INTIMATE PARTNER VIOLENCE VIS-À-VIS ITS IMPLICATIONS ON PSYCHOLOGICAL HEALTH

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ABSTRACT

Intimate partner violence is a well-known phenomenon across the globe. Intimate partner violence or domestic violence can occur from either the husband or the wife. It is the biggest problem the world is facing today and it significantly make a huge contribution to the problems related to psychological health at a global level. Intimate partner violence is a problem related to gender. The number of female victims is more than that of male victims. At the world level, approximately 27% of the girls and women have been the victim of intimate partner violence, also the number includes girls under the age of 15 years. The relationship between mental health and intimate partner violence is very difficult to understand. The chances of getting any psychological health issue increases with the exposure to intimate partner violence whether in childhood or in adulthood. Children who are subjected to intimate partner violence are also at a far higher risk of suffering from other types of abuse or neglect, and having a history of abuse or being exposed to intimate partner violence as a child considerably increases the chances of having a history of intimate partner violence as an adult. While the overall incidence of intimate partner violence is minimal, it is more common among individuals who have been diagnosed with a mental health condition. In this paper we are going to throw some light on intimate partner violence and its relationship with different mental health issues and its consequences.

Keywords- Intimate Partner Violence, Psychological Health, Child Abuse

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I. INTRODUCTION

Intimate partner violence is a worldwide concern related to public health that has disastrous effects over the persons, families and societies. It is mostly concerned with mental, physical, sexual and reproductive health and death (because of homicide and suicide). Physical violence, emotional abuse, sexual violence, controlling and coercive actions, and any other behaviours that inflict physical, psychological, or sexual harm on an intimate relationship are all included in the umbrella term "intimate partner violence," or IPV. Technology is increasingly used to facilitate abuse, including through abuse on social media and other online platforms, the installation of stalker ware on personal devices, and manipulation of smart meters, locks, and cameras.[1]

II. FACTORS RESPONSIBLE FOR INTIMATE PARTNER VIOLENCE

Several theoretical frameworks attempt to account for intimate partner violence. During the past quarter of a century, the ecological model has been front and centre, suggesting that violence is the outcome of interplay between individuals, relationships, communities, and societies. An updated version of this model sought both to capture the inter-connections between risk factors operating at different levels and to clarify which risk factors are indicators of broad underlying latent constructs.[2] Supporters of the revised model assert that economic hardship, social acceptance of violence, and discrimination against women all play a role in increasing

***Panel 1*: Forms of intimate partner violence**

- Physical violence: slapping, hitting, kicking, beating, and choking
- Sexual violence: sexual contact and behaviour that occurs without explicit consent, including rape, attempted rape, sexual touching, and forcing a person to perform sexual acts
- Emotional (psychological) abuse: insults, belittling, humiliation, intimidation, threats to harm, and threats to take away children
- Controlling behaviours: acts designed to make a person subordinate or dependent, including isolating a person from family and friends, monitoring a person's movements, and restricting a person's access to financial resources, employment, education, or health care
- Coercive behaviours: a continuing act (or pattern of acts) of assault, threats, humiliation, intimidation, or other abuse used to harm, punish, or frighten a person

[1] I.N. Lopez, T. Patel, S. Parkin, G. Danezis, L. Tanczer, '*Internet of Things': how abuse is getting smarter,* SAFE, 22-26 (2019).
[2] A. Gibbs, K. Dunkle, L. Ramsoomar, et al., *new learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions*, 13, GLOB HEALTH ACTION (2020).

the likelihood that men will engage in intimate partner violence against women (Fig. 1; Reproduced at Gibbs et al). Personal and interpersonal characteristics (such as poor mental health, substance misuse, childhood neglect and abuse, communication breakdowns and relational conflict reactions) also raise the risk of IPV, and these risks are exacerbated by gender inequality and poverty. In this model, disability is suggested to exacerbate risk factors, and individual and structural factors are intensified during conflict and post-conflict periods.[3]

