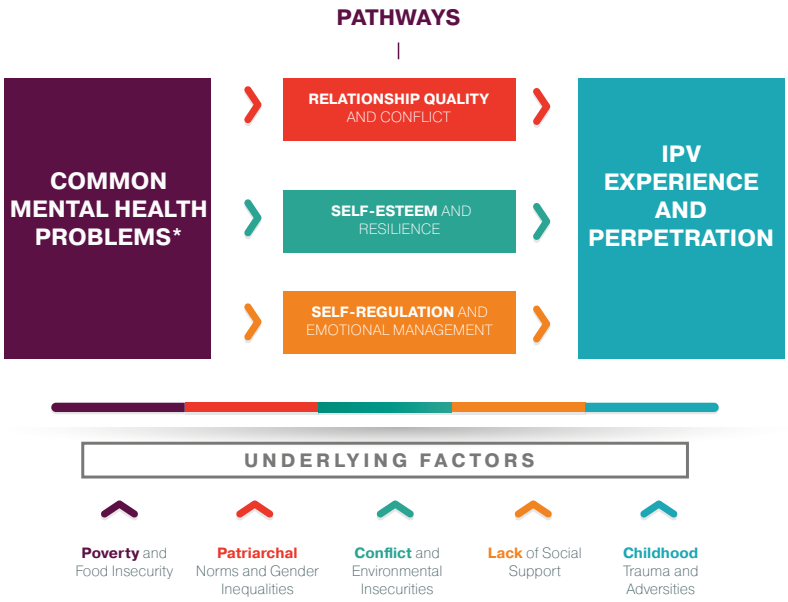
MENTAL HEALTH AND INTIMATE PARTNER VIOLENCE

The experience of intimate partner violence (IPV) damages mental health. Poor mental health, in turn, is a key driver of both experiencing and perpetrating IPV. Conversely, efforts to improve mental health reduce the risk and impacts of IPV. Past efforts have focused on addressing the mental-health impact on IPV survivors, but the evidence shows significant opportunities for prevention by:

- addressing poor mental health (particularly among men) as a driver of IPV
- improving mental health (at a population level) as a violence-prevention strategy

The better we understand the various pathways between mental health and IPV, the more effectively we can intervene to address and prevent both.

PATHWAYS BETWEEN MENTAL HEALTH AND IPV



*Common mental health problems include: depression, anxiety, trauma-related symptoms and post-traumatic stress disorder.

FIGURE 1: How does poor mental health lead to IPV? What structural factors contribute to poor mental health?

CONTROVERSY

In the past, many people objected to the definition of poor mental health as a risk factor for IPV, because the linkage:

- was used to blame IPV survivors and delegitimise women's experiences
- can individualise a fundamentally societal problem
- could avoid holding perpetrators accountable for IPV
- could stigmatise people with mental health problems as 'violent' and create barriers to care

Mental health problems can increase the risk of IPV, but the link is by no means inevitable. Mental distress and its symptoms are among many, overlapping factors that contribute to the likelihood of IPV. To minimise or deny the links, however, means that we miss an opportunity to intervene effectively to reduce both problems. (Note that complex mental disorders that require specialised care are not covered by the evidence that underlies this brief.)

RISK

STRUCTURAL FACTORS

PATRIARCHAL NORMS AND GENDER INEQUALITIES

Globally, women are more likely to experience common mental-health problems (including depression, anxiety), in part because of gender-based inequalities and violence. Dominant constructions of masculinity hinder men's willingness to seek help for emotional problems, services that do exist are seldom 'male-friendly'. Men are primed to cope with distress by affirming social expectations (dominating women, sexual promiscuity, violence). Gender intersects with other forms of inequalities and discrimination that can generate mental health consequences, including related to race and ethnicity, gender identity or sexual orientation, and disability.

CONFLICT AND ENVIRONMENTAL INSECURITIES

Environmental insecurities can have long-term impacts on people's mental health. Exposure to conflict, high-violence settings, and displacement create trauma and increases the risk of severe mental-health problems. Refugees often experience adversities (gender-based violence by fighting forces, torture, abduction, disappearance of family members); ongoing stressors pre, during, and post-migration (poverty, violence in refugee camps, lack of health care, post-migration living difficulties); and distress and anxiety. Climate change and extreme natural disasters trigger risk factors for worsened mental health (stress, disrupted access to resources and support, abrupt re-location). The devastation related to the COVID-19 pandemic has been linked with increased rates of IPV, compounded trauma and poor mental health.

