BMC Health Services Research

RESEARCH

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The quality of psychosocial health and psychosocial illness among women with and without shelter homes: a cross-sectional study

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Abstract

Background Existing research on the psychosocial wellbeing of sheltered women is primarily from Western contexts, with limited studies from collectivistic cultures like Pakistan. This study aims to compare the psychosocial health and illness of sheltered women in Pakistan with those of women living with their families.

Methods A total of 184 sheltered women and 207 women from the general population from four Pakistani cities participated in this study. Data were collected using two validated instruments: the Psychosocial Health Evaluator and the Sukoon Psychosocial Illness Scale. The study employed independent sample t-tests, simple linear regression and Pearson correlation.

Results The study revealed significant differences between women residing in shelters and those in the general population. Sheltered women exhibited lower levels of psychosocial health and higher levels of psychosocial illness. Emotional, sexual, spiritual, and social health were notably lower among sheltered women. Sheltered women also reported elevated levels of psychosocial problems, including emotional, social, and professional difficulties. Additionally, the length of stay in shelters was negatively correlated with psychosocial health and positively correlated with psychosocial illness, while education showed a positive correlation with psychosocial health.

Conclusion The current research highlights the psychosocial vulnerability of women residing in shelter homes. Government, non-governmental organizations, and mental health professionals are advised to work together to uplift the psychosocial health of women residing in Pakistani shelter homes. Appointments of psychological counselors in shelter homes are highly recommended in this regard.

Keywords Women, Sheltered women, Psychosocial health, Psychosocial illness, Collectivistic culture, Shelter homes, Pakistan

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Introduction

Women have been suppressed throughout history and civilizations [1–5]. Many societies maintain patriarchy through cultural, legal, and religious norms [6–9]. This system reinforces male superiority and female subordination. Societies assign men with roles of strength and assertiveness, and women are confined to nurturing and caregiving [10–13]. Patriarchy promotes gender inequality, where men are generally afforded greater privileges, rights, and access to resources than women [14].

Suppression of women gets worsen in collectivistic cultures where honor of men is considered extremely important [15]. Collectivistic societies allow more female oppression than individualistic or contemporary cultures [5]. Women in collectivistic cultures experience greater deprivation of their rights [16, 17] and exhibit higher levels of social compliance [18]. They are expected to adhere to societal conventions, possess strong ethical principles, uphold their family's reputation, carefully manage their public image, exercise sexual restraint, enter into marriages arranged by their parents, enhance their appearance for their husbands, fulfill their husbands' desires like servants, and conform to the idealized notion of a "good" woman [19–23]. Furthermore, women are more susceptible to mental disorders than men due to the influence of cultural pressure [24]. In addition, they encounter more cultural obstacles when attempting to access professional assistance [25] to address their problems. The pseudo-religious teachings also impede their efforts to attain empowerment [26–28]. In collectivistic cultures, women who breach the codes of their family are often confronted with dangerous consequences such as domestic violence and honor killing [29]. They are forced to escape from their families and find shelter in places assigned for destitute women.

Shelter homes, commonly referred to as women's shelters, domestic violence shelters, or battered women's shelters, are short-term residential facilities that purport to offer a protected and stable environment for women and children who have endured abuse and exploitation. Reaching a shelter is the first step for many women to escape violent relationships and start over [30]. Shelter homes are supposed to offer a safe and supportive environment for women to stop mistreatment and start over [31]. These centers usually provide several services including counseling, legal aid, healthcare, education, and employment [32, 33]. Women often seek refuge in shelter homes due to various forms of exploitation, such as domestic violence, physical abuse, financial hardships, escaping forced marriages, seeking divorce, or changing religious beliefs [16, 17]. Approximately 3 million women in the United States, the United Kingdom, and the Netherlands are currently seeking shelter due to intimate partner violence [33]. Shelter systems have also gained significant popularity among Canadian women who are victims of intimate violence and various forms of abuse [34].