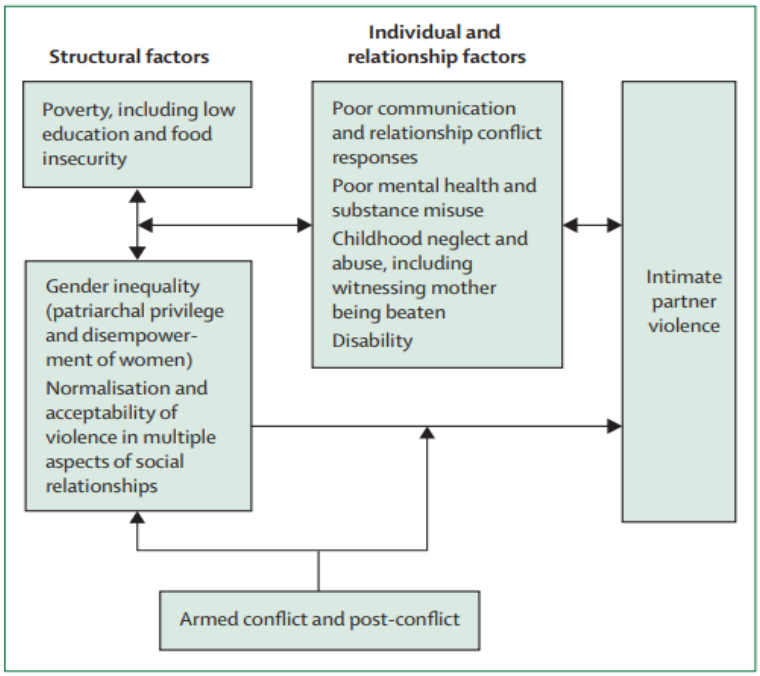

Figure 1: **Drivers of intimate partner violence**

Gender inequality is entrenched globally, and actual and threatened violence are a means through which men's dominance and control over women are expressed and gender hierarchies are maintained.[4] Research suggests that the most violent men are more likely to express hypermasculine behaviours and gender-inequitable attitudes than men who do not commit violence,[5] although the evidence for associations between such attitudes and IPV is mixed.[6] By defining what constitutes appropriate behaviour in various social contexts, social norms serve to perpetuate pre-existing beliefs about gender roles, the distribution of power, and the tolerance for violence between individuals.

Yet, additional risk factors, including as poverty and trauma, can alter the relative importance of communal vs individual attitudes. There are two ways in which poverty increases the likelihood of experiencing intimate partner violence: directly, by increasing

[3] *Id* at 2.
[4] R. Jewkes, M. Flood, J. Lang, *from work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls*, LANCET 385, 1580–89 (2015).
[5] R. Jewkes, R. Morrell, *Hegemonic masculinity, violence, and gender equality: using latent class analysis to investigate the origins and correlates of differences between men*, MEN MASCULINITIES, 21, 547–71 (2018).
[6] E. Fulu, R. Jewkes, T. Roselli, C. Garcia Moreno, *Prevalence of and factors associated with male perpetration of intimate partner violence: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific*, LANCET GLOB HEALTH, 1, e187–e207 (2013).

the likelihood of having experienced stressors like food insecurity, which contributes to heightened family conflict, and indirectly, by increasing the likelihood of having encountered other health risks for such violence (such as low educational attainment, child abuse and neglect, and low psychological health and drug misuse in adulthood).

As highlighted by the ecological model, experience of maltreatment and exposure to intimate partner violence in childhood are strongly associated with both experiencing and committing intimate partner violence.[7] Evidence consistently shows that women who experienced abuse in childhood or who were exposed to violence between their parents (or step-parents or partners) are more likely to be victimised by their partner than are women who were not abused and who did not grow up in violent households, whereas men who have experienced these forms of maltreatment are more likely to use violence against their partner than are men who did not.[8] Mental health problems and harmful substance misuse are associated with an increased risk of both IPV victimisation and perpetration and are frequently comorbid. IPV drives mental health problems and substance misuse in women.[9]

The likelihood of being a victim of IPV is higher for those with mental health issues and substance abuse histories. Men who have been given a diagnosis of a mental health issue and males who report excessive consumption of alcohol and drugs are more likely to engage in IPV than men who do not.

