. Result is indicating that all the items are significantly positively correlated with the composite score of the scale.

Table 18

Item -Total Correlation of Externalized Self-Perception Subscale of Silencing the Self Scale (N = 60)

Item No.	*r*
6	.63**
7	.57**
23	.58**
27	.72**
28	.78**
31	.68**

Table 18 is showing item-total correlation of externalized self-perception subscale of silencing the self scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 19

Item -Total Correlation of Care as Self-Perception Subscale of Silencing the Self Scale (N = 60)

Item No.	*r*
1	.66**
3	.67**
4	.44**
9	.43**
10	.61**
11	.48**
12	.45**
22	.49**
29	.65**

Table 19 is showing item-total correlation of care as self-perception subscale of silencing the self scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale.

Table 20

Item -Total Correlation of Divided Self Subscale of Silencing the Self Scale (N = 60)

Item No.	*r*
5	.59**
13	.73**
16	.74**
17	.64**
19	.66**
21	.45**
25	.65**

Table 20 is showing item-total correlation of divided self subscale of silencing the self scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 21

Item -Total Correlation of Silencing the Self Subscale of Silencing the Self Scale (N = 60)

Item No.	*r*
2	.45**
8	.33*
14	.46**
15	.28*
18	.46**
20	.62**
24	.56**
26	.65**
30	.46**

Table 21 is showing that item-total correlation of silencing the self subscale of silencing the self scale. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 22

Item -Total Correlation of Problem Focused Coping Subscale of Coping Self-Efficacy (N = 60)

Item No.	*r*
2	.40**
3	.65**
5	.69**
6	.76**
7	.77**
8	.71**
9	.69**
13	.51**
14	.58**
20	.60**
25	.46**
26	.50**

Table 22 is showing item-total correlation of problem focused coping subscale of coping self-efficacy. Result indicates that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 23

Item -Total Correlation of Unpleasant Emotions and Thoughts Subscale of Coping Self-Efficacy (N = 60)

Item No.	*r*
1	.52**
10	.81**
11	.67**
12	.83**
15	.66**
19	.72**
21	.74**
22	.77**
23	.62**

Table 23 is showing item-total correlation of unpleasant emotions and thoughts subscale of coping self-efficacy. Result is indicating that all the items are significantly positively correlated with composite score of their subscale, which is an indicator of interrelatedness of the items.

Table 24

Item -Total Correlation of Support from Friends and Family Subscale of Coping Self-Efficacy (N = 60)

Item No.	*r*
4	.47**
16	.65**
17	.81**
18	.73**
24	.49**

Table 24 is showing item-total correlation of support from friends and family subscale of coping self-efficacy. Result is indicating that all the items are significantly positively correlated with the composite score of their subscale, which is an indicator of interrelatedness of the items.

Correlation Analysis

To check the direction of relationship among study variables Pearson Product Moment Correlation was calculated. Findings of the analysis is shown in Table 25.

Table 25 is showing the results of the Pearson Product Moment correlation analysis between the study variables. The result is showing that all the subscales of coercive control scale are significantly positively related to each other. Coercive control is showing nonsignificant relation with mental health, but the direction is negative however, coercive control is showing significant negative relation with one of its subscales (i.e. emotional well-being). Coercive control is showing nonsignificant relationship with marital quality, but the direction of relation is negative. Coercive control is nonsignificantly related to self-silencing but the direction of relationship is negative. Coercive control is showing significant negative relationship with coping self-efficacy. Mental health is negatively related to self-silencing. Mental health is showing nonsignificant relation with coping self-efficacy. Marital quality is showing nonsignificant negative relationship with self-silencing. Martial quality is showing nonsignificant relationship with coping self-efficacy. Self-silencing is showing nonsignificant negative relationship with coping self-efficacy.

Table 25

Correlation between Study Variables (N = 60)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
CSS	-	.85**	.83**	.87**	.80**	.84**	.71**	-.24	-.48**	-.13	-.16	-.22	.08	-.30*
UOA		-	.61**	.63**	.71**	.74**	.61**	-.19	-.50**	-.00	-.14	-.31*	.19	-.39**
SUR			-	.73**	.54**	.61**	.47**	-.19	-.31*	-.19	-.09	-.09	-.00	-.28*
INT				-	.72**	.60**	.62**	-.23	-.49**	-.22	-.16	-.12	.00	-.22
RCR					-	.63**	.56**	-.02	-.38**	-.00	-.07	-25*	.08	-.28*
CSC						-	.55**	-.31*	-.42*	-.10	-.20	-.17	.19	-.21
SC							-	-.30*	-.20	-.11	-.12	-.30*	.01	-.18
MH								-	.72**	.72**	.86**	.17	-.18	.21
EWB									-	.40**	.51**	-.33*	.24	.22
SWB										-	.27*	.14	.02	.29*
PWB											-	.17	-.15	.08
MQ												-	-.16	.17
SS													-	-.18
CSE														-

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH = Mental Health; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy.

*$p < .05$, **$p < .01$

Discussion

Pilot study was conducted with the aim of achieving various objectives which included assessment of psychometric properties of the scales utilized, to check the understanding level of the questions being asked, to check the trend of relationships among variables of study and lastly to deal with any kind of ambiguity which can arise at the time of administration. While administration of questionnaire, mostly participants reported that some questions are quite personal and they felt little reluctant to answer them. To deal with this issue it was decided to spend more time on explanation of the objectives and purposes of the research and to ensure the confidentiality of their responses. A detailed explanation was given regarding the ethical consideration including confidentiality of data, voluntary participation, right to quit and maintaining anonymity.

Results showed that all the scales and subscales had alpha coefficients in acceptable range. According to Field (2009) the acceptable range of skewness and kurtosis is -2.96 to +2.96. With respect to pilot study, values of skewness and kurtosis were in acceptable range following the criteria of Field (2009).

To fulfill the next objective of the study i.e. to check the direction of relationships in study variables, Pearson Product Moment correlation analysis was done. The direction of the relationships and strength of the relations were almost the same as expected. The predicting and outcome variables were related to each other in expected directions except for the relation of coercive control with silencing the self scale and relation of silencing the self with marital satisfaction, which were nonsignificant but the direction was same as anticipated. So, it was assumed that the increased sample size of main study and diversity of sample will improve the strength of these relations.

Since no major problems were encountered in conducting pilot study, administration of questionnaire booklets and in analysis of data, so it was agreed upon to carry out main study. It was decided to collect a sample of at least 500 married men and women for the purpose of deriving more concrete findings.

MAIN STUDY

Chapter VI

PHASE III- MAIN STUDY

The aim of present research was to discover the relationship of coercive control on the individual and relational functioning of married individuals and the role of self-silencing and coping self-efficacy. Statistical procedures were used properly to examine the data through SPSS-21 software. To estimate the internal consistency of scales, Cronbach's alpha reliability was computed. Pearson Product Moment Correlation was applied to see the relationship between variables of study. Mediation and moderation analysis were performed. Independent sample *t*-test was conducted to see differences among various demographic variables. Multiple regression analysis was applied to discover the strongest predictor for poor individual and relational functioning of married individuals.

Objective

The objective of main study was to validate the study instrument on the sample being used and testing of the proposed hypothesis.

Sample

A sample of 500 married individuals was selected by purposive and convenient sampling technique. The sample was taken from Islamabad and Rawalpindi. The inclusion criteria was an individual who is married for at least 1 year of duration, having at least one child and having no exposure to physical violence. All those who agreed to participate were asked to provide contact numbers to keep a record. The demographic profile of the sample is given in Table 26.

Table 26

Demographic Profile of Main Study (N = 483)

Variables	*Categories*	*f*	*%*	*M*	*SD*
Gender					
	Men	251	52.0		
	Women	232	48.0		
Age (in years)				37.43	9.99
Education (in years)				14.10	2.68
Employment Status (Men)					
	Government	133	53.0		
	Private	118	47.0		
Employment Status (Women)					
	Employed	150	60.2		
	Unemployed	82	33.3		
Family System					
	Nuclear	224	46.4		
	Joint	256	53.0		
Family Size				6.22	2.43
Marriage Type					
	Love marriage	122	25.3		
	Arrange marriage	360	74.5		
Duration of marriage (in years)				11.24	9.44
Number of children				2.28	1.23
Monthly income (in rupees)				47690.6	26840.7

Note. f = frequency, % = Percentage, M = Mean, SD = Standard Deviation

Table 26 is showing the demographic profile of main study participants. Majority of the participants are men with age ranging from 20-70 years (M =37.43, SD = 9.99). The education level of sample ranges from 5 to 18 years (M = 14.10; SD =

2.68). Employment status wise the sample of men (n = 133; f = 53.0) are from government sector and (n = 118; f = 47.0) are from private sector. Majority of the women sample are employed (n = 150; f = 60.2). Most of the participants are living in joint family system (n = 256; f = 53.0 %) and have arrange marriages. Duration of marriage ranges between 2 to 46 years (M = 11.24, SD = 9.44). Number of children is between 2 to 7 children (M = 2.28, SD = 1.23). Monthly income range is from 10000 to 200000 (M = 47690.69, SD = 26840.71).

Instruments. Following instruments were used in main study:

1. Coercive Control Scale (CSS)
2. Mental Health Continuum Short Form (MH)
3. ENRICH Couple Satisfaction Scale
4. Silencing the Self Scale (STSS)
5. Coping Self-Efficacy Scale (CSE)
6. Child Exposure to Domestic Violence Scale (CEDV)
7. Demographic Sheet

Procedure

For carrying out the study various organizations (i.e. schools, offices) were contacted to get permission for conducting the research with their employees. After taking permission from the administration, questionnaire booklets were distributed. Participants were asked to give their consent (see Appendix C). Afterwards the purpose of the study was made clear to the participants. Convenient sampling was use to conduct study with housewives. Each housewife was contacted personally and were briefed about the study purpose. After that the same procedure was followed as with the working sample. Keeping in mind the sensitive and personal nature of few questions in the questionnaire, special attention and ample amount of time was given for building rapport with study participants so that they fill the questionnaire honestly. Following the phase of rapport building, distribution of questionnaire booklets was done and instructions were also given. A request was made to all the study participants to fill the questionnaire honestly. Ethical considerations were followed. A demographic sheet of personal information such as gender, age, education, occupation, family members, family type, marriage type, duration of marriage, number of children and monthly income (see Appendix D).

A total of 550 questionnaires were distributed out of which 520 were returned. 20 booklets were discarded due to unanswered questionnaires. For fulfilling the inclusion criteria of the study, participants were also asked to answer 3 questions regarding exposure to physical violence. These items were used solely for the purpose of controlling for physical violence and were not the part of any further analyses. After controlling for physical violence, out of 500 total sample, 17 women who reported experience of physical violence were also excluded from the total sample as per the inclusion criteria. Analyses for main study were carried out on a sample of ($N = 483$). Main study results are explained below.

Results of Main Study

Various statistical analysis were applied to check the general trend of data i.e., mean, standard deviation, number of items), actual and potential range, values of Skewness and Kurtosis etc. Cronbach's alpha coefficients were also calculated to assess the internal consistency of the scales being used.

Table 27

Descriptive Statistics of the Scales used in Main Study (N = 483)

			Scores					
			Raw	Transformed	Range			
Measure	*Items*	*a*	*M(SD)*	*M(SD)*	*Actual*	*Potential*	*Skew*	*Kurt*
CCS	32	.93	48.8(15.6)	1.5(.48)	32-109	32-128	1.5	2.3
UOA	8	.88	13.5(5.8)	1.6(.72)	8-31	8-32	1.2	.54
SUR	6	.83	9.7(3.9)	1.6(.64)	6-22	6-24	1.1	.61
INT	6	.86	8.1(3.0)	1.3(.51)	6-16	6-24	1.3	.32
RCR	5	.84	7.6(3.2)	1.5(.64)	5-16	5-20	1.1	.12
CSC	4	.76	6.9(2.8)	1.7(.72)	4-16	4-16	1.0	.38
SC	3	.76	4.3(1.9)	1.4(.66)	3-12	3-12	1.7	2.5
MH	14	.84	45.8(12.4)	3.2(.88)	9-70	0-84	-.43	.59
EWB	3	.82	10.7(3.3)	3.5(1.11)	1-15	0-18	-1.2	1.2
SWB	5	.71	11.7(4.7)	2.3(.94)	1-20	0-24	-.27	-.80
PWB	6	.84	20.7(6.4)	3.4(1.0)	3-30	0-36	-.71	-.07
MQ	10	.67	30.1(4.3)	3.2(.44)	16-41	10-50	-.11	-.08
SS	31	.81	101.4(15.0)	3.2(.48)	58-131	31-155	-.36	-.13
CSE	26	.91	52.6(13.6)	2.0(.52)	11-84	0-182	-.39	-.10

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH = Mental Health; EWB = Emotional Well-Being; SWB = Social Well-Being; PWB = Psychological Well-Being; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy; Skew = Skewness; Kurt = Kurtosis.

Table 27 is showing detail statistics including mean, transformed mean, standard deviation, skewness and kurtosis. Table 27 shows the reliability coefficients, of all scales and subscales respectively. All the scales and subscales have good reliabilities ranging from (a = .67 - .93). Which is an indication of good to high reliabilities. The acceptable range of skewness and kurtosis ranges from -2.96 to +2.96 (Field, 2009). High scores in distribution are represented by negative value of kurtosis and negative values in skewness show existence of asymmetrical distribution of data along the mean values. All the scales are showing values of skewness and kurtosis in acceptable range. Mean and SD are also present in Table 27. Values of SD ranges from low to high which reveals that responses are scattered from mean of each variable.

Relationship among Study Variables. In main study, the foremost aim was to check relationships among variables of study. For this purpose Pearson Product Moment correlations were calculated. Results of correlation analysis is shown in Table 28.

Table 28 is showing the results of the correlation analysis. The result is showing that coercive control is significantly positively related to all of its subscales. Significant negative relation is found between coercive control and mental health along with its subscales. Coercive control is showing significant negative correlation with marital quality and coping self-efficacy. Significant positive relation is found between coercive control and self-silencing. Mental health is showing significant positive correlation with all of its subscales. Mental health and all of its subscales is showing significant positive relation with marital quality and coping self-efficacy. There is nonsignificant relationship between mental health and self-silencing. Mental health and its subscales is showing significant positive relationship with coping self-efficacy. Marital quality is showing nonsignificant relationship with self-silencing. Marital quality is positively related to coping self-efficacy. Nonsignificant relationship is found between self-silencing and coping self-efficacy.

Table 28

Correlation between Study Variables (N = 483)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
CCS	-	.86**	.78**	.49**	.44**	.70**	.60**	-.21**	-.33**	-.11*	-.16**	-.13**	.11**	-.19**
UOA		-	.54**	.39**	.29**	.51**	.46**	-.20**	-.32**	-.08	-.15**	-.17**	.13**	-.22**
SUR			-	.32**	.35**	.49**	.33**	-.17**	-.24**	-.09*	-.16**	.01	.09*	-.14**
INT				-	.30**	.19**	.32**	-.24**	-.24**	-.22**	-.18**	-.16**	-.09*	-.14**
RCR					-	.34**	.26**	.00	-.13**	.09*	-.02	.03	.02	-.05
CSC						-	.36**	-.12**	-.20**	-.03	-.08	.05	.19**	-.06
SC							-	-.09*	-.16**	-.05	-.07	-.14**	.07	-.10*
MH								-	.57**	.77**	.84**	.32**	.02	.31**
EWB									-	.30**	.41**	.29**	-.09*	.28**
SWB										-	.47**	.20**	.09*	.25**
PWB											-	.28**	.05	.25**
MQ												-	-.01	.16**
SS													-	.00
CSE														-

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH = Mental Health; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy.

*$p < .05$, **$p < .01$

Table 29

Multiple Regression Analysis Predicting Mental Health from Coercive Control, Self-Silencing and Coping Self-Efficacy (N = 483)

Predictors	R^2	ΔR^2	β	P	$F(\Delta df)$
Constant	.12	.11			21.93***(478)
Coercive Control			-.16	.001	
Self-Silencing			.04	.28	
Coping Self-Efficacy			.27	.002	

Note. ***$p < .001$

Table 29 shows the multiple regression analysis predicting mental health from coercive control, self-silencing and coping self-efficacy. These three predictors of mental health were added simultaneously. Results show that coping self-efficacy appear to be the strongest positive predictor of mental health followed by coercive control which is a negative predictor of mental health. Self-silencing do not predict mental health in combined role.

Table 30

Multiple Regression Analysis Predicting Marital Quality from Coercive Control, Self-Silencing and Coping Self-Efficacy (N = 483)

Predictors	R^2	ΔR^2	β	P	$F(\Delta df)$
Constant	.03	.03			5.96***(478)
Coercive Control			-.10	.02	
Silencing Self			.00	.97	
Coping Self-Efficacy			.14	.002	

Note. ***$p < .001$

Table 30 shows the multiple regression analysis predicting marital quality from coercive control, self-silencing and coping self-efficacy. These three predictors of marital quality were added simultaneously. Results show that coping self-efficacy appear to be the strongest positive predictor of marital quality followed by coercive control which is a negative predictor of marital quality. Self-silencing do not predict marital quality in combined role.

Mediation analyses were conducted to find out the indirect effect of self-silencing and coping self-efficacy in predicting mental health and marital quality. Mediation analysis was performed by using Process Macro. Results are shown in the following tables.

Table 31

Mediation by Coping Self-Efficacy in the Relationship between Coercive Control and Mental Health (N = 483)

Predictor	Mental Health			
	Model 1	Model 2	95% CI	
	B	*B*	*LL*	*UL*
Constant	54.1***	38.8***	33.01	44.74
Coercive Control	-.17**	-.12***	-.19	-.05
Coping Self-Efficacy		.25***	.17	.32
R^2	.04	.11		
ΔR^2		.07		
F	23.2***	32.3***		
ΔF		1.9		

Note. CL = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***$p < .001$, **$p < .01$

Table 31 is shows that coping self-efficacy mediates the relationship between coercive control and mental health. Indirect effect appears to be significant (B =.25, 95% *CL* = .17, .32) and is explaining 7% variance in mental health. Indirect effect is further confirmed by Sobel statistic and indicating significant mediation (*Sobel* z = -3.54, $p < .05$).