Living in a shelter home is different than living with the family. Women face many challenges when entering shelters. These challenges include financial vulnerability, psychological trauma, depression, anxiety, suicidal ideation, and adjustment problems [35–43]. Lack of social support, especially from their families, creates several psychosocial problems for them [44, 45]. As compared to women living with their families, women without families find it difficult to overcome their obstacles [46, 47]. Studies indicate that women residing in shelters exhibit elevated levels of depression [48–50] and anxiety [51] as compared to the general population. These studies, however, mostly belong to Western individualistic cultures. The current study focused on comparing the quality of psychosocial health and psychosocial illness among sheltered and general women from Pakistan i.e. a collectivistic culture and the sixth most populous nation in the world. The findings of the current study would be a valuable addition to literature by providing the first ever reflection on the psychosocial issues of sheltered women from Pakistan.

Method

Participants

The current study involved women with and without shelter. One hundred and eighty-four sheltered women participated in this study. They were residing in governmental shelter homes in four Pakistani cities (Islamabad, Rawalpindi, Peshawar, and Lahore). Two hundred and seven women from public also participated in the study. They were approached in different educational institutions and public offices in the same four cities. All the participants were selected through convenient sampling technique. Regarding the inclusion criteria, they were expected to be above 18 years of age and be able to respond to the study questionnaires.

Instruments

The Psychosocial Health Evaluator (PHE) [52] was used to measure the psychosocial health of the participants. The PHE aims to assess psychosocial health in eight domains: sexual, emotional, cognitive, social, environmental, religious, moral, and spiritual. It consists of 24 items. The answer sheet has a 5-point Likert scale that spans from strongly disagree to strongly agree. The developer claimed that the scale is highly reliable ($\alpha = 0.851$) and valid (CFI = 0.956; TLI = 0.948; RMSEA = 0.049; SRMR = 0.035). The convergent and divergent validity of the scale was also established through its significant positive correlation with satisfaction with life ($r = 0.832$, $p < 0.001$) and significant inverse correlation

with depression (r= -0.892, p<0.001), anxiety (r= -0.822, p<0.001), and stress (r= -0.690, p<0.001). The PHE was found to be reliable in the current study as well (α=0.832). Sukoon Psychosocial Illness Scale (SPIS) [53] was utilized to assess the psychosocial illness. This scale consists of 21 items that measure emotional, sexual, religious, moral, social, professional, and spiritual problems. The answer sheet comprises a 7-point Likert scale ranging from strongly disagree to strongly agree. The developer claimed that the scale is highly reliable (α=0.886) and valid (CFI=0.942; TLI=0.931; RMSEA=0.055; SRMR=0.052). The convergent and divergent validity of the scale was also established through its significant positive correlation with psychological distress (r=0.699, p<0.001) and significant inverse correlation with psychosocial health (r= -0.270, p<0.001). The PHE was found to be reliable in the current study as well (α=0.853). A demographic information sheet was also used to gather information on age, education, marital status, and the length of stay of sheltered women.

Procedure

Ethical approval was granted by the departmental review committee at COMSATS University Code CUI-ISB/HUM/ERC-CPA/2023-49. The data collection process adhered to the 1964 Helsinki declaration and its subsequent amendments. The researchers sought out non-institutionalized women in various public and private offices as well as educational institutions. The women residing in institutionalized settings were approached in various shelter facilities. Each participant in the study provided their consent to participate through a check box included in the questionnaire. The administration of various shelter homes granted permission and helped the researchers in this matter. Prior to commencing the questioning, a satisfactory rapport was established with the participants, and they were duly informed about the objective of the study.

Analysis

The data gathered was recorded and analyzed in the Statistical Package for Social Sciences (version 26). Apart from the descriptive statistics, independent sample t-test was used to compare women with and without shelter for psychosocial health, psychosocial illness, and marital status. Pearson correlation coefficient was calculated to measure the correlation between psychosocial health, psychosocial illness, age, education, and length of stay at shelter home. The significant level for all the analyses was <0.05 and the results were reported using 95% confidence intervals.