IPV's mental health effects may be magnified in societies with more pronounced gender disparities because victims may have a harder time getting help or escaping violent relationship. Without recognising the pervasive and interwoven consequences of heteropatriarchy (the hegemony of heterosexual and chauvinistic social standards) and other oppressive practises like racism, transphobia, discrimination, and poverty, it will be impossible to understand the complexities of the relationships between IPV and psychiatric illness or to effectively address them.

[7] C.L. Whitfield, R.F. Anda, S.R. Dube, V.J. Felitte, *Violent childhood experiences and the risk of intimate partner violence in adults: assessment in a large health maintenance organization*, J INTERPERS VIOLENCE, 18, 166–185 (2013).
[8] *Id* at 7.
[9] KM Devries, JC Child, LJ Bacchus, et al., *intimate partner violence victimization and alcohol consumption in women: a systematic review and meta-analysis*, ADDICTION, 109, 379-391 (2014).

III. RELATIONSHIP BETWEEN INTIMATE PARTNER VIOLENCE AND PSYCHOLOGICAL HEALTH

IPV has both direct and indirect effects on health, including mental health. Hypothesised pathways between IPV and different forms of illness, disability, and mortality include direct pathways between physical violence, injury, disability, and death. Across countries with available data worldwide, 38% of all murdered women and 6% of murdered men between 1982 and 2011 were killed by an intimate partner.[10] Indirect pathways are likely to be mediated by biological stress responses, use of alcohol, drugs, tobacco, and prescription medication to manage the consequences of abuse, and restricted help-seeking and decision making.[11]

The effects of abuse seem to be cumulative: analyses[12] of data from WHO's Multi-Country Study on Women's Health and Domestic Violence have highlighted that, although all forms of IPV were damaging to physical and mental health, combined abuse—and combined abuse involving sexual IPV in particular—was associated with the highest levels of harm, including risk of suicidal ideation and attempting suicide. These effects persist long after abuse has stopped.[13]

Vulnerability to IPV is harmful to children because it puts them at a higher risk for developing anxiety, depression, and poor behavioural and learning results compared to their counterparts who have not been exposed to IPV. Kids who have been subjected to IPV are more likely to be at risk for diarrhoeal and other diseases and have higher rates of infant mortality, according to studies conducted in low-income settings. When people experience IPV, it's been linked to a wide variety of mental health issues, each with its own unique set of symptoms and ways of affecting daily life.

Psychological problems such as anxiety, depression, substance abuse, PTSD, personality disorders, insanity, self-harm, and suicide ideation and action are more common among IPV survivors. Although not everyone who experiences IPV develops mental health issues as a result, studies have found a link between IPV and poor mental health in women, men,

[10] WHO, *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence,* GENEVA: WORLD HEALTH ORGANIZATION, (2013).
[11] *Id at 10.*
[12] LC Potter, R Morris, K Hegarty, C Garcia-Moreno, G Feder, *categories and health impacts of intimate partner violence in the World Health Organization multi-country study on women's health and domestic violence, INT J EPIDEMIOL, 1, 11 (2020).*
[13] *Id at 12.*

transgender women and men, and non-binary persons at all stages of life (from childhood to old age, and even during and after pregnancy).

It has been shown by certain studies that victims of IPV are more likely to develop long-term mental health issues than those who have not been victims of IPV. Far more women than males suffer from mental health issues as a result of intimate partner violence (assuming causality). Consequently, it is crucial to examine the links between IPV and psychological effects separately for each sex.

Various types of IPV have been associated with mental health problems, including physical aggression, sexual assault, verbal and emotional or psychological abuse, controlling behaviours, and coercive control.[14] Concentrating on correlations for individual forms of IPV is likely fruitless because of how frequently they co-occur (much like how other mental health issues do). Also, when sexual IPV is included in the abuse, those who are subjected to many forms of IPV may be at a higher risk of poor mental health outcomes than those who are just subjected to a single form of IPV. More severe mental health issues are linked to long-term exposure to IPV, albeit this correlation may be at least partially type-specific.

Although much of the existing research comes from high-income countries, evidence is accruing in low-income and middle-income countries of associations between IPV and development of mental health problems.[15] For example, a study[16] done across several low-income and middle-income countries found that experience of IPV was an independent risk factor for suicide attempts. Exposure to or experience of physical, sexual, or emotionally abusive or neglectful treatment are all forms of violence that can affect a child. Children who witness or experience domestic violence between their careers are more likely to suffer from mental health issues later in life compared to those who were not exposed to such violence as children or adolescents.