Table 32

Mediation by Coping Self-Efficacy in the Relationship between Coercive Control and Marital Quality (N = 483)

Predictor	Marital Quality			
	Model 1	Model 2	95% CI	
	B	*B*	*LL*	*UL*
Constant	60.79***	29.16***	27.02	31.31
Coercive Control	-.16**	-.02**	-.05	-.004
Coping Self-Efficacy		.002**	.01	.07
R^2	.03	.01		
ΔR^2		0.02		
F	18.9***	8.9***		
ΔF		10		

Note. CL = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***$p < .001$, **$p < .01$

Table 32 shows coping self-efficacy mediates the relationship between coercive control and marital quality. Indirect effect appears to be significant (*B* =.002**, 95% *CL* = .01, .07) and explains 2% variance in marital quality. Indirect effect is further confirmed by Sobel statistic and shows significant mediation (*Sobel* $z = -2.45$, $p < .01$).

Moderation analyses was conducted to explore the potential moderating roles of different variables across study variables. SPSS (Process Macro) was used in order to conduct the analyses.

Table 33

Moderating Effect of Self-Silencing on the Relationship between Coercive Control and Mental Health (N = 483)

		Mental Health	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	46.0***	44.97	47.13
Coercive Control	-.16***	-.23	-.09
Self-Silencing	.02*	-.05	.09
Coercive control x Self-Silencing	-.002***	-.01	-.00
R^2	.07		
F	13.0		
ΔR^2	.02		
ΔF	14.0		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***p <.001 *p < .05

Table 33 illustrate the moderating effect of self-silencing on the relationship between coercive control and mental health. The interaction term of coercive control and self-silencing significantly -.002* (p < .05) moderates the relationship between coercive control and mental well-being. The moderation effect is further explained by a mod graph in Figure 3.

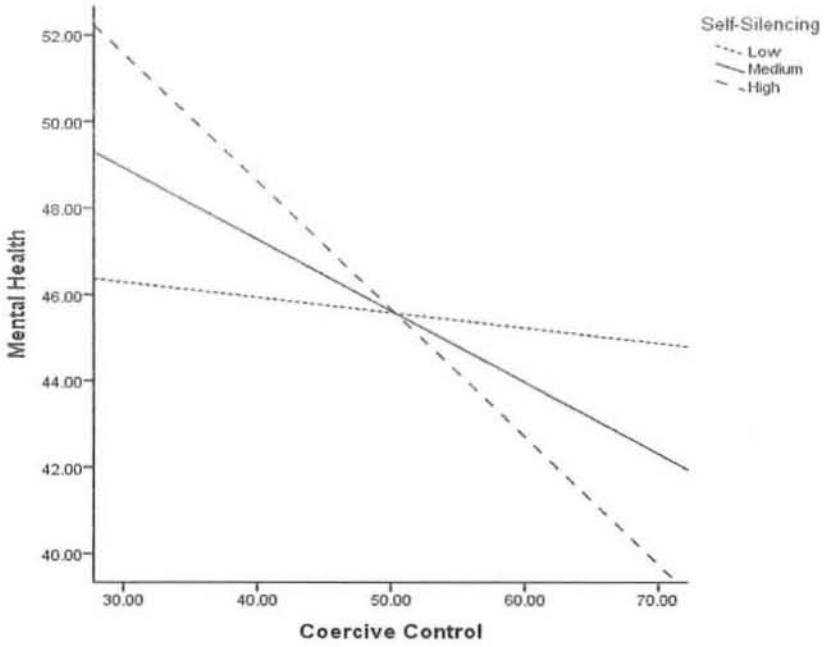

Figure 3. Graphical Representation for Moderating Role of Self-silencing in the Relationship between Coercive Control and Mental Health.

The mod graph in Figure 3 shows moderation effect of Self-silencing on the relationship between coercive control and mental health. In the above mod graph three levels of self-silencing have been depicted; low level of self-silencing is represented by dotted line; medium level of self-silencing is represented by a plain straight line and high level of self-silencing is represented by a spaced dotted line. It can be seen that a negative relationship exists for three levels of self-silencing. In other words as the coercive control is increasing, mental health is decreasing for low, medium and high levels of self-silencing. However the effect is more pronounced for high level of self-silencing followed by medium level and then low level of self-silencing.

Table 34

Moderating Effect of Self-Silencing on the Relationship between Coping Self-Efficacy and Marital Quality (N = 483)

		Marital Quality	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	30.1***	29.7	30.4
Coping Self-Efficacy	.05*	.03	.08
Self-Silencing	-.001***	-.03	.01
Coping Self-Efficacy x Self-Silencing	.003***	-.00	-.00
R^2	.06		
F	11.21		
ΔR^2	.03		
ΔF	20.11		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***p <.001 *p < .05

Table 34 illustrate the moderating effect of self-silencing on the relationship between coping self-efficacy and marital quality. The interaction term of coping self-efficacy and self-silencing significantly .003* (p < .05) moderates the relationship between coping self-efficacy and marital quality. The moderation effect is further explained by a mod graph in Figure 4.

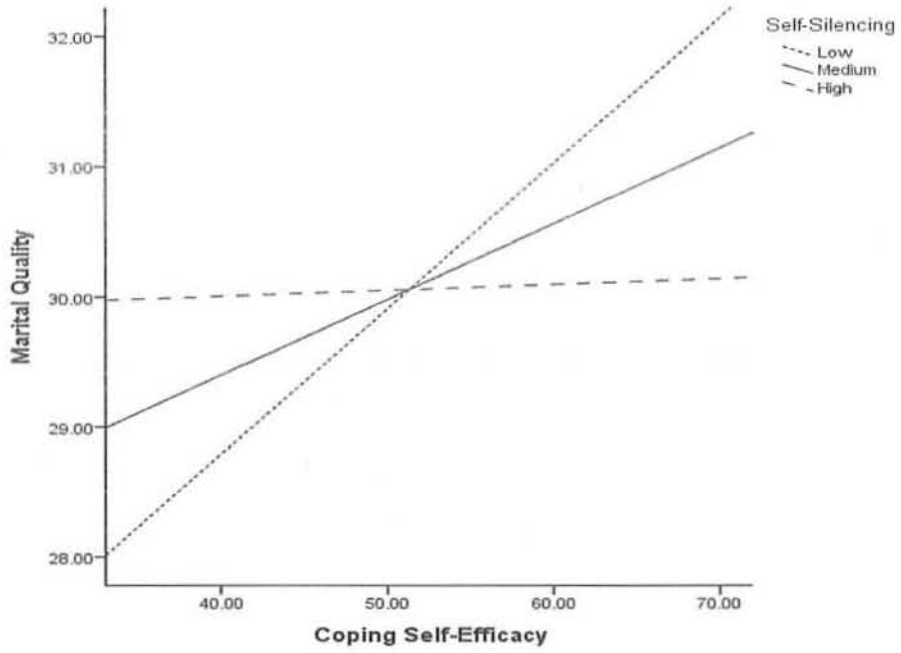

Figure 4. Graphical Representation for Moderating Role of Self-silencing in the Relationship between Coping Self-Efficacy and Marital Quality.

The mod graph in Figure 4 shows moderation effect of self-silencing on the relationship between coping self-efficacy and marital quality. In the above mod graph three levels of self-silencing have been depicted; low level of self-silencing is represented by dotted line; medium level of self-silencing is represented by a plain straight line and high level of self-silencing is represented by a spaced dotted line. It can be seen that a positive relationship exists for three levels of self-silencing. In other words as the coping self-efficacy is increasing, marital quality is increasing for low, medium and high levels of self-silencing. However the effect is more pronounced for low level of self-silencing followed by medium level and then high level of self-silencing.

Table 35

Moderating Effect of Gender on the Relation between Coercive Control and Mental Health (N = 483)

		Mental Health	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	46.05***	44.96	47.14
Coercive Control	-.10**	-.18	-.02
Gender	-2.79*	-4.9	-.61
Coercive Control x Gender	-.19*	-.35	-.04
R^2	.06		
F	11.7		
ΔR^2	.01		
ΔF	6.0		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

****p* <.001 **p* < .05

Table 35 illustrate the moderating effect of gender on the relationship between coercive control and mental health. The interaction term of coercive control and gender significantly -.19 ($p < .05$) moderates the relationship between coercive control and mental health. The moderation effect is further explained by a mod graph in Figure 5.

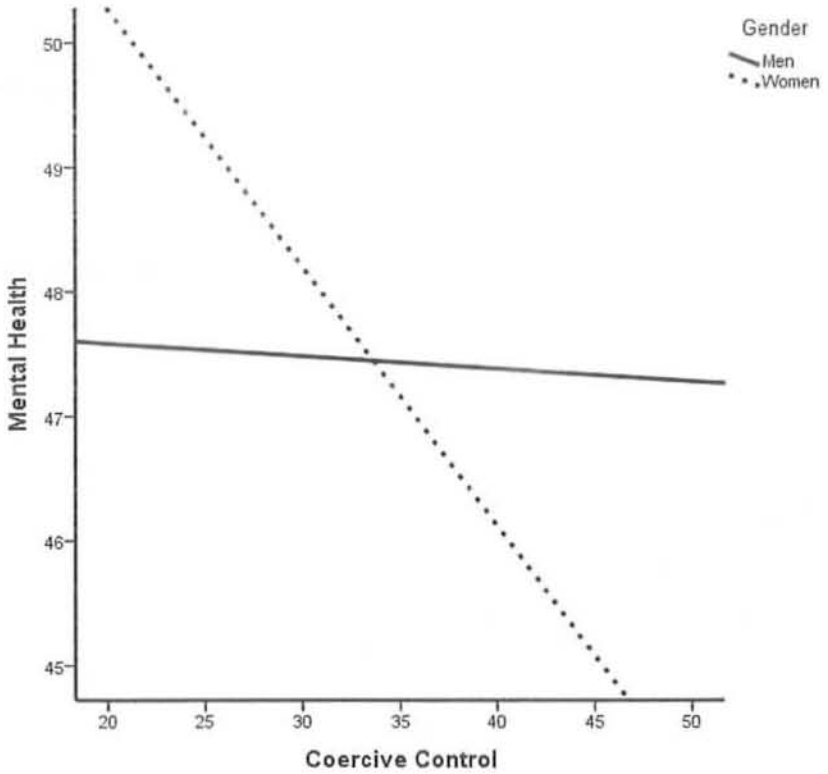

Figure 5. Graphical Representation for Moderating Role of Gender in the Relationship between Coercive Control and Mental Health.

The mod graph in Figure 5 shows moderation effect of gender on the relationship between coercive control and mental health. In the above mod graph women are represented by a dotted line and men are represented by a plain line. It can be seen that a negative relationship exists between coercive control and mental health. Which means as mental health of women is decreasing as the coercive control is increasing, whereas for men, there is a straight line which depicts no effect.

Table 36

Moderating Effect of Marriage Duration on the Relationship between Coercive Control and Coping Self-Efficacy (N = 483)

		Coping Self-Efficacy	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	52.7***	51.50	53.90
Coercive Control	-.13***	-.21	-.04
Marriage Duration	.04*	-.08	.17
Coercive Control x Marriage Duration	.01*	-.00	.02
R^2	.04		
F	7.5		
ΔR^2	.00		
ΔF	3.5		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***p <.001 *p < .05

Table 36 illustrate the moderating effect of marriage duration on the relationship between coercive control and coping self-efficacy. The interaction term of coercive control and marriage duration significantly .01 (p < .01) moderates the relationship between coercive control and coping self-efficacy. The moderation effect is further explained by a mod graph in Figure 6.

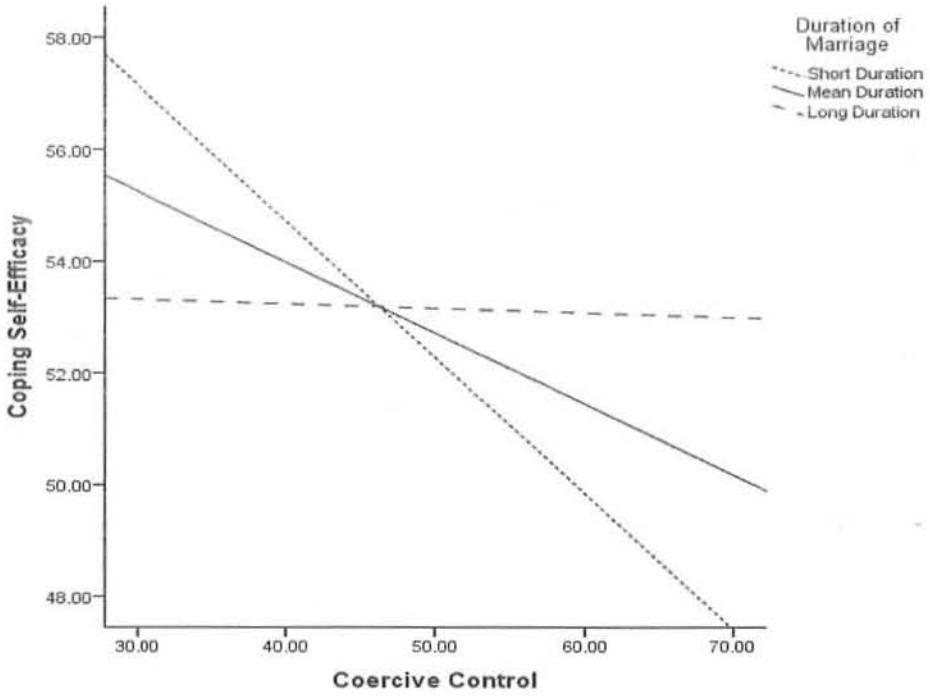

Figure 6. Graphical Representation for Moderating Role of Marriage Duration in the Relationship between Coercive Control and Coping Self-Efficacy.

The mod graph in Figure 6 shows moderation effect of marriage duration on the relationship between coercive control and coping self-efficacy. In the above mod graph three levels of marriage duration have been depicted; short duration is represented by a dotted line; mean duration is represented by a plain straight line and long duration is represented by a spaced dotted line. It can be seen that there is a negative relation between coercive control and coping self-efficacy for short marriage duration and mean marriage duration. As coercive control is increasing coping self-efficacy is decreasing for short and medium level marriage duration whereas for long marriage duration, there is no effect.

Table 37

Moderating Effect of Marriage Duration on the Relationship between Coercive Control and Self-Silencing (N = 483)

		Self-Silencing	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	101.5***	100.2	102.9
Coercive Control	.15***	.06	.25
Marriage Duration	.13*	-.01	.27
Coercive Control x Marriage Duration	.01*	-.00	.02
R^2	.02		
F	4.3		
ΔR^2	.00		
ΔF	3.3		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***p <.001 *p < .05

Table 37 illustrate the moderating effect of marriage duration on the relationship between coercive control and self-silencing. The interaction term of coercive control and marriage duration significantly .01 (p < .001) moderates the relationship between coercive control and self-silencing. The moderation effect is further explained by a mod graph in Figure 7.

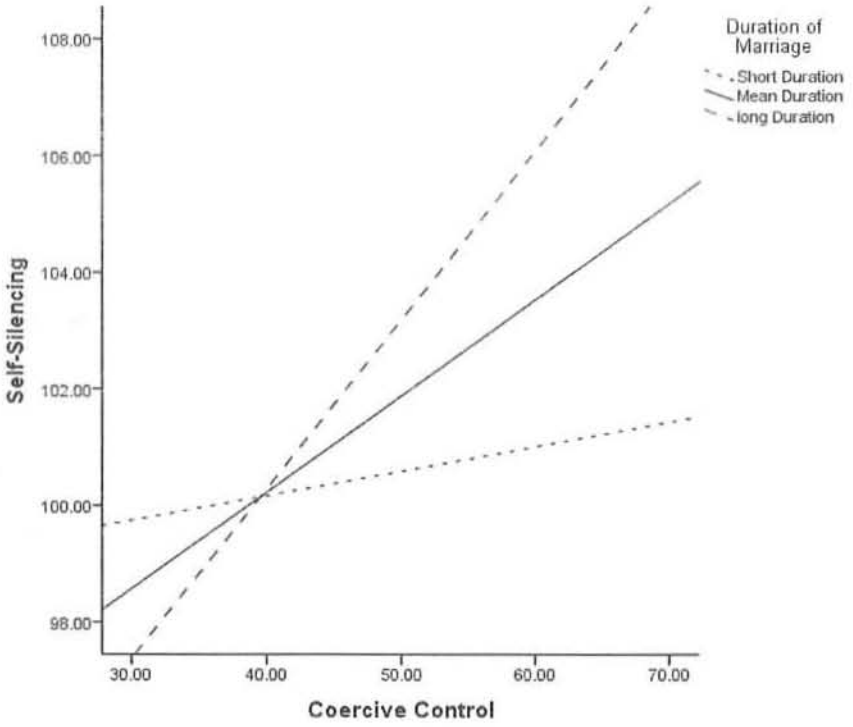

Figure 7. Graphical Representation for Moderating Role of Marriage Duration in the Relationship between Coercive Control and Self-Silencing.

The mod graph in Figure 7 shows moderation effect of marriage duration on the relationship between coercive control and self-silencing. In the above mod graph three levels of marriage duration have been depicted; short duration is represented by a dotted line; mean duration is represented by a plain straight line and long duration is represented by a spaced dotted line. It can be seen that a positive relationship exists for three levels of marriage duration. In other words as the coercive control is increasing, self-silencing is also increasing for short, mean and long duration of marriage. However, the effect is more pronounced for long duration followed by mean duration and then short duration of marriage.

Table 38

Moderating Effect of Marriage Type on the Relationship between Coercive Control and Coping Self-Efficacy (N = 483)

		Coping Self-Efficacy	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	52.6***	51.4	53.8
Coercive Control	-.17***	-.24	-.09
Marriage Type	-2.17*	-4.9	.57
Coercive Control x Marriage Type	.16***	-.00	.34
R^2	.04		
F	8.2		
ΔR^2	.00		
ΔF	3.6		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***p <.001 *p < .05

Table 38 illustrate the moderating effect of marriage type on the relationship between coercive control and coping self-efficacy. The interaction term of coercive control and marriage type significantly .16 (p < .001) moderates the relationship between coercive control and coping self-efficacy. The moderation effect is further explained by a mod graph in Figure 8.