Results

Data collected in the current study was found accurate (Table 1) and the scales used were found reliable (α=0.832 for Sukoon Psychosocial Illness Scale & 0.853 for Psychosocial Health Evaluator). The findings revealed significant differences between women with and without shelter (Table 2). Sheltered women had significantly lower levels of psychosocial health (sheltered: M=72.136, SD=8.247, %=60.113; general: M=98.899, SD=5.774, %=82.416; p=0.000; Cohen's d=3.798) including socio-environmental health (sheltered: M=18.076, SD=4.42, %=60.254; general: M=26.531, SD=3.004, %=88.438; p=0.000; Cohen's d=2.262), emotional health (sheltered: M=6.897, SD=2.814, %=45.978; general: M=13.478, SD=1.393, %=89.855; p=0.000; Cohen's d=3.019), spiritual health (sheltered: M=8.413, SD=2.901, %=56.087;

Table 1 Descriptive statistics, reliability, and data accuracy (N=391)

Variable	Items	α	M	SD	%	Range		Skewness	Kurtosis
						Potential	Actual		
Psychosocial Illness	21	0.832	66.220	16.829	45.048	21–147	21–131	0.189	0.701
Emotional Problems	6	0.829	20.072	7.959	47.790	6–42	6–42	0.279	-0.612
Sexual Problems	3	0.884	9.148	3.691	43.563	3–21	3–18	-0.336	-1.056
Religious & Moral Problems	3	0.811	6.240	3.626	29.716	3–21	3–21	1.555	2.369
Social Problems	3	0.785	12.872	4.711	61.296	3–21	3–21	-0.233	-0.909
Spiritual Problems	3	0.680	7.570	3.407	36.049	3–21	3–19	0.826	0.744
Professional Problems	3	0.724	10.317	4.520	49.129	3–21	3–21	0.224	-0.780
Psychosocial Health	24	0.853	64.384	36.498	53.653	1-120	4-112	-0.558	-1.307
Socio-environmental Health	6	0.754	22.552	5.638	75.175	1–30	6–30	-0.476	-0.696
Religious Health	3	0.613	8.859	2.545	59.062	1–15	3–15	-0.120	-0.406
Emotional Health	3	0.796	10.381	3.945	69.207	1–15	3–15	-0.502	-1.201
Cognitive Health	3	0.807	11.949	2.561	79.659	1–15	3–15	-1.136	1.071
Moral Health	3	0.605	10.875	2.070	72.500	1–15	3–15	-0.749	0.848
Spiritual Health	3	0.740	11.074	3.417	73.828	1–15	3–15	-0.658	-0.727
Sexual Health	3	0.753	10.726	3.825	71.509	1–15	3–15	-0.473	-1.231

α Cronbach's alpha, *M* Mean, *SD* Standard Deviation

Table 2 Differences between sheltered and general women ($N=391$)

Variables	Sheltered ($n=184$)			General ($n=207$)			t(389)	*p*	Cohen's d
	M	SD	%	M	SD	%			
Psychosocial Illness	77.685	13.342	52.847	56.029	12.503	38.115	16.563	0.000	1.678
Emotional Problems	24.576	7.087	58.515	16.068	6.408	38.256	12.467	0.000	1.263
Sexual Problems	10.348	3.247	49.275	8.082	3.741	38.486	6.357	0.000	0.644
Religious & Moral Problems	7.592	4.204	36.154	5.039	2.471	23.993	7.417	0.000	0.752
Social Problems	14.288	4.245	68.038	11.614	4.757	55.302	5.836	0.000	0.591
Spiritual Problems	8.728	3.724	41.563	6.541	2.719	31.148	6.680	0.000	0.677
Professional Problems	12.152	4.323	57.868	8.686	4.049	41.362	8.185	0.000	0.829
Psychosocial Health	72.136	8.247	60.113	98.899	5.774	82.416	37.484	0.000	3.798
Socio-environmental Health	18.076	4.420	60.254	26.531	3.004	88.438	22.327	0.000	2.262
Religious Health	8.880	2.656	59.203	8.841	2.447	58.937	0.154	0.877	-
Emotional Health	6.897	2.814	45.978	13.478	1.393	89.855	29.797	0.000	3.019
Cognitive Health	11.837	2.741	78.913	12.048	2.391	80.322	0.814	0.416	-
Moral Health	10.620	2.124	70.797	10.889	1.901	72.593	1.323	0.187	-
Spiritual Health	8.413	2.901	56.087	13.440	1.638	89.597	21.385	0.000	2.167
Sexual Health	7.413	2.823	49.420	13.672	1.448	91.143	28.021	0.000	2.839