[14] AB Ludermir, LB Schraiber, AF D'Oliveira, I Franca-Junior, HA Jansen, *violence against women by their intimate partner and common mental disorders,* SOC SCI MED, 66, 1008-1018 (2008).
[15] A Gibbs, K Dunkle, R Jewkes, *the prevalence, patterning and associations with depressive symptoms and self-rated health of emotional and economic intimate partner violence: a three-country based study,* J GLOB HEALTH (2020).
[16] K Devries, C Watts, M Yoshihama, et al., *violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women,* SOC SCI MED, 73, 79-86 (2011).

IV. PSYCHOLOGICAL HEALTH ISSUES AS A RISK FACTOR FOR INTIMATE PARTNER VIOLENCE

Persons struggling with mental illness are disproportionately represented among victims of domestic abuse. A meta-analysis[17] showed that individuals diagnosed with a severe mental health problem experienced high rates of IPV during the previous 1–3 years, with women reporting roughly double the rates of men. Evidence is scarce; however, it is estimated that the rate of IPV exposure among people with mental health disorders is two to three times greater than it is among people without such disorders. A meta-analysis of longitudinal studies, however, indicated that women with depression were more likely to experience IPV than women without even any psychiatric illness. Those with mental health issues may be at increased risk for abuse from intimate partners due to the effects of psychotic symptoms such as dissociation or obsession with one's own thoughts.

Encounter to childhood assault can lead to both the start of psychological issues and the childhood trauma via IPV in adult, as was stated previously; this may be the driving force behind the linkages between mental health conditions and recent experiences of IPV. Those who have been abused or neglected as children may have a distorted view of what a good or non-abusive relationship entails. They may view maltreatment as somehow; they deserve since they no longer value themselves.

V. ADDRESSING INTIMATE PARTNER VIOLENCE

Trauma and violence are often invisible in mental health policy, frameworks, services, training, and research, and as a result the connections between IPV and poor mental health across the life course can remain hidden.[18] IPV is common among mental health care users, and many survivors cannot get services. Medical conceptions of mental illness and the uniformity of psychological procedures might cause treatment to be organised by diagnosis and ignore people's real experiences and situations. Consequently, mental health professionals too often focus on IPV victims' symptoms and therapy rather than what happened to them and how to help them.

[17] H Khalifeh, S Oram, D Osborn, LM Howard, S Johnson, *recent physical and sexual violence against adults with severe mental illness: a systematic review and meta-analysis,* INT REV PSYCHIATRY, 28, 433-451 (2016).
[18] WHO, *responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, GENEVA: WHO (2013).

There is no universally accepted test for IPV, and it is usually not recommended. However, in the context of a psychological health examination, all patients should be asked about cases involving violent behaviour, including IPV, even though mental health problems may be related to or made worse by violence. Any health-care provider inquiring about IPV should be trained in how to ask about IPV safely and how to respond appropriately to a disclosure. Information for providers, including examples of how to respond during interactions with patients, is available online,[19] including a curriculum for mental health providers developed by the World Psychiatric Association.[20]

The World Health Organization has put forth guidelines for primary care professionals that place an emphasis on mental health responses for the general population. Even while this and other guidelines tend to concentrate on women who are victims of male-on-female violence, the concepts typically apply to anybody who has had such an experience, including children, young adults, women in same-sex partnerships, men, and members of other gender minorities.

Responses to IPV increasingly make use of digital technology, particularly safety decision aids with the goal of decreasing IPV. Qualitative research done in Australia suggested that survivors find these digital technologies acceptable and that digital interventions might be able to provide support that is similar to face-to-face support.[21] In the wake of the COVID-19 epidemic, when the delivery of some face-to-face support was halted, these online interventions became more prevalent. The advent of remote healthcare delivery has opened up new possibilities but also created new obstacles, such as in the field of risk assessment.

Mental health services' readiness to address IPV varies widely, from rejection of IPV's role in psychological disorders to acquiescence of the need for individualised, survivor-centred, injury reactions to IPV and the required framework for facilitating these responses. Institutions must be educated on the relevance of trauma-informed care and the links among IPV and mental health problems.