LACK OF SOCIAL SUPPORT

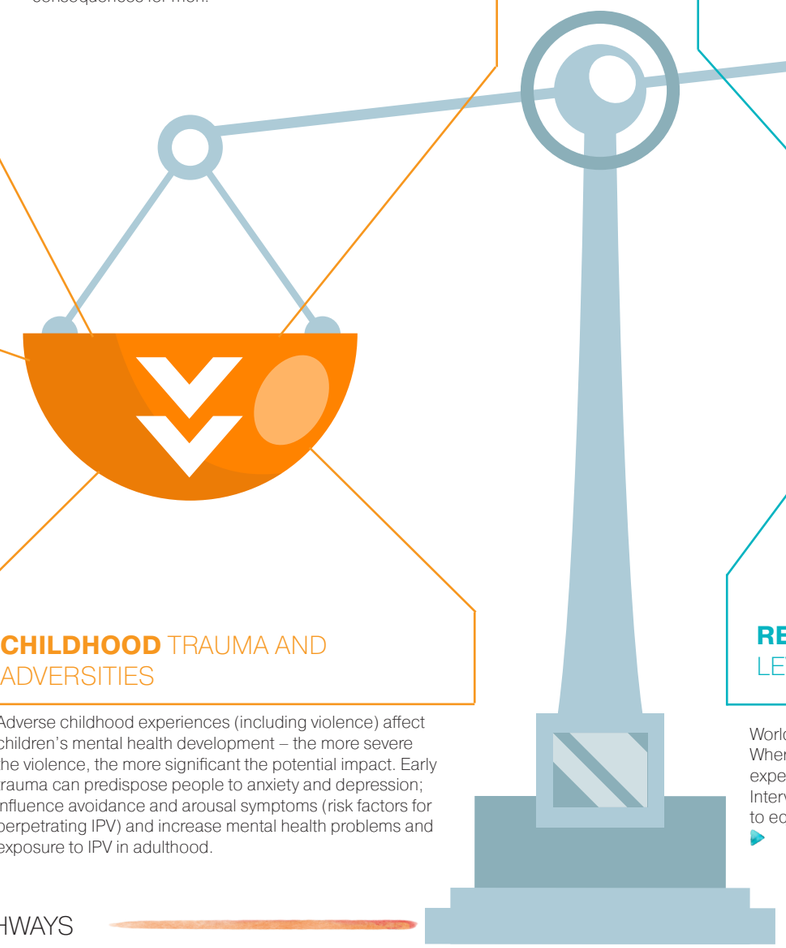
Lack of social support (both emotional and practical) is a risk factor for poor mental health. Reduced access to social safety nets (food banks, income support, personal loans) increases the likelihood of mental-health problems. Living with disabilities increases mental-health risks (marginalisation, lack of social support). Conversely, strong social support can be a protective factor.

POVERTY AND FOOD INSECURITY

Poverty can exacerbate poor mental health through income shocks; food insecurity (driver of anxiety, depression, substance misuse); a disadvantaged socio-economic environment; stressors from inadequate housing; worse physical health; greater exposure to violence, crime, and other trauma; and lower social status. Poverty and food insecurity is a particular mental health risk for women and a key risk factor for their exposure to IPV. Expectations of men as 'breadwinners' exacerbates negative mental health consequences for men.

CHILDHOOD TRAUMA AND ADVERSITIES

Adverse childhood experiences (including violence) affect children's mental health development – the more severe the violence, the more significant the potential impact. Early trauma can predispose people to anxiety and depression; influence avoidance and arousal symptoms (risk factors for perpetrating IPV) and increase mental health problems and exposure to IPV in adulthood.



INDIVIDUAL PATHWAYS

RELATIONSHIP QUALITY AND CONFLICT

Depression, for example, is associated with lower intimacy and reduced relationship satisfaction. Through symptoms (feeling worthless, unmotivated, hopeless, and sad), depression may impact couples conflict-management capacity and reduce women's interest in sexual intimacy, triggering discord and forced sex. Trauma (associated with shame, guilt, and self-blame) can lead to difficulties with trust and intimacy. Romantic jealousy can undermine the quality of intimate relationships and increase IPV risk.

EMOTIONAL MANAGEMENT AND SELF-REGULATION

Common mental health-problems (depression, trauma, reactivity) can affect individuals' ability to manage their emotions and regulate their impulses. Anger, hostility, irritability, and agitation are risk factors for perpetration of IPV. Poor mental health can reinforce maladaptive coping methods, such as substance abuse, which can heighten risk of subsequent IPV.

ERODING SELF-ESTEEM AND RESILIENCE

Pathways to experiencing IPV include the erosion of self-esteem, self-efficacy and resilience, which can reduce the ability to protect oneself or leave an abusive relationship. Pathways to perpetration of IPV include lower self-esteem (heightened sense of rejection or threat). Conversely, higher self-esteem reduces perceptions of social threat, increases sacrifice and compromise, and facilitates non-violent communication. Self-esteem, resilience, and stress management are protective factors for maintaining mental well-being and preventing IPV.

WHAT WORKS

Most efforts to improve mental health focus on the individual level: clinical diagnosis, therapies, and/or medication. But mental-health-care providers are scarce for half of the world's population, so violence-prevention should engage with the field of global mental health to develop strategies that can be implemented by lay people.

Evidence shows that:

- efforts to improve mental health should be part of a comprehensive programme to prevent abuse.
- programmes to address structural drivers of poor mental health may also reduce levels of IPV, and vice versa.
- IPV prevention programmes can result in positive impacts on women and men's mental well-being, despite not being explicitly designed to do so.
- programmes that improve mental health also reduce IPV.