Table 3 Differences between married and unmarried sheltered women ($N=184$)

Variables	Married ($n=68$)			Unmarried ($n=116$)			t(389)	*p*	Cohen's d
	M	SD	%	M	SD	%			
Psychosocial Illness	71.647	8.600	48.740	81.224	14.352	55.254	4.999	0.000	0.865
Emotional Problems	22.809	7.145	54.307	25.612	6.874	60.981	2.631	0.009	0.398
Sexual Problems	10.221	3.022	48.670	10.422	3.383	49.630	0.406	0.685	-
Religious & Moral Problems	6.368	3.002	30.322	8.310	4.633	39.573	3.096	0.002	0.527
Social Problems	13.368	3.901	63.655	14.828	4.360	70.608	2.277	0.024	0.358
Spiritual Problems	7.500	3.127	35.714	9.448	3.868	44.992	3.531	0.001	0.570
Professional Problems	11.382	4.435	54.202	12.603	4.209	60.016	1.862	0.064	-
Psychosocial Health	74.353	5.534	61.961	70.836	9.262	59.030	2.846	0.005	0.493
Socio-environmental Health	19.147	3.751	63.824	17.448	4.671	58.161	2.554	0.011	0.413
Religious Health	9.456	2.147	63.039	8.543	2.869	56.954	2.275	0.024	0.374
Emotional Health	7.324	3.029	48.823	6.647	2.661	44.311	1.582	0.115	-
Cognitive Health	11.721	2.585	78.137	11.905	2.838	79.368	0.440	0.661	-
Moral Health	10.441	2.346	69.608	10.724	1.985	71.494	0.872	0.384	-
Spiritual Health	8.632	2.562	57.549	8.285	3.087	55.230	0.784	0.434	-
Sexual Health	7.632	2.764	50.883	7.285	2.861	48.563	0.806	0.421	-

general: M=13.44, SD=1.638, %=89.597; $p=0.000$; Cohen's d=2.167), and sexual health (sheltered: M=7.413, SD=2.823, %=49.42; general: M=13.672, SD=1.448, %=91.143; $p=0.000$; Cohen's d=2.839). Sheltered women also had significantly higher levels of psychosocial illness (sheltered: M=77.685, SD=13.342, %=52.847; general: M=56.029, SD=12.503, %=38.115; $p=0.000$; Cohen's d=1.678) including emotional problems (sheltered: M=24.576, SD=7.087, %=58.515; general: M=16.068, SD=6.408, %=38.256; $p=0.000$; Cohen's d=1.263), sexual problems (sheltered: M=10.348, SD=3.247, %=49.275; general: M=8.082, SD=3.741, %=38.486; $p=0.000$; Cohen's d=0.644), religious and moral problems (sheltered: M=7.592, SD=4.204, %=36.154; general: M=5.039, SD=2.471, %=23.993; $p=0.000$; Cohen's d=0.752), social problems (sheltered: M=14.288, SD=4.245, %=68.038; general: M=11.614, SD=4.757, %=55.302; $p=0.000$; Cohen's d=0.591), spiritual problems (sheltered: M=8.728, SD=3.724, %=41.563; general: M=6.541, SD=2.719, %=31.148; $p=0.000$; Cohen's d=0.677), and professional problems (sheltered: M=12.152, SD=4.323, %=57.868; general: M=8.686, SD=4.049, %=41.362; $p=0.000$; Cohen's d=0.829).

Psychosocial health and psychosocial illness were also analyzed based on marital status among sheltered women (Table 3). Married sheltered women had significantly higher levels of psychosocial health (married: M=74.353, SD=5.534, %=61.961; unmarried: M=70.836, SD=9.262, %=59.030; $p=0.005$; Cohen's d=0.493) including socio-environmental health (married: M=19.147,