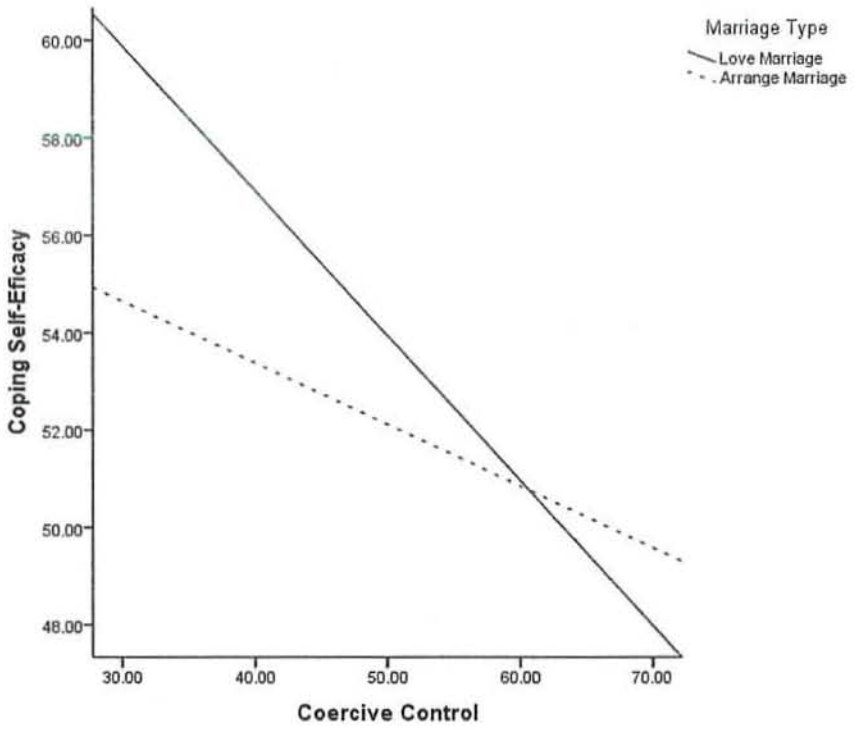

Figure 8. Graphical Representation for Moderating Role of Marriage Type in the Relationship between Coercive Control and Coping Self-Efficacy.

The mod graph in Figure 8 shows moderation effect of marriage type on the relationship between coercive control and coping self-efficacy. In the above mod graph love marriage is represented by a plain line and arrange marriage is represented by a dotted line. The mod graph shows a negative relation between coercive control and coping self-efficacy for love marriage as well as for arrange marriage. As it can be seen that as the coercive control is increasing coping self-efficacy is decreasing for love marriage. Whereas for arrange marriage the same effect is seen but on relatively low level.

Table 39

Moderating Effect of Marriage Type on the Relationship between Coping Self-Efficacy and Mental Health (N = 483)

		Mental Health	
		95% CL	
Predictor	*B*	*LL*	*UL*
Constant	45.7***	44.72	46.82
Coping Self-Efficacy	.28***	.20	.36
Marriage Type	-.28*	-2.7	2.1
Coping Self-Efficacy x Marriage Type	-.00***	-.43	-.06
R^2	.11		
F	19.8		
ΔR^2	.01		
ΔF	7.3		

Note. *CL* = confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit

***p <.001 *p < .05

Table 39 illustrate the moderating effect of marriage type on the relationship between coping self-efficacy and mental health. The interaction term of coping self-efficacy and marriage type significantly -.00 (p < .001) moderates the relationship between coping self-efficacy and mental health. The moderation effect is further explained by a mod graph in Figure 9.

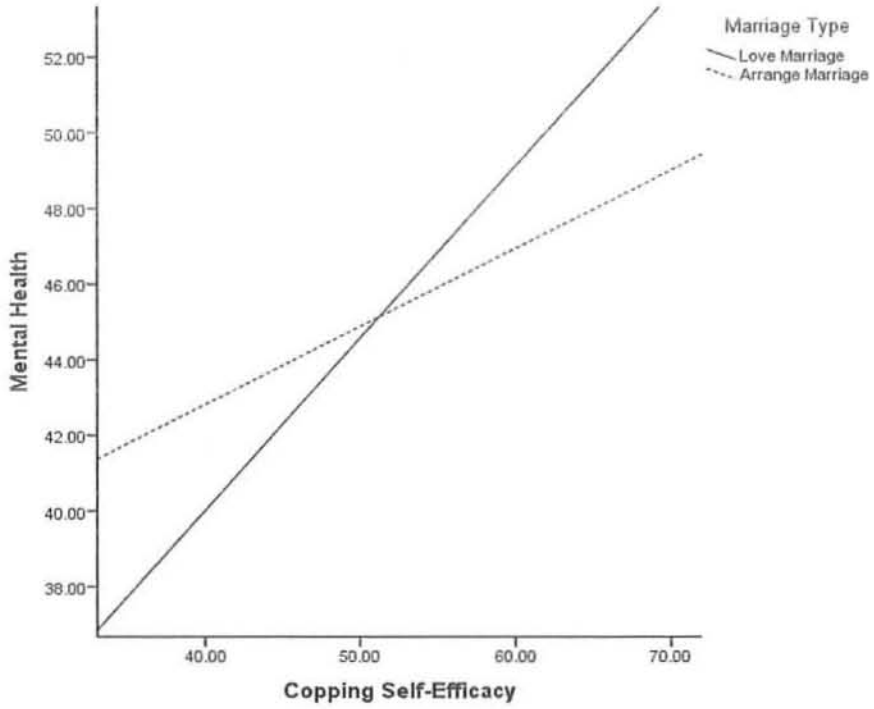

Figure 9. Graphical Representation for Moderating Role of Marriage Type in the Relationship between Coping Self-Efficacy and Mental Health.

The mod graph in Figure 9 shows moderation effect of marriage type on the relationship between coping self-efficacy and mental health. In the above mod graph love marriage is represented by a plain line and arrange marriage is represented by a dotted line. It can be seen that a positive relationship exists for both types of marriages between coping self-efficacy and mental health, in other words as coping self-efficacy is increasing mental health is also increasing. However, the positive effect is more pronounced for love marriage as compared to arrange marriages.

Table 40

Mean Differences along Gender on Study Variables (N = 483)

	Men ($n = 251$) *M(SD)*	Women ($n = 232$) *M(SD)*	*t*	*p*	95% CI *LL*	95% CI *UL*	Cohen's d
CCS	46.5(11.0)	51.4(19.1)	3.2	.00	1.7	7.1	0.2
UOA	12.1(4.7)	15.0(6.5)	5.2	.00	1.6	3.6	0.4
SUR	9.8(3.7)	9.6(4.2)	-1.1	.24	-1.0	0.27	-
INT	7.7(2.7)	8.6(3.3)	3.0	.00	0.29	1.36	0.2
RCR	7.5(2.9)	7.7(3.5)	.68	.49	-0.37	0.76	-
CSC	6.8(2.5)	7.1(3.2)	1.3	.18	-0.16	0.84	-
SC	4.0(1.7)	4.5(2.1)	2.6	.00	0.11	0.80	0.2
MH	47.4(10.7)	44.0(13.7)	-3.2	.00	-5.6	-1.4	0.2
EMW	11.1(3.0)	10.1(3.5)	-3.3	.00	-1.5	-0.41	0.3
SMW	12.1(4.3)	11.2(5.0)	-2.3	.00	-1.8	-0.17	0.2
PMW	21.3(5.8)	20.0(6.9)	-2.1	.00	-2.3	-0.09	0.2
MQ	30.8(4.6)	29.2(3.8)	-3.8	.00	-2.21	-0.72	0.3
SS	101.6(13.9)	101.2(16.1)	-.13	.89	-2.8	2.4	-
CSE	51.2(13.6)	54.2(13.4)	-2.4	.01	-5.4	-0.64	0.2

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH= Mental Health; EWB = Emotional Well-Being; SWB = Social Well-Being; PWB = Psychological Well-Being; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy.

Table 40 shows mean differences on the basis of gender across study variables. It can be seen in the Table 40 that women are reporting significantly higher than men on coercive control and coping self-efficacy. Whereas men are scoring significantly higher than women on mental health along its subscales and marital quality.

Table 41

Differences along Job Status of Women on Study Variables (N = 232)

	Unemployed ($n = 82$)	Employed ($n = 150$)			95% CI		
Measures	*M(SD)*	*M(SD)*	*t*	*p*	*LL*	*UL*	Cohen's d
CSS	51.9(17.3)	49.2(15.6)	1.1	.23	-1.7	7.0	-
UOA	15.6(6.6)	14.6(5.7)	1.2	.22	-.66	2.7	-
SUR	10.0(4.1)	9.2(3.7)	1.5	.12	-.21	1.8	-
INT	7.5(2.1)	7.3(2.1)	.40	.68	-.45	.69	-
RCR	6.4(1.8)	6.2(1.7)	1.0	.31	-.23	.73	-
CSC	7.4(2.9)	7.3(2.6)	.38	.70	-.60	.89	-
SC	5.6(1.6)	5.5(1.6)	.32	.74	-.37	.52	-
MH	41.9(11.9)	44.9(13.0)	-1.7	.08	-6.4	.40	-
EWB	10.7(2.9)	10.1(3.0)	1.3	.16	-.24	1.3	-
SWB	10.3(4.0)	11.9(4.8)	-2.8	.00	-2.8	-.49	0.3
PWB	18.8(5.8)	20.4(7.3)	-1.7	.07	-3.3	.16	-
MQ	29.7(3.7)	29.1(3.9)	1.0	.31	-.51	1.5	-
SS	100.5(17.7)	101.5(15.2)	-.45	.65	-5.3	3.3	-
CSE	46.8(11.1)	53.1(14.4)	-3.4	.00	-9.6	-2.9	0.4

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH= Mental Health; EWB = Emotional Well-Being; SWB = Social Well-Being; PWB = Psychological Well-Being; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy.

Table 41 illustrates the mean differences between study variables across women's employment status. Results is showing that social well-being is significantly higher in employed women. Similarly employed women is scoring significantly higher on coping

self-efficacy as compared to unemployed women. Difference on other study variables are nonsignificant.

Table 42

Differences along Marriage Type on Study Variables (N = 483)

	Love ($n = 122$)	Arrange ($n = 359$)			95% CI		
	M(SD)	*M(SD)*	*t*	*p*	*LL*	*UL*	Cohen's d
CSS	50.5(15.6)	48.2(15.6)	-1.5	.13	-5.5	0.7	-
UOA	13.9(6.1)	13.3(5.7)	-1.1	.26	-1.8	0.5	-
SUR	9.9(3.6)	9.6(3.9)	-.81	.41	-1.1	0.4	-
INT	8.1(2.8)	8.1(3.1)	.02	.98	-0.6	0.6	-
RCR	8.3(3.4)	7.4(3.1)	-2.7	.00	-1.6	-0.2	0.2
CSC	7.1(2.9)	6.9(2.8)	-.88	.37	-0.8	0.3	-
SC	4.3(1.7)	4.3(2.0)	-.39	.69	-0.4	0.3	-
MH	46.5(12.5)	45.6(12.3)	-.70	.47	-3.4	1.6	-
EMW	10.7(3.1)	10.6(3.4)	-.44	.65	-0.8	0.5	-
SMW	12.1(4.4)	11.5(4.8)	-1.1	.24	-1.5	0.3	-
PMW	20.2(6.4)	20.8(6.4)	.86	.38	-0.7	1.8	-
MQ	29.9(3.9)	30.1(4.4)	.44	.65	-0.6	1.0	-
SS	103.4(13.9)	100.9(15.3)	-1.6	.11	-5.5	0.5	-
CSE	53.7(13.2)	52.4(13.7)	-.91	.35	-4.1	1.4	-

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH= Mental Health; EWB = Emotional Well-Being; SWB = Social Well-Being; PWB = Psychological Well-Being; MQ = Marital Quality; SS = Self-Silencing; CSE = Coping Self- Efficacy.

Table 42 shows mean difference across study variables across marriage type. The only significant difference is seen on the subscale of coercive control (i.e., restricting contact with relatives) which is significantly higher in love marriages.

Analysis with Demographic Variables

Table 43

Correlation of Demographic Variables with Study Variables (N = 483)

Variable	Age	Edu	F.size	MD	NOC	M.Inc
CCS	-.10*	-.01	-.00	-.09*	-.02	-.08
UOA	-.09*	.08	-.02	-.10*	-.01	-.00
SUR	-.12**	-.09*	.01	-.10*	-.00	-.15**
INT	-.10*	.05	.08	-.16**	-.01	-.09*
RCR	-.07	-.03	.06	-.04	-.01	-.11*
CSC	-.01	-.02	.03	-.00	.04	-.03
SC	-.06	-.08	-.02	-.07	-.05	-.13**
MH	.07	.13**	.00	.05	.11*	-.02
EWB	.09*	-.07	-.06	.06	.07	.06
SWM	-.01	-.07	.06	-.00	.08	-.05
PWB	.09*	-.07	-.00	.05	.08	.04
MQ	.13**	-.17**	.04	.12**	.13*	-.05
SS	.08	-.07	-.05	.06	.00	-.03
CSE	.10*	.02	.09*	-.05	-.03	.11*

Note. CCS = Coercive Control Scale; UOA = Use of Authority; SUR = Surveillance; INT = Intimidation; RCR = Restricting Contact with Relatives; CSC = Control on Social Contacts; SC = Sexual Coercion; MH = Mental Health; EWB = Emotional Well-Being; SWB = Social Well-Being; PWB = Psychological Well-Being; MQ = Marital Quality; SS = Self-Silencing The Self Scale; CSE = Coping Self-Efficacy; Edu = Education; Fam-Mem = Family Member; MD = Marriage Duration; NOC = Number of Children; M.Inc = Monthly Income.

*$p < .05$, **$p < .01$

Table 43 shows the relationship of demographic variables with study variables. The result is showing that coercive control is significantly negatively related with age and marriage duration. Mental health is showing significant positive correlation with education and number of children. Marital quality is significantly positively related

with age, marriage duration and number of children, and negatively related with education. Self-Silencing is showing no significant relation with any demographic variables. Coping self-efficacy is significantly positively related with age, family size and monthly income.

Model Testing

Mediational analyses conducted previously showed significant direct and indirect paths that lead from coercive control to mental health and marital quality in married individuals. However, it is important to test these paths simultaneously rather than individually. Therefore, model testing was used to test the simultaneous relationship between coercive control, mental health, marital quality, self-silencing and coping self-efficacy.

Model testing was carried by AMOS version 21. An output was generated with multiple goodness of fit indices that showed the degree to which proposed model was a goodness of fit. These indices include chi-square (x^2), relative/normed chi square (x^2/df), Root Mean Square of Approximation (RMSEA), Incremental Fit Test (IFI), Goodness of Fit (GFI) and Comparative Fit Index (CFI). The criteria for goodness of fit requires IFI, GFI and CFI > .90 and RMSEA < .08 (Brown & Cudeck, 1993). For x^2 recommendations range from as high as 5.0 (Wheaton, Muthen, Alwin & Summers, 1977) to as low as 2.0 (Tabachink & Fidell, 2007).

Table 44

Model Fit Indices for Model Predicting Mental Well-Being and Marital Quality (N = 483)

	$x^2(df)$	NFI	IFI	TLI	CFI	RMSEA	$\Delta x^2(\Delta df)$
Model 1	38.44(2)	.73	.74	-.35	.72	.19	
Model 2	39.16(4)	.72	.75	.34	.73	.13	.72(2)
Model 3	1.43(3)	.99	.96	1.0	1.0	.00	37.72(1)

Note. NFI = Normed Fit Index, IFI = Incremental Fit, TLI = Tucker Lewis Index, CFI = Comparative Fit Index, RMSEA = Root Mean Square Error of Approximation

Model 1 = default model

Model 2 = model 1 after deleting nonsignificant paths

Model 3 = model 2 after adding error variances

In Table 44 Model 1 shows the model fit indices for the initial hypothesized model which showed a direct path from coercive control to mental well-being and marital quality, and indirect paths that showed the mediating role of self-silencing and coping self-efficacy. The model fit indices of this model failed to meet the criteria for good fit, in addition to that, results showed that self-silencing did not significantly predicted mental well-being and marital quality, and therefore, these paths were deleted. In the above Table Model 2, shows the model fit indices after the deletion of nonsignificant paths. However, it can be seen that the criteria for good model fit was still not achieved. In order to achieve good model, error covariance were added. Model 3, shows the model fit indices after adding the error covariance. The final model depicting only the significant paths and error covariance is shown in Figure 10.

Table 45

Standardized Path Coefficients for Direct and Indirect Effects (N = 483)

Dependents	Predictors			
	CCS		CSE	
	β *Direct*	*β* *Indirect*	*β* *Direct*	*β* *Indirect*
CSE	-.19**	-	-	-
SS	.12*	-	-	-
MQ	-.10*	-.02**	.14*	-
MH	-.16**	-.05**	.26**	-

Note. CCS = Coercive Control Scale; CSE = Coping Self-Efficacy; SS = Self-Silencing; MQ = Marital Quality; MH = Mental Health.

**$p < .01$, *$p < .05$

Table 45 depicts the standardized coefficients for direct and indirect paths, along with their significance level indicated through asterisks. The results show that coercive control has a significant negative direct effect on CSE (β = -.19**, $p < .01$). The results also showed that coercive control had significant negative direct effect on marital quality (β = -.10;*, $p < .01$) and mental health (β = -.16**, $p < .01$). Moreover, the results showed significant negative indirect effect on marital quality (β = -.02**, $p < .01$) and mental health (β = -.05**, $p < .01$). Lastly coping self-efficacy showed positive direct effect on marital quality (β = .14*, $p < .05$) and mental health (β = .26**, $p < .01$).