[19] WHO, *caring for women subjected to violence: a WHO curriculum for training health-care providers,* GENEVA: WHO (2014).
[20] DE Stewart & PS Chandra, *WPA international competency-based curriculum for mental health providers on intimate partner violence and sexual violence against women,* WORLD PSYCHIATRY, 16, 223 (2017).
[21] L Trazia, R Cornelio, K Forsdike, K Hegarty, *women's experiences receiving support online for intimate partner violence: how does it compare to face-to-face support from a health professional?* INTERACT COMP, 30, 433-443 (2018).

Although many mental health services reference trauma-informed approaches, in practice little attention is paid to addressing the system-wide changes that are needed[22]— e.g., strengthening of leadership and governance, provision of care in environments that are private and safe (i.e., safe, well-lit corridors, women-only inpatient corridors, private spaces, posters detailing how to access IPV support), implementation of clear policies and procedures, and ensuring coordination of care (with roles defined, referral pathways mapped, and an emphasis on reduction of waiting times).[23]

VI. CONCLUSION

Everyone, from women and children to the elderly and the young, is susceptible to intimate partner violence, making it a worldwide epidemic. There has been substantial increase in knowledge over the past few years about the links between IPV and mental health problems and about how to protect and react to IPV as well as the related psychological harms, but there are still open areas of inquiry. In response to violence against intimate partners, the Global Health Organization has developed clinical and policy guidance as well as a training program for health-care providers to help fill these voids.

Individuals who have been subjected to IPV, whether as youngsters or as adults, are at a higher risk of developing a wide range of psychological problems; conversely, people who already have psychological disorders are more likely to be exposed to IPV. These associations appear to be lifelong, to have their roots in sexual identity and other intersection of two forms of social inequalities, and to be connected to both the onset and the development of mental health problems.

Reducing rates of domestic violence is likely to improve mental health outcomes. This holds true whether IPV is encountered in early childhood, later in life, or at both stages.

Some people with psychological conditions have a greater tendency to contribute violence against partners compared to people who do not have mental health problems, despite the low absolute rates and the fact that those who have mental disorders are more likely to experience than to commit intimate partner violence. Treatment studies have linked reduced

[22] WA Tol, SM Murray, C Lund, et al., *can mental health treatments help prevent or reduce intimate partner violence in low- and middle-income countries? A systematic review,* BMC WOMMEN HEALTH, 19, 34 (2019).
[23] C Garcia-Moreno, K Hegarty, AFL d'Oliveira, et al., *the health-systems response to violence against women,* LANCET, 385, 1567-1579 (2015).

alcohol consumption to lower rates of IPV and less severe IPV. This has ramifications for the practise of psychology and for social policy as a whole.

SUGGESTIONS:

Schools have an opportunity to reduce the risk of IPV, through purposively creating an ethos that models gender equality and respectful relationships. Mental health services should address IPV by using approaches that are gender sensitive, trauma informed, and coproduced with survivors.[24]

However, because psychological disorders are often linked to or exacerbated by violence, it is important to inquire about any exposure to violence, including domestic violence, from all people who seek mental health care, and especially from women and sexuality-related minorities.

Assessments ought to be carried out in private by practitioners who have received proper training and who operate within an established referral network. It is important to determine whether or not emotionally disturbed children and adolescents have been subjected to intimate partner violence (IPV). They might need specific interventions in conjunction with or independently from the carers who are providing care for them, but this requirement should be determined based on a comprehensive assessment.

Measurement of IPV should be improved in future mental health research, including as a potential moderator of treatment response in intervention studies and in new population cohorts. Improved coordination and cooperation across sectors (eg, academia, policy, health services, specialist services, criminal justice services) are needed in terms of both data collection for IPV and core indicators and outcomes to assess interventions to reduce IPV, which should reflect the priorities and expectations of survivors.[25]

[24] S Oram, HL Fisher, H Minnis, S Seedat, S Walby, et al., *the Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research and policy, 9,* THE LANCET PSYCHIATRY COMMISION, 487, 488 (2022).
[25] *Id* at 24.