SD=3.751, %=63.824; unmarried: M=17.448, SD=4.671, %=58.161; p=0.011; Cohen's d=0.413), and religious health (married: M=9.456, SD=2.147, %=63.039; unmarried: M=8.543, SD=2.869, %=56.954; p=0.024; Cohen's d=0.374). Married women also had significantly lower levels of psychosocial illness (married: M=71.647, SD=8.600, %=48.740; unmarried: M=81.224, SD=14.352, %=55.254; p=0.000; Cohen's d=0.865) including emotional problems (married: M=22.809, SD=7.145, %=54.307; unmarried: M=25.612, SD=6.874, %=60.981; p=0.009; Cohen's d=0.398), religious and moral problems (married: M=6.368, SD=3.002, %=30.322; unmarried: M=8.310, SD=4.633, %=39.573; p=0.002; Cohen's d=0.527), social problems (married: M=13.368, SD=3.901, %=63.655; unmarried: M=14.828, SD=4.360, %=70.608; p=0.024; Cohen's d=0.358), and spiritual problems (married: M=7.500, SD=3.127, %=35.714; unmarried: M=9.448, SD=3.868, %=44.992; p=0.001; Cohen's d=0.570).

The correlation between psychosocial health, psychosocial illness, age, education, and length of stay was also observed (Table 4). Length of stay at shelter home was positively correlated with overall psychosocial illness (r=0.462; p<0.001), emotional problems (r=0.357; p<0.001), sexual problems (r=0.188; p<0.001), religious and moral problems (r=0.287; p<0.001), social problems (r=0.238; p<0.001), spiritual problems (r=0.241; p<0.001), and professional problems (r=0.277; p<0.001). Length of stay at shelter home, on the other hand, was inversely correlated with psychosocial health (r= -0.701; p<0.001) including socio-environmental health (r= -0.573; p<0.001), emotional health (r= -0.660; p<0.001), moral health (r= -0.114; p<0.05), spiritual health (r= -0.597; p<0.001), and sexual health (r= -0.634; p<0.001). A simple linear regression analysis also revealed that length of stay was a strong predictor of psychosocial illness (R=0.462; R2=0.213; Adj. R2=0.211; df=390; F=105.387; B=3.702; SE B=0.361; β=0.462; t=10.266; p<0.001). Education was positively correlated with psychosocial health (r=0.756; p<0.001) and inversely correlated with psychosocial illness (r= -0.572; p<0.001). Age was inversely correlated with psychosocial health (r= -0.189; p<0.001).

Table 4 Correlation between psychosocial illness, psychosocial health, age, education, and length of stay at shelter homes (N=391)

Variable	Age	Education	Length of stay at shelter home
Psychosocial Illness	0.058	-0.572***	0.462***
Emotional Problems	0.093	-0.468***	0.357***
Sexual Problems	0.012	-0.321***	0.188***
Religious And Moral Problems	0.08	-0.283***	0.287***
Social Problems	-0.011	-0.242***	0.238***
Spiritual Problems	0.006	-0.279***	0.241***
Professional Problems	-0.015	-0.355***	0.277***
Psychosocial Health	-0.189***	0.756***	-0.701***
Socio-Environmental Health	-0.155**	0.629***	-0.573***
Religious Health	0.04	-0.015	0.008
Emotional Health	-0.171***	0.732***	-0.66***
Cognitive Health	-0.037	0.026	-0.035
Moral Health	-0.019	0.02	-0.114*
Spiritual Health	-0.16**	0.627***	-0.597***
Sexual Health	-0.19***	0.725***	-0.634***

* p<0.05, ** p<0.01, *** p<0.001

Discussion

The results of the current study highlight critical differences in the psychosocial health and illness of women residing in shelters compared to those in the general population. Sheltered women exhibited significantly lower levels of psychosocial health across various domains, including socio-environmental, emotional, spiritual, and sexual health. Furthermore, the findings revealed that sheltered women experience higher levels of psychosocial illness. This includes heightened emotional, sexual, social, and spiritual problems, all of which suggest that shelter residents face considerable psychological challenges. This significant disparity indicates the profound impact that shelter living conditions can have on women's overall well-being. The correlation analyses further emphasize the detrimental effects of prolonged shelter stay on psychosocial health. The length of stay in shelters was inversely correlated with overall psychosocial health and positively correlated with psychosocial illness. This suggests that the longer women remain in shelters, the more likely they are to experience deteriorating mental health. The same was verified through a simple linear regression analysis that also regarded length of stay at shelter homes as a strong predictor of psychosocial illness. The emotional problems reported by sheltered women could stem from the trauma of displacement or personal crises that led them to the shelter in the first place. Their elevated social and professional difficulties may also reflect the stigma and social exclusion often associated with shelter residency. It is conceivable that the challenging environments and limited resources in shelters contribute to emotional distress, social isolation, and a sense of instability that affects psychosocial health adversely. Prior international research has linked women residing in shelter homes to various negative mental health consequences [54, 55] including lower levels of life satisfaction [35], post-traumatic stress disorder [56], and depression [57]. However, there was a noticeable absence

of such studies within the specific setting of Pakistani shelter homes.