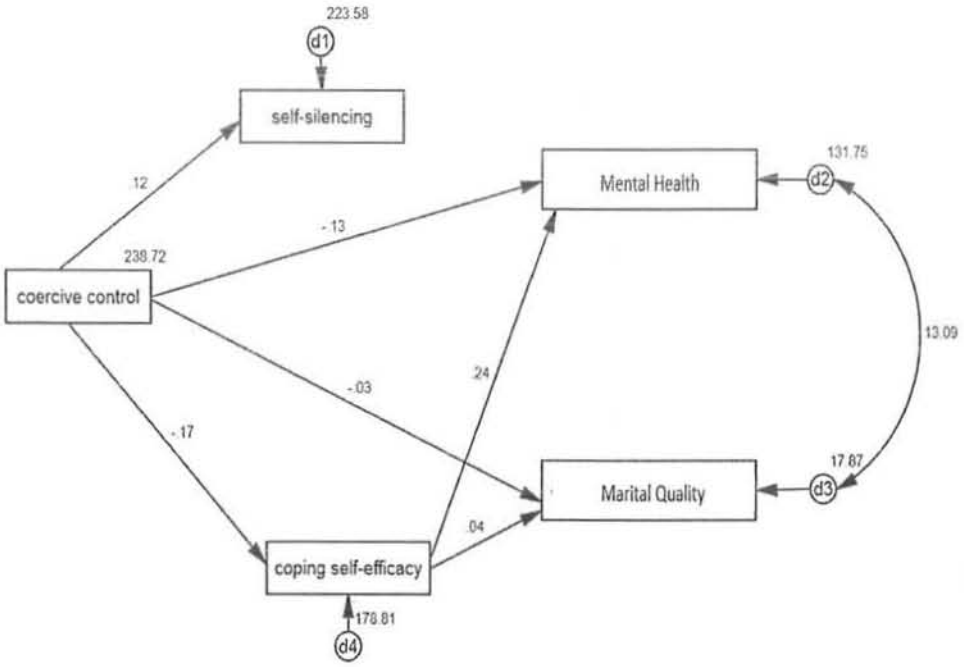

Figure 10. Model Fit Showing Direct and Indirect Paths between Coercive Control, Mental Health and Marital Quality.

DISCUSSION

Chapter VII

DISCUSSION

The major focus of the study was to highlight the impact of coercive control on individual and relational functioning of married individuals and also to explore the roles of self-silencing and coping self-efficacy. The present research consisted of two studies. Study I was the qualitative exploration of coercive control phenomenon which has been discussed previously (see Page). Study II was based on three phases which were I) development of the indigenous measure for coercive control experiences in a marital relationship, II) pilot study and III) the main study. Based on the qualitative information, it was decided to develop an indigenous scale for coercive control (phase I). The whole process is discussed previously (see Page).

Pilot study (phase II) was carried out with three main objectives including to see psychometric properties of scales used in the study, to see the direction of relationships among variables, and to identify any issue in the administration of the questionnaires. Due to the sensitive nature of the study and to eliminate the factor of social desirability bias in study, special attention was given on rapport building and to find ways to maximize genuine responses. To conduct the pilot study 60 participants (30 men & 30 women) from Islamabad and Rawalpindi were approached using convenient sampling technique. The results of the pilot study showed acceptable Cronbach's alpha reliability coefficients (See Table 7) and item total correlations for all study variables (See Table 8-24).

Exploring the directions of relationship between study variables was the second objective of pilot study. To achieve this objective, correlation analysis was carried out (see Table 25). The results were in accordance with previous findings. Due to the sensitivity of the topic and personal nature of the questions, some participants were reluctant in answering few items. To tackle this problem in main study it was decided to give more time for rapport building and explaining the purpose and objectives of the research before taking their consent. Ethical considerations including making sure that the data will remain confidential, the right to leave the research anytime and keeping the identity anonymous were also explained clearly to the participants. Before starting the distribution of questionnaires, participants were clearly told about the sensitive

nature of few statements. After spending ample amount in rapport building, the response rate was found to be increased on sensitive statements.

Phase III was based on main study. To conduct the main study a sample of 500 married individuals ($N = 500$) was collected. Keeping in mind the inclusion criteria of the study, exposure to physical violence was controlled for the final inclusion of sample in the study. For this purpose a subscale of Child Exposure to Domestic Violence Scale (Edleson et al., 2008 translated by Masood, 2014) was used. After controlling for physical violence a total of 17 women who reported exposure to physical violence were excluded from the main study sample. So hypotheses testing was carried out on a sample of 483 married men and women.

First of all psychometric properties of the main study data were checked (see Table 27). In the main study, reliability estimates were satisfactory and showed acceptable to high internal consistency. The results revealed that values of skewness and kurtosis were in acceptable range as per the criteria of Field (2009) which is +2.96 to -2.96 (see Table 27).

The underlying relationships among variables of study (i.e., coercive control, mental health, marital quality, self-silencing, & coping self-efficacy) was explored by using Pearson Product Moment correlations. Carrying out correlation analysis in researches is important as it helps in predicting relationships and to conduct higher order analyses based on these relationships. For the first hypothesis, which was based on previous literature it was assumed that coercive control will be negatively related to the mental health of married individuals. The hypothesis was supported in the study (see Table 28). Coercive control had significant negative relationship with mental health. This finding was consistent with the previous researches where researchers have repeatedly reported negative relationship between intimate partner violence and mental health leading to depression, PTSD, anxiety, self-harm, and sleep disorder (Dutton et al., 2005; Dillon et al., 2013; Mazher, 2017; Williamson, 2010). In the previous literature those women who had experienced violence showed more symptoms of PTSD (Coker et al., 2003; Kelly & Johnson, 2008; Pico-Alfonso et al., 2006; Scott-Tilley et al., 2010). More severe and higher levels of depression have been reported by women experiencing abuse as compared to those who did not experienced abuse in past studies (Bonomi et al., 2006; Devries et al., 2013; Zahnd et al., 2011). Low psychological well-

being has been linked with the presence of intimate partner violence (Beeble et al., 2009). According to Stark (2009) coercive control is an ongoing process of threat. This presence of threat becomes the reason for poor mental health and low psychological well-being. The reason for the negative relationship between coercive control and mental health might be that marriage itself is a big responsibility which can cause stress and when the added stressor of controlling partner is present, it is likely to result in poor mental health consequences for married individual. Mostly in Pakistani society it is seen that men enjoy the dominant status and control their wives which impact their mental health negatively. Living in an environment where the women's individual identity and self-esteem is lost and they have no right to object the demands of their husband increases the risk of mental health issues.

For the second hypothesis it was assumed that coercive control will be positively related to self-silencing. This hypothesis was supported by the study results (see Table 28). The results showed that coercive control had significant positive relationship with self-silencing. Previous literature has also shown similar findings. It has been found in empirical studies that presence of intimate partner violence in married life whether it is physical or non-physical is positively related to self-silencing (Gilbert & Gordon, 2017; Leitao, 2014). The trait of self-silencing is considered as a coping mechanism against marital conflicts (Whiffen et al., 2007). This positive relationship might be because of the cultural contexts in which we are living. It is preferred to stay silent than to speak against your partner. In an effort to keep the relationship and for avoiding the negative consequence such as family disruption, financial problems, and societal pressure, couples keep on living with each other by adopting the trait of self-silencing after experiencing coercive control or any kind of abuse. Especially, women are trained in this manner that they have to take care of the moral standards of the society and maintain the image of good wife. Moreover, women are financially dependent on their partners due to which they prefer to stay quiet even in abusive relationship. Another major reason might be the children, mostly women stay quiet and keep living with the abuser due to their children. All these factors show that why positive relationship exist in coercive control and self-silencing.

For the third hypothesis, it was assumed that coercive control will be negatively related to marital quality. This hypothesis was supported by results of the study (see Table 28). Coercive control had significant negative relationship with marital quality.

This finding is according to the past literature where intimate partner violence had been associated negatively with marital quality. A number of empirical findings suggests that there is a negative relationship between intimate partner violence experiences and marital quality; presence of any form of violence leads to lower levels of marital quality, increased stress in relationship and fewer or no benefits from the relationship (Langhinrichsen-Rohling et al., 1998; Lawrence & Bradbury, 2001; Testa & Leonard, 2001; Stith et al., 2008; Williams & Frieze, 2005). A study was carried out on Turkish women which revealed that women who were experiencing insults, physical violence, and fulfilling the demands of their husbands showed lower levels of marital quality (Erci & Ergin, 2005). Another study confirmed that intimate partner violence had negative impact on the relationship quality of the spouses (Shortt, Capaldi, Kim, & Laurent, 2010). Panuzio and DiLillo (2010) found in their study that psychological form of intimate partner abuse had strong negative relationship with marital quality of the partner who is experiencing it and marital quality of people increases as the hostility and violence is decreased by the abuser. This negative relationship might be due to the fact that coercive control is an ongoing process, consistent criticism, insults, attack on self-image, identity and self-esteem of the victim is likely to result in negative consequence and lower marital quality. Women in our culture are raised in a manner that they are told only the pros of getting married. When such women enter in married life and their partner start controlling, dominating and imposing their demands on them, their idea of perfect married life and partner is distorted which eventually effects their marital quality. Moreover, when a girls gets married she is told that her husband will be her guardian and when she experience abuse (physical/non-physical) from that guardian, it damages her mental health and have negative impact on her marital quality as well.

For the fourth hypothesis it was assumed that coercive control will be negatively related to coping self-efficacy of married individuals. This hypothesis was approved by the results (see Table 28). The result showed significant negative relationship between coercive control and coping self-efficacy. This finding is in line with past literature. Studies have found that presence of severe IPV and low levels of mental health is related to lower levels of coping self-efficacy (Johnson & Benight, 2003). Studies have also found that the presence of IPV effect the ability of coping self-efficacy negatively (Calvete et al., 2008; Clements & Sawhney, 2000; Krause et al., 2008; Kocot &

Goodman, 2003; Lee et al., 2007). The reason behind this can be that the person experiencing any form of violence has low mental health due to which he/she is not able to fully recognize and trust his/her abilities to overcome the trauma. Moreover, a victim of coercive control feel that they have no control of the situation due do which they are not able to use their coping self-efficacy abilities.

For the fifth hypothesis it was assumed that mental health will be positively related to marital quality. This hypothesis was supported by the study results (see Table 28). Correlation analysis results showed that mental health had significant positive relationship with marital quality. This finding was in congruence with the previous literature. A study was conducted to see the relationship of psychological well-being with marital quality. The results of the study showed a significant positive correlation between psychological well-being and marital quality (Khajeh, Goodarzi, & Soleimani, 2014). Proulx et al. (2007) conducted a meta-analysis and the findings showed that high marital quality had positive association with mental health. A number of empirical studies have highlighted the relationship of low marital quality with low levels of self-rated health, less life satisfaction, more chances of depression and feelings of loneliness (Dykstra & Fokkema, 2007; Hawkins & Booth, 2005; Umberson et al., 2006; Walker, Isherwood, Burton, KitweMagambo, & Luszcz, 2013; Whisman, Uebelacker, Tolejko, Chatav, & McKelvie, 2006). This positive relationship between mental health and marital quality might be because when an individual is satisfied in his/her married life, it will automatically impact the overall well-being of that person. A happily married couple will not face any distress related to their relationship which will increase their marital quality and mental health. When an individual feels satisfied and adjusted in his/her married life, it is more likely that he/she will have better mental health as there are no stressors in the relationship. As the quality of marriage increases, the advantages associated with it also increase which impact the overall well-being of the person. Moreover, as found in previous literature low levels of marital quality and high levels of marital distress leads to depression and overall poor satisfaction with life.

For the sixth hypothesis it was assumed that mental health will be negatively related to self-silencing. This hypothesis was not supported by the study (See Table 28). There was nonsignificant relationship between mental health and self-silencing. This finding was not in congruence with the previous literature. In previous studies self-silencing had been associated with a number of negative mental health outcomes such

as anger suppression, lower self-esteem, depression eating disorders, self-alienation and loneliness (Ali & Toner, 2001; Besser et al., 2003; Besser et al., 2010; Frank & Thomas, 2003; Haemmerlie et al., 2001; Mauthner, 2010; Morrison & Sheahan, 2009; Page et al., 1996; Piran & Cormier, 2005; Wechsler et al., 2006; Zaitsoff et al., 2002). This difference between the finding of the study and previous literature might be due to the cultural differences. Pakistan is a male dominated country, women here are taught to stay quiet, to be patient, more tolerant and obedient to their husband's. This training is given to them by birth, as a result they become a self-sacrificing person who feels good by keeping their husband and in-laws happy (Winkvist & Akhtar, 2000; Hamid et al., 2010).

Moreover, a study was conducted in Pakistani context and it found self-silencing to be a pro-social behavior as it helps in avoiding arguments and save the relationship (Ali et al., 2000). Self-silencing is also used as a coping mechanism to deal with marital conflict. In trying to maintain the traditional roles, both men and women adopt self-silencing. Men are considered as less expressive and women are thought to take care of everyone and keep the relationships. Marriage is considered a very sacred relationship in Pakistani culture, usually couples try their best to continue with each other even when they are not satisfied or experience violence of any kind. This is a major reason why intimate partners adopt self-silencing for the sake of maintaining their relationship and take it as a positive trait rather than negative, because the advantages of adopting self-silencing seems to be more then disadvantages and because of which it does not impact their mental health negatively. This might be the one possible reason of having nonsignificant relationship between mental health and self-silencing in the current study sample.

For the seventh hypothesis it was assumed that mental health will be positively related to coping self-efficacy. This hypothesis was approved by the results of the study (see Table 28). Mental health showed significant positive relationship with coping self-efficacy. Previous studies have also showed similar results. A number of studies have reported that use of coping self-efficacy strategies increases the mental health of the person by reducing depression, PTSD, and hopelessness (Benight & Harper, 2002; Bosmans et al., 2013; Flower & Hill, 2004; Melato, Eeden, Rothmann, & Bothma, 2017). Similarly Chesney et al. (2006) has reported that frequent use of problem-focused coping and emotion-focused coping is related to more psychological well-

being and low psychological distress. The reason for this positive association is that when a person feels and believes that he is self-vivacious and has all the resources to deal with the stress then it automatically effect the negative mental health problems by reducing them. Hence mental health is increased by presence of coping self-efficacy.

For the eighth hypothesis it was assumed that marital quality will be positively related to coping self-efficacy. This hypothesis was supported by the results of the study (See Table 28). Marital quality showed significant positive relationship with coping self-efficacy. This finding is according to previous literature in which it was found that martial quality is positively related to coping self-efficacy or vice versa (Cui, Fincham, & Pasley, 2008). In a study conducted the use of effective coping techniques such as problem-focused coping and positive emotion-focused coping was found to correlate positively with marital quality and psychological well-being and showed negative correlation with psychological distress. Moreover, the study indicated that ineffective coping techniques such as negative emotion-focused coping had negative relationship with marital quality and psychological well-being, and had positive relationship with psychological distress (Besharat et al., 2006). Researches have confirmed that a person who has high marital quality is likely to use problem focus coping techniques and a dissatisfied person is likely to use emotion focus coping techniques (Sabourin, Laporte, & Wright, 1990; Salabifard, Rafezi, & Haghighatbayan, 2015). The possible explanation for this positive association between marital quality and coping self-efficacy might be that when anxiety, depression and conflict is not present in a relationship and the person is fully satisfied with his/her relationship, they are more likely to invest all their energies towards a sudden stressor. Moreover, the support from partner will also help to accomplish the daily life challenges more effectively. In this way they will be able to use all the effective coping strategies to deal with the problem. Therefore, a person with high marital quality is more capable of using more effective coping techniques.

For the ninth hypothesis it was assumed that self-silencing will be negatively related to marital quality. The result of the study showed nonsignificant relationship between self-silencing and marital quality, but the direction was negative (See Table 28). Previous literature has shown contrary results from the present study. Self-silencing is found to be negatively related to marital quality (Harper & Welsh, 2007; Uebelacker et al., 2003; Zehra, 2012). This lack of relationship between self-silencing

and marital quality might suggest that in Pakistani settings, self-silencing can be less threatening for women's individual and relational functioning. One possible explanation can be that women in our culture are more familiar to the norm of self-silencing before and after marriage, due to which less impairment in psychological functioning is seen as compare to western countries. Moreover, remaining silent for individual and relational well-being in a collectivistic culture can be less damaging.

Multiple linear regression was conducted to determine the strongest predictors of mental health and marital quality in the present study. Result of multiple linear regression predicting mental health from coercive control, coping self-efficacy and self-silencing showed that coping self-efficacy was the strongest positive predictor of mental health. Coercive control was a significant negative predictor of mental health, whereas self-silencing was found to be nonsignificant predictor of mental health. Regression model accounted for 11% variance (see Table 29). The results indicated that those individual who have high levels of coping self-efficacy will have better mental and psychological health. Sullivan, McPartland, Price, Cruza-Guet, and Swan (2013) carried a research and found similar finding suggesting that coping self-efficacy plays the role of a protective factor for mental health and having coping self-efficacy beliefs enhances the mental health of an individual . Whereas those experiencing coercive control in intimate relationship will have poor mental health. This finding was supported by previous literature which also indicated that presence of intimate partner abuse in intimate relationship can have severe negative impact on mental health of the victim including depression, anxiety, PTSD and suicide (Pico-Alfonso, 2005; Pico-Alfonso, 2006).

Another multiple linear regression analysis was carried to explore the strongest predictors of marital quality. Result of multiple linear regression predicting marital quality from coercive control, coping self-efficacy and self-silencing showed that coping self-efficacy was the strongest positive predictor of marital quality. Coercive control was a significant negative predictor of marital quality, whereas self-silencing was found to be nonsignificant predictor of marital quality. Regression model accounted for 3% variance (see Table 30). The results indicated that those individual who have high levels of coping self-efficacy will have better marital quality. A study reported the same finding which suggested that having coping self-efficacy beliefs can predict more marital quality because it allows the individual to deal with any conflict

in marital relationship (Riggio, et al., 2013). Whereas those experiencing coercive control in intimate relationship will have poor marital quality. This finding was in line with previous studies which also found that intimate partner violence especially psychological type of violence decreases marital quality over time (Razera et al., 2016; Shortt et al., 2010; Panuzio & DiLillo 2010).