INDIVIDUAL-LEVEL STRATEGIES

Brief psychosocial interventions by lay providers can successfully reduce depression, anxiety, trauma-related symptoms, and IPV. For example:

- Women receiving brief psychological treatment for depression (a Healthy Activity Program) were nearly 50% less likely to report IPV than women in usual care.
- Problem-solving therapy (PST) does not require extensive training or complex skills; teaches people better ways to cope; and can alleviate depression, anxiety, and psychological distress.
- A PST programme in Zimbabwe trains grandmothers and other lay people to counsel community members who approach the 'Friendship Bench' for support, achieving reduced depression and suicidal ideation by 80% and fostered a 60% improvement in quality of life.
- Cognitive processing therapy (CPT)/ cognitive behavioral therapy (CBT) can successfully address depression and post-traumatic stress disorder (PTSD), for example with survivors of GBV in the Democratic Republic of Congo (DRC).

Broader, more scalable approaches address more than a single mental-health diagnosis. For example:

- Trained and supervised lay people can deliver the Common Elements Treatment Approach (CETA), a single intervention to address a range of mental-health issues (depression, anxiety, harmful substance use, trauma, and stress-related disorders).
- Mindfulness interventions (typically around eight sessions) can effectively treat depression, anxiety, and PTSD. Meditation and yoga promote awareness, compassion for self and others, resilience, recovery from trauma, and enhanced emotional regulation.

RELATIONSHIP AND COMMUNITY-LEVEL STRATEGIES

Worldwide, communities have long practised collective healing. Where people understand recovery from trauma as a shared experience, individual therapies will not necessarily be effective. Interventions can improve mental health by offering group support to equip individuals to cope with distress and anxiety. For example:

- The Living Peace project, a 15-week intervention in the DRC, uses contextually appropriate support groups to help men and their partners in post-conflict and high violence settings to develop positive coping strategies after traumatic experiences, build social cohesion, and restore violence-free relationships.
- The Indashyikirwa couples curriculum incorporates social support to equip couples to build non-violent, equitable, and higher quality relationships, reducing the odds of women and men reporting IPV by 54%.
- Gender-transformative interventions help communities confront the harmful effects of restrictive and inequitable norms and their impact on mental health.

STRUCTURAL-LEVEL STRATEGIES

Some strategies have shown success in addressing the fundamental causes that drive both IPV and mental-health problems. For example:

- Cash transfers, broader anti-poverty programmes, and welfare policies can significantly reduce anxiety, depression, and IPV, achieving greater impact on mental health than psychotherapy in some studies in low-income settings.
- Income-based interventions that move people out of poverty can improve mental health as effectively as individual-level interventions such as CBT and antidepressants.

Increasingly, the global mental-health field addresses social distress from structural factors (economic difficulties, social isolation, poor access to health care or education, and sub-standard housing).

PROVIDE TRAINING AND SUPPORT
Critically, lay providers must receive quality training, supervision, and support to deliver interventions and programmes. CETA providers, for instance, receive an intensive 10-day training followed by 6 months of ongoing coaching and support.

ADDRESS STIGMA
Interventions must address the stigma around mental health that exists in nearly every setting. Better framing can increase community acceptance of efforts to support people experiencing mental health challenges. For instance, organizers in Zimbabwe realized that stigma was slowing community uptake and so they changed the name of their intervention from the Mental Health Bench to the Friendship Bench.

CONNECT MENTAL HEALTH AND IPV
The violence-prevention field should foster wider awareness of the relationships between mental health and IPV. Prevention practitioners need to understand the symptoms of depression and anxiety and the local words that people use to express these symptoms. Frontline staff need to be trained to respond to mental distress and to know when and how to refer people for specialist services.

CONTEXTUALISE PATHWAYS
For both IPV and mental health, it is important to understand major risk factors and pathways in a particular setting. Where possible, interventions should build on local coping strategies or rituals that already exist to support positive mental health.

MEASURE IMPACT ON BOTH
Evaluations of mental-health interventions should measure IPV, and vice versa. This will further clarify the pathways between poor mental health and IPV and help to bridge these two, often disparate fields.

OVERCOME BARRIERS TO ACCESS
Programme designers should identify and address obstacles to engagement. People living with disabilities, for instance, typically face stigma, discrimination, and additional barriers to accessing services as well as IPV-prevention programmes.

COLLABORATE WITH SPECIALIST SERVICES
Some mental-health problems require specialised support or medication beyond the scope of an intervention. Where possible, collaborate closely with existing mental-health services and professionals.

MAINTAIN A GENDERED LENS
Consider how to better integrate gender-sensitive and transformative approaches within promising mental health interventions. Evaluations should identify how strategies to improve mental health reinforce or challenge harmful gender norms, and how this may be linked to risks for IPV.

References
Find citations in the **evidence review** on which this brief is based.

CONCLUSION

Efforts to alleviate common mental health problems can be a critical IPV prevention strategy. Inadequate attention to underlying risk factors for IPV, such as poor mental health, can compromise the effectiveness of IPV prevention. Conversely, efforts to improve mental health may be ineffective without IPV prevention. Addressing both IPV and mental health may enhance the magnitude, cost effectiveness, and sustainability of impacts on both outcomes.

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