An important aspect of the study is the influence of marital status on the psychosocial health of sheltered women. Married women in shelters demonstrated relatively better psychosocial health and lower psychosocial illness compared to their unmarried counterparts. This suggests that having a spouse, despite residing in a shelter, may provide a form of emotional or social support that mitigates some of the negative psychological impacts of shelter life. On the other hand, unmarried women may feel a deeper sense of isolation or lack access to similar support systems, exacerbating their emotional and social problems. Earlier studies also confirm that being married is positively associated with better mental health. A satisfying marriage is strongly associated with several positive outcomes, including a longer and healthy life [58], better physical and psychological health [59–66], better quality of life [67], better outcomes in life [68], happiness and life satisfaction [69], and prevention from depression and anxiety [60, 66, 70–75].

The negative correlation between education and psychosocial illness, and the positive correlation between education and psychosocial health, suggest that educational attainment may serve as a protective factor, possibly providing women with greater resilience, coping mechanisms, or opportunities to navigate out of adverse circumstances. Earlier studies also reveal that education improves mental health and helps in overcoming depression, anxiety, and several other psychosocial problems [76–79]. Interestingly, age was inversely correlated with psychosocial health, indicating that older women may experience more significant challenges in maintaining their well-being. This could be due to the cumulative stress of life events or difficulties in adapting to the environment. Literature supports the notion that physical and cognitive function decreases with age [80] that may lead to poor psychosocial health [81].

Limitations

The present study would have been more insightful had it explored the underlying reasons that drive women to seek shelter. Additionally, its value could have been further enhanced by incorporating a broader range of psychosocial variables, such as depression, suicidal ideation, and self-efficacy. It is recommended that future researchers address these limitations to deepen the understanding of the psychosocial challenges faced by sheltered women.

Conclusion

The current study underscores the significant disparities in psychosocial health and illness between women residing in shelters and those in the general population. Sheltered women experience marked reductions in psychosocial health and an increase in various psychosocial illnesses including emotional, social, spiritual, and sexual difficulties. The detrimental impact of prolonged stay at shelter homes points to the need for targeted interventions. Interventions should focus on enhancing emotional and social support, addressing the unique challenges faced by both married and unmarried women, and mitigating the negative effects of prolonged shelter stays. Educational and vocational programs may offer a pathway to improving psychosocial health, particularly for women with lower levels of education. Moreover, addressing the emotional and psychological impacts of shelter life should be a priority to ensure that these environments foster resilience and healing, rather than exacerbating illness. Future research should focus on expanding the range of psychosocial variables to explore the underlying factors that lead Pakistani women to seek shelter.

Acknowledgements

None.

Authors' contributions

Author Contributions: Conceptualization, Waqar Husain and Haitham Jahrami; Data curation, Farrukh Ijaz and Muhammad Ahmad Husain; Writing – original draft, Waqar Husain, Farrukh Ijaz, and Muhammad Ahmad Husain; Writing – review & editing, Waqar Husain, Farrukh Ijaz, Muhammad Ahmad Husain, Achraf Ammar, Khaled Trabelsi, and Haitham Jahrami.

Funding

This research received no external funding.

Data availability

Data associated with this paper can be produced on request from the first author.

Declarations

Ethics approval and consent to participate

Ethical approval was granted by the departmental review committee at COMSATS University Code CUI-ISB/HUM/ERC-CPA/2023-49. Informed consent was obtained from all subjects involved in the study. All the procedures performed in this study were in accordance with the 1964 Helsinki Declaration and its later amendments.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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Received: 13 February 2024 / Accepted: 22 October 2024
Published online: 08 November 2024

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