Another objective of the study was to investigate the mediating role of self-silencing and coping self-efficacy on individual and relational functioning of married individuals. For this purpose mediation analysis were conducted. For the tenth hypothesis it was assumed that coping self-efficacy would mediate the relationship between coercive control and mental health of married men and women. This hypothesis was confirmed by the results (see Table 31). Results showed that coping self-efficacy mediated the relationship between coercive control and mental health. The mediation analysis showed that the pathway between coercive control and mental health is not direct and it is mediated by coping self-efficacy. Which means that coercive control was not only directly effecting the mental health but the pathway was from coercive control to coping self-efficacy and coping self-efficacy further affected mental health. Previous literature has also supported the role of coping self-efficacy as a mediator between the relationship of intimate partner violence and mental health outcomes. According to Lazarus and Folkman (1984) coping within intimate partner violence acts as a mediator, which tries to mediate the negative impact of intimate partner violence with the aim of reducing the psychological stress caused by it. A number of researchers supported this notion and found empirical evidence of coping strategies acting as a mediator between the relationship of intimate partner violence and mental health problems (Arias & Pape, 1999; Dempsey, 2002; Lee et al., 2007; Merrill et al., 2001; Mitchell et al., 2006;; Mengo et al., 2017). These results indicate that if coping resources are available it can indirectly help in reducing the effects of intimate partner violence. Another study was conducted in Pakistani context by Mazher (2017) which showed similar finding, the result of the study showed that coping self-efficacy was mediating the relationship between coercive control and mental health. Although, the previous findings of the studies exploring the mediational pathways between intimate partner violence and mental health are inconclusive. On one hand, coping was found to mediate the relationship between Intimate partner violence and mental health (Lee et al., 2007), on the other hand mental health was found to mediate the relationship

between Intimate partner violence and coping (Bradley Schwartz, & Kaslow, 2005). The mixed findings in previous literature showed that more longitudinal researches can help in clarifying these relationships. The reason for such result can be that in mostly Asian countries keeping family intact and saving family face are valued. Due to these cultural values, disclosing intimate partner violence and seeking help from others is considered as breaking family ties. As a result the person experiencing intimate partner violence try to save the family face and use the available coping resources to deal with the stress. Another reason can be when a person is in any stress, the demand of getting away from the stressor is increased, and the person tries to use all the available coping strategies which can help him/her in reducing the impact of the stressor.

For the eleventh hypothesis, it was assumed that coping self-efficacy would mediate the relationship between coercive control and marital quality of married men and women. This hypothesis was supported by the study (see Table 32). The result of the study showed that coping self-efficacy mediated the relationship between coercive control and marital quality. Result of the study indicated that the path between coercive control and marital quality is not direct and it is mediated by coping self-efficacy. The mediation analysis showed that the pathway between coercive control and marital quality is not direct and it is mediated by coping self-efficacy. Which means that coercive control was not directly affecting the marital quality but the pathway was from coercive control to coping self-efficacy and coping self-efficacy further affected marital quality. In the past studies coping has been studied in relation to individual and marital problems (Senlet, 2012). Coping is an individuals personal ability to reduce or minimize the stress caused by a stressor. Different coping strategies are used in intimate partner abuse, as it is a recurring strain and it requires other coping method then what a person normally use to deal with daily life negative events (Bowman, 1990). Coping is considered to buffer the negative effects of intimate partner violence (Löbmann, Greve, Wetzels, & Bosold, 2003). Various previous researches have shown that different coping techniques helps in reducing the stress caused by intimate partner violence, which in is also a reason why many people remain in abusive marital relationships (Clements & Sawhney, 2000; Calvate et al., 2008, Krause et al., 2008; Waldrop & Resick, 2004).

For the twelfth hypothesis it was assumed that self-silencing would mediate the relationship between coercive control and mental health of married men and women. This hypothesis could not be tested because there was nonsignificant relationship between the relationship of self-silencing and mental health. According to researchers there are four criteria which should be fulfilled in order to conduct mediation analysis. One of the criteria confirms that in order to conduct mediation analysis the mediating variable should be correlated (Baron & Kenny, 1986; MacKinnon, Fairchild, & Fritz, 2007). Hence, the mediating role of self-silencing cannot be explored in the current study.

For the thirteenth hypothesis it was assumed that self-silencing would mediate the relationship between coercive control and marital quality of married men and women. This hypothesis could not be tested because there was nonsignificant relationship between the relationship of self-silencing and marital quality, reason explained in previous paragraph. In the previous literature a study was conducted by Harper and Welsh (2007) which also found similar results. Their study indicated no significant relationship between self-silencing and marital quality. Hence, the mediating role cannot be explored in the current study.

Other than the fulfillment of objectives of the study, additional analysis were carried out for further exploration. In exploring the moderating role of self-silencing it was found that self-silencing was moderating the relationship between coercive control and mental health (see Table 33). The result showed that the negative impact of coercive control declining mental health was significantly more pronounced for high level of self-silencing followed by medium and then low levels of self-silencing (see Figure 3). One possible reason for such findings can be that when individuals adopt high levels of self-silencing, they keep all the things which are bothering them in their heart. In this way negative thoughts and feelings get piled up which impacts the mental health of such individuals negatively. Moreover, in Pakistani culture it is a common practice to hide marital issues in front of society to keep the positive happy image of the family intact. In doing so, self-silencing is opted as the best possible solution.

Self-silencing was also found to moderate the relationship between coping self-efficacy and marital quality (see Table 34). The result showed that positive impact of coping self-efficacy increasing marital quality was significantly more pronounced for

low level of self-silencing followed by medium and then high level of self-silencing (see Figure 4). A possible explanation for such result can be that when a married individual is good in communicating their thoughts, feelings and any problematic issue with their spouse, it will automatically lead to low levels of self-silencing which will enhance the relationship between marital quality and coping self-efficacy. Moreover, when an individual is happily married it will lead to better mental health due to which he/she will be better able to use his/her coping resources which have positive impact on marital quality.

While investigating the moderating role of gender it was found that gender moderated the relationship between coercive control and mental health (see Table 35). The result showed that the negative impact of coercive control declining mental health was significantly more pronounced for women as compared to men (see Figure 5). The reason for such findings might be that women in or society are under the dominance of men. They have to fulfill the demands and obey their husband even if they are not willing to do a certain task. All these factors contribute towards more negative impact on mental health of women.

Next moderating role of marriage duration was explored. Marriage duration was found to moderate the relationship between coercive control and coping self-efficacy (see Table 36). The result showed that the negative impact of coercive control declining coping self-efficacy was significantly more pronounced for short duration of marriage followed by mean duration and for long duration of marriage there was no effect (see Figure 6). The possible explanation for such findings can be that when an individual is newly married, both the partners try to adjust in the new phase of life and accept the changes in their surroundings. Both partners are new in the relationship and are not mentally prepared to deal with any kind of stressor, due to which they are not fully aware of their coping self-efficacy abilities. When the added stressor of coercive control is experienced it is likely to see that newly married individual will have low levels of coping self-efficacy as compare to those who have been married for quit long. The reason could be that those couples who are married from many years may have learned the ways to cope with the stressor of coercive control and have adopted ways of coping self-efficacy which help them in dealing with it. Whereas, newly married individual are in initial phase and do not have the experience to deal with such stressors and hence their coping self-efficacy declines in the presence of coercive control.

Marriage duration also moderated the relationship between coercive control and self-silencing (See Table 37). The result showed that the positive impact of coercive control increasing self-silencing was more pronounced for long duration followed by mean duration and then short duration of marriage (see Table 7). The possible reason for such findings could be that as the marriage duration increases, individuals becomes use to certain behaviors of their spouse and adjust themselves in such environment. As the positive relationship of coercive control with self-silencing is increasing more for long duration of marriage as compare to short duration, this could be explained by the fact that the spouse becomes use to in dealing with such behaviors and with the passage of time whereas those who are new in marital relationship will be low in self-silencing.

Next moderating role of marriage type was explored. Marriage type was found to moderate the relationship between coercive control and coping self-efficacy (see Table 38). The result showed that the negative impact of coercive control declining coping self-efficacy was significantly more pronounced for love marriages as compare to arrange marriages (see Figure 8). The possible explanation for such findings could be that in love marriages both the partners know each other and decide to get married with their mutual understanding, after marriage when they experience coercive control it is likely that their coping self-efficacy will decrease more. The reason could be that they are not mentally prepared to experience such behaviors by their spouse and are not able to use their coping resources.

Marriage type also moderated the relationship between coping self-efficacy and mental health (see Table 39). The result showed that the positive impact of coping self-efficacy increasing mental health was significantly more pronounced for love marriage as compare to arrange marriage (see Figure 9). The possible reason for such findings could be that in love marriage both the partners know each other's and have more understanding between them due to which they are more likely to use their coping self-efficacy abilities and hence it will have positive impact on their mental health. Another explanation could be that without the presence of any stressor in marital relationship, individuals who have done love marriage will be better able to invest all their coping resources to deal with a sudden stressor from practical or daily life. As a result mental health will be enhanced.

Another objective of the study was to see the differences in demographic variables in the sample being used. For this purpose *t*-test were computed to find out the mean differences in demographic variables among various groups. Based on past literature, it was assumed that women will experience more coercive control as compared to men. Fourteenth hypothesis was supported by the results of the study (See Table 40). The previous literature shows mixed findings regarding the use of intimate partner violence by both gender. Many scholars have emphasized that gender asymmetry exist in the patterns of intimate partner violence with women being more likely to be the victim than men (Coker et al., 2002; Harned, 2001; Policastro & Finn, 2017; Slashinski, Coker, & Davis, 2003; Stark, 2007; Tjaden & Thoennes, 2000). On the other hand, some scholars had reported empirical evidences for gender symmetry in the use of intimate partner violence and in some cases men had higher rate of victimization than women (Archer, 2000; Moffitt, Robin, & Caspi, 2001; Melton & Belknap, 2003; Johnson, 2006; White, 2009; Straus, 2010, 2011). A number of previous researchers have found evidences that the motives involved behind using intimate partner violence is different for men and women (Holtzworth et al., 2000; Graham-Kevan & Archer, 2003; Johnson, 2006). Broadly the previous literature suggests that use of violence by men is characterized by the motive of control upon women (Swan & Snow, 2002; Stets & Hammond, 2002; Johnson, 2006; Swan et al., 2008). However, few researchers supported the idea that both men and women use the same controlling tactics in their relationship (Graham-Kevan & Archer, 2008; Tanha et al., 2010), but a study conducted by Felson and Outlaw (2007) showed that wives were more controlling as compare to husbands and used non-aggressive means to control, such as complaints and verbal expressions of anger. One of the reason proposed by Johnson (2006, 2008) for mixed findings regarding the role of gender in intimate partner violence is the use of various measures and sampling techniques. Another reason for this contradiction in previous studies may be because mostly the focus of researchers was on male directed violence against women and may be the measures used for coercive control were biased i.e., focusing on male controlling tactics and not adequately tapping the types of controlling tactics used by women in their relationships. However this finding is applicable upon Pakistani population as our culture is based on patriarchal system and favors man over women. Men in our culture is in a position to assert control and domination on their wives.

For the fifteenth hypothesis, it was hypothesized that men will have high mental health as compared to women. This hypothesis was supported by the present study (see Table 40). Result showed that there were significant mean difference between mental health of men and women, and men scored higher than women. These results are supported by a previous study conducted in Bangkok which showed that married men had more psychological well-being (i.e., mental health) as compared to their counterparts (Fuller, Edwards, Vorakitphokatorn, & Sermsri, 2004). The possible reason for women having low mental health can be attributed to the patriarchal system in Asian countries in which women is consistently under the dominance of men and in turn their mental health is affected. Moreover, the increased responsibilities of looking after the family and performing household chores adds to the daily life stress of women and negatively impact their mental health. Whereas men enjoy the higher status given by the society and in turn have better mental health.

For the sixteenth hypothesis, it was assumed that self-silencing will be higher in women. This theory based hypothesis was not supported by current study (See Table 40). Results showed that there was nonsignificant mean difference in scores of men and women on self-silencing. This hypothesis was based on the theory of self-silencing and was partially supported by previous literature. The gender differences are the result of various motivations behind suppressing oneself. The proponents of this theory Jack and Dill (1992) were of the view that women are brought up and socialized in a manner to adopt self-silencing as a way of making new relations. Whereas men self-suppress themselves in order to gain influence over those whom they attract (Page et al., 1996; Remen et al., 2002; Ward, Bergner, & Kahn, 2003) or to maintain a traditional gender role (Smolak, 2010). Moreover, suppressing oneself in relationships have more negative consequence for women (Ayduk, May, Downey, & Higgins, 2003; Harper et al., 2006; Jack & Dill, 1992; Thompson, 1995; Uebelacker et al., 2003) as compare to men (Duarte & Thompson, 1999; Gratch, Bassett, & Attra, 1995). A number of researchers have reported that men may score equal or greater than women on the silencing the self scale (Cowan, Bommersbach, & Curtis, 1995; Gratch et al., 1995; Jack & Dill, 1992; Thompson, 1995; Jack & Ali, 2010; Smolak, 2010) or even higher than women's (Cramer & Thoms, 2003; Duarte & Thompson, 1999; Page et al., 1996; Whiffen et al., 2007). A number of possibilities have been documented in the literature for this contradiction in theory and empirical findings (Smolak, 2010). The empirically

sound explanation which has received most attention is that a number of different etiological and motivational factors are involved in shaping self-silencing which have various emotional outcomes for men and women (Jack & Ali, 2010; Page et al., 1996; Smolak, 2010; Thompson, 1995). This explanation is partially supported by some empirical findings which suggested that the factor structure which emerged as a result of exploratory factor analysis of the measure showed differences for men and women, with a new factor emerging for only men i.e., Autonomy/Concealment (Cramer & Thoms, 2003; Remen et al., 2002). The results of this study showed that men and women had equal levels of self-silencing which is partially supported by previous literature. A number of possible reasons for this contradiction have also been discussed above. Seeing this result from cultural perspective another explanation might be that, being in Pakistani society a man is considered the leader of the family who is also responsible for keeping the family intact and woman on other hand is brought up in a way to please everyone. Due to these reasons it might be possible that both man and woman adopt self-silencing to save their relationships and family from separation.

For the seventeenth hypothesis, it was assumed that working women will experience less coercive control as compared to non-working women. This hypothesis was not supported by the current study (see Table 41). The result of mean differences showed nonsignificant difference between employed and unemployed women. This hypothesis was partially supported by previous studies. Mixed findings have been reported by previous researchers. Some found more abuse against working women (DeMaris, Benson, Fox, Hill, & Van Wyk, 2003), some found the less chances of abuse against working women (Kalmuss & Straus, 1990; Villarreal, 2007), and some found no relationship at all (Fox, Benson, DeMaris, & Van Wyk, 2002; Kaukinen, 2004). The past literature suggests that interpreting women's employment as a risk or protective factor against intimate partner violence is an ambiguous task, because employment on one hand provides opportunity to women to leave the home, meet people, socialize and stay away from their intimate partner during their work hours. Thus for these reason it is logical to hypothesize that employed women are at lower risk of experiencing intimate partner violence. However, at the same time it has also been found that in some conditions the chance of intimate partner violence increases i.e., if the husband has been unemployed for long time and the wife is working (Macmillan & Gartner, 1999). One possible reason for the disparity in the previous findings is the different theories used

in researches. For example, the proponents of resource theory suggested that violence is caused by differences in economic resources between partners. Men being the main bread winner of the family, use this status to impose control and power within a relationship. When men is unemployed, they will use violence as a last option to maintain their control and power (Kaukinen, 2004). On the other hand, the proponents of marital dependency theory argue that employment reduces women's risk of violence and those women who are economically dependent on their husbands are more likely to experience abuse and stay in an abusive relationship (Kalmuss & Straus, 1990). The cultural dynamics in our society promotes male dominance regardless of the fact that women is employed or not. Women in Pakistan are subjected to male dominance and have to face negative consequences whether they are employed or not. For further exploration, mean differences were checked with marriage type along study variables (see Table 42). The only significant mean difference for marriage type was found on one subscale of coercive control (i.e., RCR = restricting contact with relatives) which was significantly higher in love marriages as compared to arrange marriages.

For additional exploration the relationship of demographic variables with study variables was also explored. For this purpose Pearson Product Moment Correlation analysis was carried out to see the relationship of various demographic variables with study variables (see Table 43). The results showed that coercive control had significant negative relationship with age and marital duration showing that as the age and marital duration increases, coercive control will decrease. Previous studies have shown mixed findings for various types of abuse. A study found that the rate of physical violence decreases with age but non-physical violence do not decrease with age (Mezey, Post, & Maxwell, 2002). A possible explanation for age being not negatively related to non-physical violence could be that in older age the abuser may adopt the non-physical forms of abuse to still maintain his/her dominance over the victim. However, a few studies showed similar findings as the current study. Few studies have reported that intimate partner violence is more prevalent in younger ages and the rate of victimization decreases as age increases (Capaldi et al., 2012; Truman & Langton, 2015). Previous literature showed mixed findings which indicates that the relationship of age with coercive control is not yet clear. However, one possible explanation for the negative relationship of age with coercive control could be that as the person becomes old all his/her energies start declining due to which it is not possible for him/her to keep

practicing coercive control on the other partner. The current study also showed significant negative relationship between coercive control and duration of marriage. A study found out that there was nonsignificant correlation between duration of marriage and intimate partner abuse (Razera et al., 2016). Another study found that longer duration of marriage was a protective factor against intimate partner abuse (Waqman et al., 2016). A study conducted in Iran found shorter duration of marriage as a risk factor of domestic violence (Rasoulian et al., 2014). The current study showed negative relationship between coercive control and duration of marriage which means that as marriage duration will increases, coercive control will decrease. A possible explanation for such relationship could be as the duration of marriage increases the couple adjusts and becoming parents can also play a major role. As the couple will avoid violence due to the presence of children in house. In this way long marriages can reduce the incidence of intimate partner violence.

In the present study mental health showed significant positive correlation with number of children and education (see Table 43). Review of previous literature showed mixed findings. A number of studies have indicated that presence of children can contribute negatively to mental health of married individuals (Evenson & Simon, 2005; McLanahan & Adams, 1989; Nomaguchi & Milkie, 2003). The reason for negative effects of having more children has been linked with the role strain concept that is having more children makes it difficult for parents to balance their work and family lives (McLanahan & Adams, 1989) or by increasing the economic burden of supporting more children (Nomaguchi & Milkie, 2003). However, a study conducted in Thailand and Pakistani context found positive relationship between mental health and number of children promoting the role enhancement perspective than role strain perspective (Fuller et al., 2004; Mazhar, 2017). It can also be because in our culture children are thought as a supportive system for parents leading to better mental health outcomes. Previous studies related to the role of education in mental health also showed similar findings. A number of studies showed that higher level of education is related to less chances of having any negative mental health problem like depression (Miech & Shanahan, 2000; Mazhar, 2017).

Marital quality had significant positive relationship with age, marital duration, and number of children and significant negative correlation with education (see Table 43). Previous studies, however, showed contrasting findings. Many researchers

conducted in western culture showed that marital quality tend to decrease as the age increases (Vaillant & Vaillant, 1993; Van Laningham, Johnson, & Amato, 2001). It has also been found that women are more likely to report lower marital quality with increase in age as compare to men because women have the additional burden of domestic cores and looking after the children (Meijer & Van den Wittenboer, 2007; Shapiro, Gottman, & Carrère, 2000). However, the results of current study showed that age is positively relate to marital satisfaction. The possible reason for this difference could be the culture variation, unlike western culture people in Pakistan live in a collectivistic culture and maintaining relationship is a priority for them. It is possible that as the age increases married individuals feel more secure and satisfied with their relation by looking at how far they have come together and thus a positive relationship is seen between age and marital quality. The results also showed that marital quality was positively related to marital duration. The previous literature however showed mixed findings. Some studies showed that marital quality was not related to duration of marriage and length of relationship was not predictive of marital quality (Oprisan & Cristea, 2012; Shortt et al., 2010; Razera et al., 2016). Some studies showed that a negative relationship exist between length of marriage and marital quality i.e., it decreases as the duration of relation increases (Kurdek, 1999; Lavner & Bradbury, 2010). Some researchers showed that a U-shaped relation exist between marital quality and marital duration which means that in the beginning marital quality is low and increases after sometime (Karney & Bradbury, 1995; Kurdek, 1999).

One possible reason for the variations in findings is that this variable may act differently across cultures. The results showed that number of children was positively associated with marital quality. The literature showed mixed findings. A number of studies found that presence of child or increase in number of children can negatively impact the marital quality of husband and wife. The reasons highlighted for this negative associations were less time to communicate with each other, increased responsibilities of parents to look after the children, anxiety and depression (Hirschberger et al., 2009; Jose & Alfons, 2007). Few studies showed no significant relationship between number of children and marital quality (Allendorf & Ghimire, 2013; Ashraf, 2001). Few studies also showed findings which were in line with the present study that number of children increases marital quality. Reason which were highlighted for this positive association between number of children and marital quality

were that couples feel complete specially women for successfully completing the biological function of fertility and children enhances the bond between parents and strengthen the relationship (Marci et al., 2012; Reis et al., 2013). The current study showed that marital quality was negatively related to education. The previous literature showed mixed findings. Some researchers found a positive relationship between educational level and marital quality and reported higher education as predictor of marital quality (Kim, 1992; Mirfardi, Edalati, & Redzuan, 2010; Vaijayanthimala, Kumari, & Panda, 2004). Another study found the opposite relation in which highly educated women had lower marital quality (Sorokowski et al., 2017). Another study found no association of education with marital quality (Razera et al., 2016). Western findings regarding the relationship between marital quality and education level are not clear, however in current study it was found that education was negatively associated with marital quality. A possible reason for this negative association is that majority of the population of Pakistan is not literate. When a more educated individual marries a less educated individual, their thinking does not match and gap in communication results in lower marital quality.

Self-Silencing showed nonsignificant relationship with any demographic variable (see Table 43). Coping self-efficacy had significant positive correlation with family size and monthly income (see Table 43). A study found that having support of family can contribute positively in the coping abilities but it is only possible if the family members are responsive towards the person asking for help otherwise it can impact negatively (Waldrop & Resick, 2004). This finding was in line with the present study. Study conducted in Pakistani context found similar finding that coping self-efficacy had positive relationship with monthly income (Mazher, 2017).

Lastly the hypothesized model was tested to see significant direct and indirect paths simultaneously leading from coercive control to mental health and marital quality in married individuals (see Figure 10). Model testing was carried by AMOS version 21. Results were generated with multiple goodness of fit indices that showed the degree to which proposed model was a goodness of fit (see Table 44 & 45).

Limitations and Suggestions

Despite the fact that the every study is well-planned, there still can be some limitations. This study was no exception to this and had its limitations and strengths.

The total number of sample collected was large to enhance the generalizability of findings, however, as the groups involved in the study did not had equal representation of all population groups because data was collected only from cities like Islamabad and Rawalpindi. Due to which the results of the study may thus not be generalized to all population groups. Moreover, national representative sample of research is required to empirically verify whether the findings of present study are applicable to Pakistani context or not. Moreover, the sample of the study mainly included participants only from urban areas i.e., Islamabad/Rawalpindi which is limiting the scope of the study. It is possible that the same constructs may have different impact on people living in rural areas. A comparison of rural and urban population would add the strengths of the future studies.

A limitation which was observed during the phase of data collection both qualitative and quantitative was that people were reluctant to participate in the study due to the sensitive nature of the topic. Usually people in our culture are not willing to discuss their personal matters in front of others which might have limited the findings of present research. Confirmatory factor analysis (CFA) could not be done for validation of the scale which is also a limitation. Future researcher using the coercive control scale can carry out confirmatory factor analysis to confirm the factor structure emerged in present study. This will further enhance the validation of the scale. The present study was based on a cross-sectional design due to limited amount of time and resources available. It was not a longitudinal design due to which long term evaluation was not possible of the study variables. It is suggested for future researcher to plan longitudinal studies to elaborate the understanding of the constructs used in present study.

In present study data collection was done through self-reported measures, due to which elimination of the element of social desirability and biasness was inevitable and objectivity of the study was in question. It is suggested that another partner rater version of coercive control scale should be developed to cater this limitation in future researches. Another limitation was that no discriminant validity of the coercive control scale was established. In future, researchers can evaluate the validity of the coercive control scale by checking the discriminant validity as well. In the present study, the sample did not adequately represented the diverse cultures found in Pakistani context,

which may have provided additional information. Various subcultures should be studied in future researches.

Implications of the Study

Present research was based on exploring the impact of coercive control on mental health and marital quality of married individuals and to find out how the presence of self-silencing and coping self-efficacy affects the relationship between coercive control and its outcomes. Despite the limitations identified, this study will still be extremely beneficial for researchers working in the domain of non-physical abuse and for organizations working for the betterment of victims of domestic violence abuse. As coercive control is a relatively new variable, it has captured the attention of a lot of researchers in past years due to its unique characteristic. As coercive control is used by an intimate partner in intimate relationships, its negative impact on the individual and relational functioning (i.e., mental health & marital quality) is inevitable. A lot of researchers have documented the negative impact of coercive control on victim's individual functioning (i.e., depression, anxiety & PTSD) and relational functioning (i.e., low marital quality, poor parenting & relationship with family is disturbed).

Moreover, the relationship between coercive control and its negative outcomes is not direct; it is influenced by a number of factors. This study will help in identifying the mechanism through which the negative effect of coercive control on individual and relational functioning can be mitigated. A distinct feature of coercive control is that it does not involve any physical violence, it is a non-physical type of abuse due to which it is more difficult to recognize. This study will essentially help in exploration of the complex context in which coercive control occurs. It will in turn enable us to look beyond the impact of physical violence in intimate partner abuse, which is the most common type to be explored by researchers. As the construct of coercive control is explored both qualitatively and quantitatively, it will deepen our understanding of the developmental sequence of coercive control, how it is exerted in daily life activities by intimate partner and how it impacts daily life functioning. Moreover, the findings of this study will shed light on the significance of the association among marital distress due to coercive controlling violence and its adverse consequences upon psychological/mental health of women.

This research will prove beneficial in understanding the mechanism by which the negative impact of abuse can be mitigated and it will help in developing intervention plans for future, by exploring the role of coping self-efficacy and self-silencing. This research will also help in drawing the attention of researchers, government organizations and non-governmental organizations towards the non-physical form of violence (i.e., coercive control) which is equally damaging as physical form which is easier to identify. This research will aid the concerned organizations in recognizing the importance of developing awareness programs for general population to help them identify what is coercive control. This course of action will instigate a higher level of understanding about the cultural and contextual dynamics of coercive control for general population. Furthermore, another aspect in which this research will prove beneficial is that it will help in developing better understanding of the relationship between these constructs and this will allow the future researchers to conduct more in-depth studies with these variables. Moreover, the findings of this study can serve as a precursor to instigate exploration of further avenues in this zone. The study will hold a particular significance for the psychological researchers who aim to study the dynamics of the relationship of these variables in domestic violence domain.

Conclusion

Intimate partner violence has long been a public health issue around the world. The recent advancement in the domestic violence research highlighted the significance of studying the non-physical form of violence. The relatively new concept of coercive control gained a lot of popularity due to its distinct characteristics and most importantly the absence of physical violence in it. However, empirical findings suggests that there are numerous adverse effects of coercive control on the individual and relational functioning of married men and women. In Pakistan the focus of domestic violence researchers has been on studying the physical form of violence neglecting the non-physical forms and carrying out more quantitative researches instead of using qualitative methods. The present study was an effort to fill this gap in literature. Coercive control is a quite new phenomenon among researchers of Pakistan so there is scarcity of researches and no attempts have been made to study the construct qualitatively. Keeping in mind the context dependent nature of coercive control, it was decided to qualitatively explore the phenomenon to get the first hand views of Pakistani population about what is coercive control in their perception. The qualitative

exploration was beneficial because it enabled us to deduce the perspectives of Pakistani men and women upon coercive control instead of imposing a western definition upon them. An indigenous scale was developed for coercive control. Current study showed that presence of coercive control in marital relationship has significant negative impact on the mental health and marital quality. Lastly coercive control or intimate partner violence in general should not be considered a private issue. However, it is a public problem and to decrease the incidence of intimate partner violence it is required that proper legal policies and law should be developed for protection of rights of women in Pakistan.

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APPENDICES

APPENDIX - A

Focus Group Guide

derator: Place: Date:

سوالات

1- شادی شدہ زندگی میں شریک حیات کو کنٹرول کرنے سے کیا مراد ہے یا کسے کہتے ہیں؟

2- شادی شدہ زندگی میں خاوند بیوی کو کنٹرول کرنے کے لیے کیا طریقے استعمال کرتے ہیں؟

3- ہمارے معاشرے میں شادی شدہ افراد میں خاوند کا بیوی پہ کنٹرول رکھنا ان کا حق سمجھا جاتا ہے؟

4- ہمارے معاشرے میں مرد کس حد تک اپنی بیوی کے روزمرہ کے معاملات + گھریلو معاملات (Personal Activities) پہ نظر رکھتا ہے؟

5- ہمارے ہاں شادی شدہ زندگی میں مرد کا اپنی شریک حیات کی کمائی پہ کتنا حق ہوتا ہے یا میاں بیوی کو ایک دوسرے کی آمدنی کہاں خرچ ہو رہی ہے علم ہونا چاہیے؟

6- شادی شدہ زندگی میں خاوند بیوی کی صحت یا اس کے کھانے پینے پر کتنا کنٹرول رکھتے ہیں؟

7- ہمارے ہاں میاں بیوی پر بچوں کے ذریعے کیسے کنٹرول رکھتے ہیں؟

8- ہمارے معاشرے میں شادی شدہ زندگی میں مسائل یا اختلافات کی وجہ سے مذہبی سکالر یا سرکاری مدد لینا یا کسی تیسرے کو بتانا صحی نہیں سمجھا جاتا آپ کے میاں کی جانب یا وہ رکاوٹ بنتے ہیں؟

9- ہمارے معاشرے میں مرد کس حد تک اپنی شریک حیات کا دوسروں سے ملنا جلنا، اُٹھنا بیٹھنا، سوشل تقریبات میں جانا، دوستوں سے ملنا، باہر جانا یا مرضی کے بغیر گھر ان سب چیزوں میں نظر رکھتا ہے؟

10- آپ کے خیال میں ہمارے جنسی عمل قائم کرنا یا بچوں کی پیدائش میں وقفے کے طریقے استعمال کرنا یا نہ کرنا اس میں مرد کس حد تک کنٹرول کرتا ہے۔

ITEM POOL

نمبر شمار	سوالات
	کیا آپ کا شریک حیات:
-1	ان رشتے داروں سے ملنے سے روکتا/روکتی ہے جسے وہ ناپسند کرتا/کرتی ہے۔
-2	آپ کو گھر سے باہر اس کی مرضی کی بغیر نہیں جانے دیتا/دیتی ہے۔
-3	بغیر بتائے گھر سے باہر جانے کی اجازت نہیں دیتا/دیتی ہے۔
-4	آپ کو اپنی پسند کے کپڑے پہننے پر مجبور کرتا/کرتی ہے۔
-5	اُسکی غیر حاضری میں گھر پہ مہمان بُلانے سے منع کرتا/کرتی ہے۔
-6	آپکو گھر سے نکلتے وقت پردے (Abaya/Scarf) پہننے کا کہتا ہے۔
-7	گھر سے نکلتے وقت گھر کو تالا لگا کر جاتا ہے۔
-8	آپکو اپنے ارشتے داروں سے بات کرنے سے روکتا/روکتی ہے۔
-9	آپکو اپنے رشتے داروں کے گھر نہیں جانے دیتا/دیتی ہے۔
-10	آپکو اپنی ماں کے گھر نہیں جانے دیتا/دیتی ہے۔
-11	آپکو قطع تعلق کر دیتا/دیتی ہے۔
-12	آپکو طلاق کی دھمکیاں دیتا/دیتی ہے۔
-13	بچوں کو پاس دیکھ کر آپکو گھر روانہ کرنے کی دھمکی دیتا ہے۔
-14	آپکو دوسری شادی کرنے کی دھمکی دیتا/دیتی ہے۔
-15	آپکو بچوں سے علیحدہ کرنے کی دھمکی دیتا/دیتی ہے۔
-16	طلاق کی صورت میں بچوں کی مستقبل کے بارے میں ڈراتا ہے۔
-17	گھر آکر آپ سے سوالات کرتا ہے
-18	پوچھتا/پوچھتی ہے کی اس کی غیر حاضری میں کون آیا تھا۔
-19	آپ سے پورے دن کی مصروفیات کے بارے میں پوچھتا/پوچھتی ہے۔
-20	آپ کا موبائل چیک کرتا/کرتی ہے۔
-21	آپ کے سونے اور اُٹھنے کے اوقات پہ نظر رکھتا/رکھتی ہے۔
-22	آپ کو بننے سنوارنے پر ٹوکتا/ٹوکتی ہے۔
-23	آپ سے پوچھتا/پوچھی ہے کہ فون پہ کس سے بات کر رہے تھے۔
-24	آپکو بار بار کال کر کے پوچھتا/پوچھتی ہے کہ آپ کہاں ہیں۔
-25	بچوں سے آپ کے متعلق سوالات کرتا/کرتی ہے۔
-26	تمام اہم فیصلے لینے کا اختیار رکھتا/رکھتی ہے۔

-27	آپ پر غالب/حکمرانی کرتا/کرتی ہے۔
-28	خود کو آپ سے برتر سمجھتا/سمجھتی ہے۔
-29	خود کو آپ سے بہتر سمجھتا سمجھتی ہے
-30	آپ کو ترقی کرتے ہوئے نہیں دیکھ سکتا/سکتی ہے۔
-31	اپنے سامنے آپ کا جواب دینا برداشت نہیں کرتا/کرتی ہے۔
-32	آپکی تعریف کر کے آپ کو کنٹرول میں رکھتا/رکھتی ہے۔
-33	آپکی پسند کو ترجیح دیتا/دیتی ہے
-34	آپ کی فیملی کی تعریف کرتا/کرتی ہے۔

-35	اپنی بات منوانے کے لیے آپکو مکھن لگاتا/لگاتی ہے۔
-36	گھر کے کام کاج میں اپنی مرضی چلاتا/چلاتی ہے۔
-37	گھر کے تمام بڑے فیصلے اپنی مرضی سے کرتا/کرتی ہے۔
-38	گھر کے فیصلوں میں آپ کی رائے نہیں لیتا/لیتی ہے۔
-39	بچوں سے متعلق ہر فیصلہ خود لیتا/لیتی ہے۔
-40	بچوں اور آپ کے ساتھ سخت رویہ رکھتا/رکھتی ہے۔
-41	بچوں سے متعلق تمام فیصلے خود کر لیتا/لیتی ہے۔
-42	بچوں کے سامنے آپ کی تربیت پر سوال کرتا/کرتی ہے۔
-43	بچوں کی لیے مخصوص قائدے قانون بنا دیتا/دیتی ہے۔
-44	بچوں کے ذہن میں ڈالتا/ڈالتی ہے کہ اس کو تمہارا خیال نہیں۔
-45	آپ کو بچوں کے سامنے بُرا بھلا ثابت کرنے کی کوشش کرتا/کرتی ہے۔
-46	آپ سے آپ کی تنخواہ کے بارے میں پوچھتا/پوچھتی ہے۔
-47	گھر کے خرچے کے پیسے اپنے ہاتھ میں رکھتا/رکھتی ہے۔
-48	آپ کو Joint Account بنوانے کا کہتا/کہتی ہے۔
-49	آپ سے ATM کارڈ لے لیتا/لیتی ہے۔
-50	آپ کو بتائے بغیر پیسے خرچ کرنے نہیں دیتا/دیتی ہے۔
-51	چاہتا/چاہتی ہے کہ آپ دبلے پتلے رہیں۔

-52	آپ کے کھانے پینے پر نظر رکھتا/رکھتی ہے۔
-53	آپ کو بار بار موٹاپا بڑھنے کا احساس دلاتا/دلاتی ہے۔
-54	غصہ ہوتا/ہوتی ہے اگر آپ اس کی خلاف ورزی کریں۔

-55	اپنے غصے سے آپ کا فیصلہ تبدیل کروالیتا/ لیتی ہے۔
-56	بچوں کو آپ سے دور کرتا/کرتی ہے
-57	علیحدگی ہونے پر بچوں کو آپ سے چھین لے گا/گی۔
-58	آپ سے علیحدہ ہو جائے گا/گی، اگر اس کی مرضی کے مطابق عمل نہ کیا۔
-59	آپ کو بچوں کے مستقبل سے ڈرا کر آپ کا علیحدگی کا فیصلہ تبدیل کروادیتا/ دیتی ہے۔
-60	اپنے رشتے کو بچانے کے لیے ہر ممکن کوشش کرے گا/گی۔
-61	آپ کو آپ کے والدین کی عزت بچانے کا کہہ کر آپ کو چُپ رکھتا/ رکھتی ہے۔
-62	آپ کو اپنی آواز دبا کر رکھنے کا کہتا/کہتی ہے۔
-63	آپ کو بدنامی کے ڈر سے شادی شدہ مسائل دوسروں کے سامنے لانے سے منع کرتا/کرتی ہے۔
-64	جنسی عمل قائم کرنے یا بچوں کی پیدائش میں وقفہ کرنے پر آپ کا مشورہ لیتا/ لیتی ہے
-65	اپنی مرضی سے جنسی عمل کرنے پر مجبور کرتا/کرتی ہے۔
-66	آپ پر اپنی مرضی مسلط کرتا/کرتی ہے۔
-67	آپ کو اپنی مرضی کے آگے جھکاتا/ جھکاتی ہے۔
-68	آپ کا دوستوں سے ملنا جلنا ناپسند کرتا/کرتی ہے۔

-69	فیملی کی تقریبات میں جانے کی اجازت نہیں دیتا/ دیتی ہے۔
-70	مارکیٹ ، بازار ، ہوٹل آپ کے ساتھ جانا پسند کرتا/کرتی ہے
-71	آپ کو مخصوص وقت سے پہلے گھر آنے کا کہتا/کہتی ہے۔
-72	چاہتا/ چاہتی ہے کہ آپ اس سے زیادہ کسی کو اہمیت نہ دیں۔
-73	گھر سے نکلنے پہ آپ کا پیچھا کرتا/کرتی ہے۔
-74	چاہتا ہے کہ آپ کسی غیر مرد سے نہ ملیں نہ بات کریں۔
-75	چاہتی ہے کہ آپ کسی دوسری عورت سے نہ ملیں نہ بات کریں۔
-76	چاہتا/ چاہتی ہے کہ آپ اس کا ٹائم کسی اور کو نہ دیں۔
-77	چاہتا/ چاہتی ہے کہ آپ گھر میں آفس (Office) کا کام نہ کریں۔
-78	چاہتا/ چاہتی ہے کہ آپ ہر جگہ اُس کے ساتھ جائیں۔

اجازت نامہ

میں قومی ادارہ نفسیات قائداعظم یونیورسٹی، اسلام آباد میں ایم فل کی طلبہ ہوں۔ یہ ایک تحقیقی ادارہ ہے۔ یہاں مختلف انسانی اور سماجی مسائل پر ریسرچ کی جاتی ہے۔ موجودہ ریسرچ میری ایم فل کی ڈگری کا حصہ ہے۔ اس ریسرچ کا مقصد شادی شدہ افراد کی انفرادی اور ازدواجی زندگی کے تجربات کے بارے میں کچھ اہم معلومات حاصل کرنا ہے۔ اس سلسلہ میں آپ کو کچھ سوال نامے دیئے جائیں گئے۔ جن کو آپ نے اپنے آپ کو ذہن میں رکھ کر پُر کرنا ہے۔ اس میں آپکے تقریباً 15 سے 20 منٹ لگ جائیں گئے۔ ہر سوالنامے کو پُر کرنے کے لیے الگ سے ہدایات دی گئی ہیں۔۔ آپ پر کوئی زبردستی نہیں ہے کہ آپ اس ریسرچ میں حصہ لیں۔ اور دوران ریسرچ اگر آپکو لگے کے آپ چھوڑ کر جانا چاہتے تو آپ کو مکمل آزادی ہوگئی کہ بغیر بتائے چھوڑ کر چلے جائیں۔ ایسا بھی ممکن ہے کہ سوال ناموں میں دیئے گئے چند ذاتی نوعیت کے سوالات کے جواب دینے میں آپ کو ہچکچاہٹ محسوس ہو۔ اس لیے یاد رکھیں کہ اس سوال نامے میں کہیں بھی آپ کا نام یا شناخت نہیں پوچھی جائے گئی۔ لہذا آپ کے دیئے گئے جوابات مکمل طور پر صیغہ راز میں رہیں گئے۔ آپ اس ریسرچ میں حصہ لیں گے تو ہماری بہت مدد ہوگئی۔ اس ریسرچ سے جو معلومات حاصل ہوں گی وہ ازدواجی زندگی کو مزید بہتر بنانے کے پروگرام تشکیل کرنے میں کردار ادا کریں گی۔ ان معلومات سے مستقبل میں پالیسی عمل میں آسکتی ہے۔

اگر یہ سوالنامہ پُر کرنے کے دوران آپکو کچھ سمجھ نہ آئے تو آپ مجھ سے پوچھ سکتے ہیں۔

رابعہ سلیم
قومی ادارہ نفسیات قائداعظم یونیورسٹی، اسلام آباد

آپ سے گزارش ہے کہ اس ریسرچ کا حصہ بننے کے لیے آپ اپنی رضامندی کا اظہار واضح طریقے سے کریں۔

میں اس ریسرچ میں حصہ لینے کے لیے رضامند ہوں۔ میرے پاس اختیار ہے کہ میں کسی بھی وقت اس ریسرچ میں اپنی شمولیت سے دستبردار ہوسکتا/سکتی ہوں۔

دستخط شامل کنندہ

ذاتی کوائف

جنس: _____ عمر: _____ آپکا صوبہ: _____

آپ کی تعلیم: _____ شریک حیات کی تعلیم: _____

نوکری کی قسم: سرکاری: _____ پرائیویٹ: _____

آپ کا پیشہ: _____ شریک حیات کا پیشہ: _____

خاندانی نظام: انفرادی: _____ مشترکہ: _____

آپکے گھر میں کتنے افراد ہیں؟ _____

شادی کی قسم: پسند کی شادی _____ والدین کی پسند: _____

شادی کو کتنے سال ہوئے ہیں؟ _____

بچوں کی تعداد: _____ ماہانہ آمدنی: _____

سماجی اقتصادی حیثیت: لوئر کلاس: _____ مڈل کلاس: _____ اپر کلاس: _____

☆ کیا پچھلے تین ماہ کر دوران آپ کے ساتھ کوئی ایسا ناخوشگوار المناک (Traumatic) واقعہ پیش آیا ہے جس سے آپ کو صدمہ پہنچا ہو؟

ہاں _____ نہیں _____

APPENDIX - E

Coercive Control Scale

رعب و دبدبہ قائم رکھنے اکیلئے میاں/ بیوی مختلف طریقے استعمال کرتے ہیں۔ یہ سوالنامہ یہ جاننے کے لیے ہے کہ آپ کا شریک حیات ان طریقوں میں سے کن کا کس حد تک استعمال کرتا/کرتی ہے۔ آپ سے درخواست کی جاتی ہے کہ ہر بیان کو غور سے پڑھیں اور وہ جس حد تک آپ کو صحیح لگے انکا اظہار دیئے گئے پیمانے کی مدد سے کریں۔ مثلاً اگر ایک بیان پر' ہمیشہ ایسے ہوتا ہے' لاگو ہوتا ہے تو پہلے کالم میں ( ) کا نشان لگائیں۔ اور اگر' ایسا کبھی نہیں ہوا' لاگو ہوتا ہے۔ تو آخری کالم میں ( ) کا نشان لگائیں۔ اسی طرح کالم 2 اور 3 کا استعمال کریں۔

نمبر شمار	بیانات	ہمیشہ ایسا ہوتا ہے	اکثر ایسا ہوتا ہے	کبھی کبھار ایسا ہوتا ہے	ایسا کبھی نہیں ہوا
	کیا آپ کا شریک حیات آپ پر رعب و دبدبہ قائم رکھنے کے لیے:				
1-	آپ کو اپنے رشتے داروں سے بات کرنے سے روکتا/ روکتی ہے۔				
2-	آپکو اپنے رشتے داروں کے گھر نہیں جانے دیتا/ دیتی ہے۔				
3-	آپ کو اپنی ماں کے گھر نہیں جانے دیتا/ دیتی ہے۔				
4-	آپ کو آپ کے رشتے داروں سے قطع تعلق کر دیتا/ دیتی ہے۔				
5-	آپکو بچوں سے علیحدہ کرنے کی دھمکی دیتا/ دیتی ہے۔				
6-	آپکو دوسری شادی کرنے کی دھمکی دیتا/ دیتی ہے۔				
7-	طلاق کی صورت میں بچوں کے مستقبل کے بارے میں ڈراتا/ ڈراتی ہے۔				
8-	پوچھتا/ پوچھتی ہے کہ اس کی غیر حاضری میں کون آیا تھا۔				
9-	آپ کا موبائل چیک کرتا/کرتی ہے۔				
10-	آپ کو بننے سنوارنے پر ٹوکتا/ٹوکتی ہے۔				
11-	آپ سے پوچھتا/ پوچھتی ہے کہ فون پہ کس سے بات کر رہی/ رہے تھے۔				
12-	آپ کو بار بار کال کر کے پوچھتا/ پوچھتی ہے کہ آپ کہاں ہیں یا کیا کر رہے/ رہی ہیں؟				
13-	بچوں سے آپ کے متعلق پوچھ گچھ کرتا/کرتی ہے۔				
14-	تمام اہم فیصلے لینے کا اختیار اپنے پاس رکھتا/ رکھتی ہے۔				
15-	آپ پر حکمرانی کرتا/کرتی ہے۔				
16-	خود کو آپ سے برتر سمجھتا/سمجھتی ہے۔				
17-	اپنے سامنے آپ کا جواب دینا برداشت نہیں کرتا/کرتی ہے۔				
18-	گھر کے کام کاج میں اپنی مرضی چلاتا/ چلاتی ہے۔				
19-	گھر کے فیصلوں میں آپ کی رائے نہیں لیتا/ لیتی ہے۔				
20-	آپ کے والدین اور خاندان پر تنقید کرتا/کرتی ہے۔				

نمبر شمار	بیانات	ہمیشہ ایسا ہوتا ہے	اکثر ایسا ہوتا ہے	کبھی کبھار ایسا ہوتا ہے	ایسا کبھی نہیں ہو
	کیا آپ کا شریک حیات آپ پر رعب و دبدبہ قائم رکھنے کے لیے:				
21-	بچوں کی پرورش سے متعلق آپ کو تنقید کا نشانہ بناتا/ بناتی ہے۔				
22-	بچوں کے لیے سخت قائدے قانون بنا دیتا/ دیتی ہے کہ وہ ڈرے، سہمے ہوئے رہیں۔				
23-	بچوں کے سامنے آپ کو بُرا بھلا ثابت کرنے کی کوشش کرتا/کرتی ہے۔				
24-	گھر کے خرچے کے پیسے اپنے ہاتھ میں رکھتا/ رکھتی ہے۔				
25-	آپ کو اُسے بتائے بغیر پیسے خرچ کرنے نہیں دیتا/ دیتی ہے۔				
26-	جنسی عمل قائم کرنے پر آپ سے مشورہ نہیں لیتا/ لیتی ہے۔				
27-	بچوں کی پیدائش میں وقفہ کرنے پر آپ سے مشورہ نہیں لیتا/ لیتی ہے۔				
28-	آپ کو اپنی مرضی سے جنسی عمل کرنے پر مجبور کرتا/کرتی ہے۔				
29-	آپ کے دوستوں سے ملنے جلنے پر اعتراض کرتا/کرتی ہے۔				
30-	گھر سے باہر جانے کی صورت میں آپ کو مقررہ وقت پر گھر پہنچنے پر اصرار کرتا/کرتی ہے				
31-	چاہتا/ چاہتی ہے کہ آپ اُس سے زیادہ کسی کو اہمیت نہ دیں۔				
32-	چاہتا/ چاہتی ہے کہ آپ دوسری جنس (gender) کے افراد سے بات چیت نہ کریں نہ ملیں۔				

NIP

Rabia Saleem <rabia.saleem@nip.edu.pk>

QUEST FOR SCALE TRANSLATION

es, Corey <ckeyes@emory.edu> Sat, Sep 23, 2017 at 1:15 AM
Rabia Saleem <rabia.saleem@nip.edu.pk>

ere is the urdu version.

orey Keyes
rofessor of Sociology
mory University

om: Rabia Saleem <rabia.saleem@nip.edu.pk>
te: Friday, September 22, 2017 at 3:01 AM
: Corey L Keyes <ckeyes@emory.edu>
bject: REQUEST FOR SCALE TRANSLATION

ear Dr. Keyes

ope you are well. My name is Rabia Saleem and I am a student of MPhil Psychology at National Institute Psychology,Quaid-i-Azam University Islamabad, Pakistan. As part of my MPhil I am conducting a search on **"Impact of Coercive Control on Individual and Relational Functioning of Married omen: Role of Self-Silencing and Copping Self-Efficacy".**

connection with this research, I hope to use Mental Health Continuum Short Form (Keyes, 2009). kistan being a developing country, it is difficult to access reliable psychological tests and scales, therefore, equest your permission to allow me to translate it in Urdu.

would appreciate your kind support if you permit me to translate the above mentionedscale at the earliest ssible convenience enabling me complete my project in a timely manner. It is worth mentioning that I may t be able to purchase this scale being a student of a developing country as all of the expenses are borne by e students themselves in our country.

nsidering your significant contributions to the concept of Mental Health, if you could share some formation, suggestions or guidance relevant to my research topic, as well as provide me with extra formation regarding your scale, I would be very grateful.

ook forward for a favorable response from your side.

ncerely,

bia Saleem

Phil. Psychology

tional Institute of Psychology

aid-i-Azam University, Islamabad Pakistan

Urdu Version of MHC-SF.docx
28K

Mental Health Continuum Short Form Scale

مندرجہ ذیل بیانات کو پڑھیں اور اس خانے میں نشان لگائیں جو کہ آپ کے تجربات اور احساسات کہ بہترین عکاسی کرتا ہے۔

نمبر شمار	بیانات	کبھی نہیں	ایک یا دو مرتبہ	ہفتے میں تقریباً ایک مرتبہ	ہفتے میں دو یا تین مرتبہ	تقریباً ہر روز	ہر
	پچھلے مہینے کو ذہن میں رکھتے ہوئے جواب دیجئے کہ آپ نے کتنی مرتبہ درج ذیل طریقوں سے محسوس کیا۔						
-1	خوش۔						
-2	زندگی میں دلچسپی لینا۔						
-3	زندگی سے مطمئن۔						
-4	کہ آپ کے پاس کچھ ایسا اہم موجود ہے جس سے آپ معاشرے کو فائدہ پہنچا سکیں۔						
-5	کہ آپ کا تعلق ایک معاشرے سے ہے (مثلاً سماجی گروہ، اسکول، ہمسائیگی وغیرہ)۔						
-6	کہ ہمارا معاشرہ تمام لوگوں کے لیے ایک اچھی جگہ ہے یا بہتر جگہ بن رہی ہے۔						
-7	کہ لوگ بنیادی طور پر اچھے ہیں۔						
-8	کہ ہمارے معاشرے کا کام کرنے کا طریقہ آپ کے لیے قابل فہم ہے۔						
-9	کہ آپ کو اپنی شخصیت کے زیادہ تر پہلو پسند ہیں۔						
-10	آپ اپنی روزمرہ زندگی کہ ذمہ داریوں کو اچھے طریقے سے سنبھال لیتے ہیں۔						
-11	کہ آپ کے دوسروں کے ساتھ پُر اعتماد تعلقات ہیں۔						
-12	کہ آپ ایسے (دشوار) تجربات سے گزرے ہیں جنہوں نے آپ کو میچور (Mature) ہونے اور ایک بہتر انسان بننے میں مدد کی۔						
-13	سوچنے اور اپنے نظریات اور رائے کے اظہار میں پُر اعتماد ہونا۔						
-14	کہ آپ کی زندگی باسمت اور بامعنی ہے۔						

Gmail RaBIya saleem <rabia.saleem45@gmail.com>

uest for scale permission

em Fatima <naseem_f15@nip.edu.pk> Thu, Nov 2, 2017 at 1:49 PM
aBIya saleem <rabia.saleem45@gmail.com>

ar Rabia you certainly have my permission.
st of luck with your work.
gards
seem Fatima

1 Nov 2017 9:50 am, "RaBIya saleem" <rabia.saleem45@gmail.com> wrote:
espected Ma'am

Hope you are well. My name is Rabia Saleem and I am a student of MPhil Psychology at National Institute of Psychology,Quaid-i-Azam University Islamabad, Pakistan. As part of my MPhil I am conducting a research on **"Impact of Coercive Control on Individual and Relational Functioning of Married Women: Role of Self-Silencing and Copping Self-Efficacy".**

n connection with this research, I hope to use your translated version of "Enrich Couple Satisfaction Scale". Pakistan being a developing country, it is difficult to access reliable psychological tests and scales, herefore, I request your permission to use your well-established translated version of the scale for the urpose of my study.

would appreciate your kind support if you permit to use above mentioned scale at the earliest possible onvenience enabling me complete my project in a timely manner.

look forward for a favorable response from your side.

incerely,

abia Saleem

MPhil. Psychology

lational Institute of Psychology

uaid-i-Azam University, Islamabad Pakistan

APPENDIX - H

Student Copy

PERMISSION FORM
(For Research Only)

Applicant's Name Rabia Salem Supervisor's Name Dr. Sabir Masood

Applicant's Email rabia.salem45@gmail.com

Institution/ Department NIP

Topic of Research Impact of Coercive Control of Ind. & relational Functioning & Women: Role of Self Silencing & Self-Efficacy (

M.Sc. / M.Phil / M.S / Ph.D / Diploma M.Phil

Test Required: (scale title, year, author) ENRICH COUPLE SATISFACTION SCALE

Undertaking

- This is hereby specified that the above mentioned information is correct.
- I applied for the above mentioned scale after consultation with my supervisor.
- I also understand that I have to follow the copy rights requirements of the National Institute of Psychology.
- This test / scale is the intellectual property of the National Institute of Psychology. No part of this test / scale may be reproduced or photocopied or disseminate or to republish without written permission from the National Institute of Psychology.
- I am also under obligation to share my data and research findings with the TRC of National Institute of Psychology.

Research Supervisor

Student

Permission granted for the above mentioned research only.

You are not allowed to share this scale /test with other students.

6/11/17

Incharge TRC (Signature)
Test Resource Centre,
National Institute of Psychology, Quaid-i-Azam University

Enrich Marital Satisfaction Scale

یہ سوالنامہ آپ کی ازدواجی زندگی سے متعلق ہے۔ کہ آپ اپنی ازدواجی زندگی میں کس قدر مطمئن ہیں۔ برائے مہربانی درست ( ) کا نشان لگا کر نشاندہی کیجئے کہ آپ جملوں سے کس حد تک متفق یا غیر متفق ہیں۔

نمبر شمار	سوالات	انتہائی غیر متفق	غیر متفق	معلوم نہیں	متفق	انتہائی متفق
1-	ہمارے تنازعات کو حل کرنے کے طریقہ کار پر میں خوش ہوں۔					
2-	میں ہمارے رابطے/ بات چیت کے معیار کے بارے میں فکر مند ہوں۔					
3-	ہمارے گھریلو کام کاج کی تقسیم کے طریقہ کار پر میں اچھا محسوس کرتا/کرتی ہوں۔					
4-	ہمارے روحانی عقائد کی وجہ سے میں اور میرا/میری شریک حیات خود کو قریب تر محسوس کرتے ہیں۔					
5-	میری خواہش ہے کہ میں اور میرا/میری شریک حیات ایسی اور بھی سرگرمیوں میں شریک ہوتے۔ جن سے ہم دونوں لطف اندوز ہوتے ہوں۔					
6-	ہمیں ہماری مالی معاملات سے نپٹنے کے متعلق فیصلہ کرنے میں مشکل آتی ہے۔					
7	ہمارے جنسی تعلقات مجھے تکمیل اور اطمینان بخشتے ہیں۔					
8-	کبھی کبھار میرے/میری شریک حیات کے دوست احباب یا خاندان کے لوگ ہمارے رشتے میں دخل اندازی کرتے ہیں۔					
9-	جس طرح سے ہم نے اپنے بچوں کی پرورش کی ذمہ داریاں بانٹی ہوئی ہیں۔ اس سے میں مطمئن ہوں۔					
10-	میں اپنے/اپنی شریک حیات کی شخصیت کی کچھ پہلوؤں یا ذاتی عادات سے ناخوش ہوں۔					

APPENDIX-J

NIP

nidamunir599@gmail.com

Mail

Move to Inbox

COMPOSE

Inbox (882)

Starred

Sent Mail

Drafts (5)

More

Rabia +

No recent chats
Start a new one

Quaid-i-Azam University, Islamabad Pakistan

Nida Munir <nidamunir599@gmail.com>
to me

Dear Rabia,
Assalam'o'Alaikum,

You can use the translated version of STSS for your study.
For any query feel free to contact.

Best of Luck!

Kind Regards,

Nida Munir

E: nidamunir599@gmail.com

Kind Regards,

Rabia Saleem <rabia.saleem@nip.edu.pk>
to Nida

thanks a lot Ma'am.

APPENDIX- J

Student Copy

PERMISSION FORM
(For Research Only)

Applicant's Name Rabia Saleem Supervisor's Name Dr. Sobia Masood

Applicant's Email rabia.saleem45@gmail.com

Institution/ Department NIP

Topic of Research Impact of Coercive Control on Ind. & relational Func. of married women: Role of SUJ- Silencing & Coping Self-efficacy

M.Sc. / M.Phil / M.S / Ph.D / Diploma M.Phil

Test Required: (scale title, year, author) Silencing the Self Scale (Munir, 2014)

Undertaking

- This is hereby specified that the above mentioned information is correct.
- I applied for the above mentioned scale after consultation with my supervisor.
- I also understand that I have to follow the copy rights requirements of the National Institute of Psychology.
- This test / scale is the intellectual property of the National Institute of Psychology. No part of this test / scale may be reproduced or photocopied or disseminate or to republish without written permission from the National Institute of Psychology.
- I am also under obligation to share my data and research findings with the TRC of National Institute of Psychology.

Research Supervisor

Student

Permission granted for the above mentioned research only.

You are not allowed to share this scale /test with other students.

Incharge TRC (Signature)
Test Resource Centre,
National Institute of Psychology, Quaid-i-Azam University

Silencing The Self-Scale

برائے مہربانی نیچے دیئے گئے بیانات کوغور سے پڑھیں اوران کے سامنے دی گئی آپشنز میں سے اس آپشن کا انتخاب کریں جوان جملوں کے بارے میں آپ کی بہترین عکاسی

ہے۔

نمبر شمار	بیانات	بھرپور غیر متفق	کچھ حد تک غیر متفق	نہ متفق نہ غیر متفق	کچھ حد تک متفق	بھرپور متفق
1-	میرے خیال میں خود کر ترجیح دینا بہترین ہے کیونکہ کوئی اور میری پرواہ نہیں کرے گا۔					
2-	میں کسی قریبی تعلق سے اپنے احساسات بیان نہیں کرتا/کرتی جب مجھے معلوم ہو کہ ان سے اختلاف پیدا ہوگا۔					
3-	خیال رکھنے کا مطلب ہے کہ کسی دوسرے کی ضروریات کو خود پر ترجیح دینا۔					
4-	اپنی ضروریات کو اتنی اہمیت دینا خود غرضی ہے جتنی کہ ان لوگوں کی، جن سے پیار کرتا/کرتی ہوں۔					
5-	قریبی تعلق سے میرے لئے اپنے خیالات ومحسوسات کا احساس زیادہ مشکل ہے ۔بہ نسبت اسکے جب میں اکیلا ہوں۔					
6-	میں خود کو دوسروں کی نظر سے پرکھتا/پرکھتی ہوں۔					
7-	میں اپنے آپ سے غیر مطمئن محسوس کرتا/کرتی ہوں کیونکہ مجھے بھی وہ تمام کام کرنے کے قابل ہونا چاہیے جنکو کرنے کی توقع آج کل دوسروں سے کی جاتی ہے۔					
8-	جب کبھی میرے اور میری شریک حیات کے احساسات میں اختلاف (Conflict) ہوتا ہے تو میں اپنا نقطہ نظر صاف بیان کر دیتا/دیتی ہوں۔					
9-	کسی قریبی تعلق میں یہ میری ذمہ داری ہے کہ میں دوسروں کی خوش رکھوں۔					
10-	خیال رکھنے کا مطلب ہے کہ میں وہی کروں جو دوسرا چاہتا ہے، حالانکہ میں کچھ مختلف کرنا چاہتا/چاہتی ہوں۔					
11-	اپنے بارے میں اچھا محسوس کرنے کے لیے ضروری ہے کہ مجھے خود مختار اور خود کفیل ہونے کا احساس ہو۔					
12-	بدترین کام جو میں کرسکتا/کرسکتی ہوں وہ یہ ہے کہ میں خود غرض ہو جاؤں۔					
13-	مجھے لگتا ہے کہ مجھے اپنے شریک حیات کو خوش کرنے کے لئے ایک خاص انداز سے پیش آنا پڑتا ہے۔					
14-	قریبی تعلق میں مخالفت مول لینے کی بجائے میں ترجیح دوں گا/گی کہ بھڑوں کے چھتے میں ہاتھ نہ ڈالوں۔					

نمبر شمار	بیانات	بھرپور غیر متفق	کچھ حد تک غیر متفق	نہ متفق نہ غیر متفق	کچھ حد تک متفق	بھرپور متفق
15-	میں اپنے احساسات کا اظہار اپنے قریبی ساتھی سے اس وقت بھی کر دیتا/کر دیتی ہوں جب یہ کسی مسائل اور اختلاف کا باعث بنتا ہو۔					
16-	اکثر میں بظاہر تو کافی خوش نظر آتا/آتی ہوں لیکن اندر سے غصہ اور بغاوت محسوس کرتا/کرتی ہوں۔					
17-	شریک حیات کی محبت پانے کے لیے میں اس کے سامنے اپنے متعلق چند باتیں ظاہر نہیں کر سکتا/سکتی۔					
18-	جب میرے اور میری شریک حیات کی ضروریات یا رائے میں اختلاف/تصادم (Conflict) ہوتا ہے تو اپنے نقطہ نظر پر اصرار کرنے کی بجائے میں اُس سے متفق ہو جاتا/جاتی ہوں۔					
19-	جب میں کسی قریبی تعلق سے منسلک ہوتا/ہوتی ہوں۔تو میں اپنی انفرادیت کھو دیتا/دیتی ہوں۔					
20-	کسی رشتے میں جب مجھے یہ لگتا ہے کی میری کچھ ضروریات پوری نہیں ہو رہی تو میں سمجھتا/سمجھتی ہوں کہ وہ اتنی زیادہ اہم بھی نہیں تھیں۔					
21-	میں جیسا/جیسی بھی ہوں شریک حیات مجھے پیار کرتا اور مجھے سراہتا ہے۔					
22-	صرف اپنی ذات کے لیے کام کرنا خودغرضی ہے۔					
23-	جب میں فیصلہ کرتا/کرتی ہوں۔تو اس وقت دوسروں کے خیالات اور رائے مجھ پر زیادہ اثر انداز ہوتی ہے بہ نسبت میرے اپنے خیالات اور رائے کے۔					
24-	میں شاذ و نادر ہی اپنے قریبی لوگوں پہ اپنے غصے کا اظہار کرتا/کرتی ہوں۔					
25-	مجھے محسوس ہوتا ہے میرا شریک حیات میری حقیقی ذات سے ناواقف ہے۔					
26-	میرے خیال میں جب میرے اور میری شریک حیات کے احساسات میں اختلاف/تصادم (Conflict) ہو تو مجھے اُنہیں خود تک رکھنا بہتر ہے۔					
27-	میں اکثر دوسروں کے احساسات کے لئے خود کو ذمہ دار محسوس کرتا/کرتی ہوں۔					
28-	مجھے یہ جاننے میں مشکل ہوتی ہے کہ میں خود کیا سوچتا/سوچتی ہوں کیونکہ میرا زیادہ تر وقت یہ سوچنے میں گزر جاتا ہے کہ دوسرے کیا محسوس کرتے ہیں۔					
29-	قریبی تعلق میں جب تک دوسرا شخص خوش ہو تو میں عام طور پر یہ پرواہ نہیں کرتا/کرتی کہ ہم کیا کرتے ہیں۔					

-30	میں اپنے احساسات کو دبانے کی کوشش کرتا/کرتی ہوں۔ جب مجھے یہ لگے کہ یہ میرے قریبی تعلق میں بگاڑ پیدا کریں گے۔					
-31	مجھے کبھی نہیں لگتا کہ میں اپنے لیے مقرر کردہ معیار پہ پورا اترتا/اترتی ہوں۔					

NIP

Rabia Saleem <rabia.saleem@nip.edu.pk>

quest for Scale permission

sney, Margaret <Margaret.Chesney@ucsf.edu> Sat, Sep 23, 2017 at 9:04 PM
Rabia Saleem <rabia.saleem@nip.edu.pk>
s.masood@nip.edu.pk" <s.masood@nip.edu.pk>

ar Rabia,

ank you for your very nice and respectful email. You are welcome to use the Coping Self Efficacy scale. You ntioned that you will be using the scale in your research as part of fulfillment of a MPhil degree in a project, entitled, **npact of Coercive Control on Individual and Relational Functioning of Married Women: Role of Self-Silencing d Coping Self-Efficacy.**" As a woman, I am very interested in your topic and what you may find. I can only imagine e stress that women in Pakistan may experience. I think the scale should work well with this.

ere is a translation of the scale into Urdu that was actually developed by another MPhil student from your department your university, her name is Ms. Sanam Younis and she worked with Dr. Humaira Jami; Assistant Professor, also at ur university. I will contact Ms. Younis and let her know of your interest and that I have sent you the copy of the scale at she sent to me. Can you let me know the name of your adviser, just so that I have it on record. I have a log or cord of people working on the CSE from various countries for occasions just like this – where there is a translation ailable.

I recommended to Ms. Younis, I recommend that you use the full scale and I have also attached a copy in English. e Urdu translated scale also has the full set of items. The full 26-item scale will give you the most reliable measure and one that other investigators are using. By using the full scale you also have the total scores and have the option of ng the full scale or the subscales, which are described in that attached paper on the reliability and validity of the scale. ing the full scale is important because we built the subscales on our studies with HIV patients and your population will different. The CSE as a full scale is being used with many different populations, young and old, with a full range of essful conditions, including psychological and physical. I'm attaching general scoring instructions and if you have any blems, just let me know.

u can also use the information in the article to score the subscales but I've also attached some scoring guidelines that y be helpful. If you have any question, I work closely with Tor Neilands and he or I can answer any questions you may ve.

also attached a copy of the first paper that my colleagues and I wrote which showed how coping self-efficacy was pful in evaluating a coping intervention and mediated the effect of the intervention on outcomes.

agreeing to use the scale for research purposes, I also ask that you keep me informed of what you find. As I mentioned ve, I have created a log of all the researchers, such as yourself who are using the scale and will let everyone on the know when there are developments as well as the results found by others who are using the scale. For the log, could send me any other contact information such as an email that it not associated with your educational institution, should graduate from there?

more than happy to discuss how the concept of "self-efficacy" may relate to your findings as things develop, I view ring ideas as an important role for all of us who are involved in discovery and education.

APPENDIX - L

ll be getting back in touch with you very soon with the Urdu translation and again, please let me know with whom you working.

rgaret

rgaret A. Chesney, Ph.D.
fessor of Medicine

ool of Medicine

versity of California, San Francisco

415-613-7343

rgaret.chesney@ucsf.edu

om: Rabia Saleem [mailto:rabia.saleem@nip.edu.pk]
nt: Thursday, September 21, 2017 12:35 AM
Chesney, Margaret
s.masood@nip.edu.pk
bject: Request for Scale permission

spected Ma'am

ted text hidden]

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ttachments

Coping Self-Efficacy Scale_2016.pdf
19K

CSE URDU.Pakistani.pdf
445K

Coping Self-efficacy Scale Scoring.pdf
11K

Chesney Psychosomatic Medicine (2).pdf
87K

Coping Self Efficacy Scale Rel and Valid.pdf
152K

APPENDIX- L

Student Copy

PERMISSION FORM
(For Research Only)

Applicant's Name Rabia Saleem Supervisor's Name Dr. Sabir Masood

Applicant's Email rabia.saleem459@gmail.com

Institution/ Department NIP

Topic of Research Impact of coercive control on Ind. & relationship functioning of women: Role of Self Silencing & Coping Self-efficacy.

M.Sc. / M.Phil / M.S / Ph.D / Diploma M.Phil

Test Required: (scale title, year, author) Coping Self-efficacy Scale (Translated by Samam Yonis)

Undertaking

- This is hereby specified that the above mentioned information is correct.
- I applied for the above mentioned scale after consultation with my supervisor.
- I also understand that I have to follow the copy rights requirements of the National Institute of Psychology.
- This test / scale is the intellectual property of the National Institute of Psychology. No part of this test / scale may be reproduced or photocopied or disseminate or to republish without written permission from the National Institute of Psychology.
- I am also under obligation to share my data and research findings with the TRC of National Institute of Psychology.

Research Supervisor

Student

Permission granted for the above mentioned research only.

You are not allowed to share this scale /test with other students.

6/11/17

Incharge TRC (Signature)
Test Resource Centre,
National Institute of Psychology, Quaid-i-Azam University

Coping Self-Efficacy

جب چیزیں آپ کے حق میں نہ جارہی ہوں یا آپ مشکلات سے دوچار ہوں تو آپ کتنی/ کتنے پُر اعتماد یا پُر یقین ہوتے/ ہوتی ہیں کہ آپ مندرجہ ذیل چیزیں کر سکتے/سکتی ہیں

0 بالکل نہیں کر سکتے/سکتی ہیں	1	2	3 درمیانی حد تک کر سکتا/سکتی ہوں	4	5	6 بالکل کر سکتا/سکتی ہوں

اوپر دیئے گئے پیمانے کو استعمال کرتے ہوئے مندرجہ ذیل بیانات میں ہر ایک کے لیے 1 سے لے کر 6 تک کوئی ہندسہ لکھیں۔

نمبر شمار	بیانات	0	1	2	3	4	5
	جب چیزیں آپ کے حق میں نہ جارہی ہوں تو آپ کتنے پُر اعتماد ہوتے ہیں کہ:						
-1	خود کو افسردگی سے بچا سکیں۔						
-2	اپنے آپ سے مثبت بات کر سکیں۔						
-3	تلاش کر سکیں کہ کیا تبدیل کیا جا سکتا ہے اور کیا نہیں۔						
-4	دوستوں اور خاندان والوں سے جذباتی سہارا لے سکیں۔						
-5	اپنے مشکل ترین مسائل کا حل تلاش کر سکیں۔						
-6	ایک پریشان کن مسئلے کو (حل کرنے کے لیے) چھوٹے چھوٹے حصوں میں تقسیم کر سکیں۔						
-7	جب چیزیں ذہنی دباؤ ڈالنے لگیں تو اپنے لیے ترجیحات (راستے) کھلے چھوڑیں۔						
-8	ایک حکمت عملی بنائیں اور جب کوئی مسئلہ پیش آئے تو اس پر عمل کریں۔						
-9	نئے مشاغل یا تفریحات پیدا کر سکیں۔						
-10	اپنے دماغ کو ناخوشگوار خیالات سے چھٹکارا دلا سکیں۔						
-11	منفی صورتحال میں بھی کچھ اچھا پہلو دیکھ سکیں۔						
-12	افسردہ ہونے سے بچ سکیں۔						
-13	گرما گرم بحث کے دوران چیزوں کو دوسروں کے نقطہ نظر سے دیکھ سکیں۔						
-14	اگر آپ کی پہلی تدبیر کارآمد نہ ہو تو اپنے مسائل کے لیے کوئی دوسرے حل آزما سکیں۔						
-15	خود کو ناگوار سوچوں سے پریشان ہونے سے بچا سکیں۔						
-16	نئے دوست بنا سکیں۔						
-17	اپنی ضرورت کی چیزیں پوری کرنے کے لیے دوستوں کی مدد حاصل کر سکیں۔						
-18	جب آپ حوصلہ شکن محسوس کر رہے ہوں تو اپنے لیے کچھ مثبت کر سکیں۔						
-19	ناخوشگوار سوچوں کو دور بھگا سکیں۔						
-20	ایک وقت میں مسئلے کے کسی ایک پہلو پر ہی سوچ سکیں۔						
-21	کوئی خوشگوار کام یا جگہ کا تصور کر سکیں۔						

							-22	اپنے آپ کو تنہائی کے احساس سے بچا سکیں اور دور رکھ سکیں۔
							-23	عبادت یا مراقبہ (دل سے خدا کو یاد کرنا) کر سکیں۔
							-24	معاشرتی اداروں (ایدھی سینٹر، 1122، سکول وغیرہ) یا ذرائع سے جذباتی سہارا لے سکیں۔
							-25	اپنے مؤقف یا نقطہ نظر پر ڈٹے رہیں اور جو آپ چاہتے ہیں اُس کے لیے لڑ سکیں۔
							-26	جب دباؤ میں ہوں تو جلد بازی میں کام کرنے کی بے اختیار (زوردار) خواہش کو روک سکیں۔