



## PATHWAYS BETWEEN POOR MENTAL HEALTH AND INTIMATE PARTNER VIOLENCE

**A wealth of evidence shows that experiencing intimate partner violence (IPV) contributes to a range of adverse mental health outcomes**, including anxiety, depression, post-traumatic stress disorder (PTSD), and suicidality.<sup>1,2,3</sup> The higher the frequency and severity of IPV, the greater the risk of mental health consequences for survivors.<sup>4</sup> This review synthesises existing evidence around how and why common mental health problems can be a significant risk factor for both perpetrating and experiencing IPV. Significant attention has already been given to the mental health impacts of experiencing IPV and how to improve the mental health of survivors. This review examines the reverse pathway and considers the potential role that improving mental health at a wider population level, including among men, could play as a violence prevention strategy.

**It also outlines the growing evidence around what works to improve mental health, with an emphasis on strategies that work in low-and middle-income countries.** The review does not differentiate strategies that work better for men versus women, although this is an important area of investigation. The findings should be of interest to practitioners and researchers working in the domains of IPV prevention and/or efforts to improve mental health. We specifically address common mental health problems, including depression, anxiety, and trauma-related symptoms. Other mental health disorders, including schizophrenia and bipolar disorder, are more complex, require specialised care, and are thus beyond the scope of this review.

## BACKGROUND

**The mental health consequences of IPV are manifold.** Women who experience IPV are more likely to have physical and psychosocial outcomes that contribute to poor mental health, including unwanted pregnancies, sexually transmitted infections, stigmatisation, and discrimination within their families or communities.<sup>5,6</sup> Mental health symptoms can also undermine help-seeking among survivors of IPV.<sup>7</sup>

**Importantly, poor mental health is also a key driver of both experiencing and perpetrating IPV.**<sup>8</sup> Some estimates suggest that the frequency of experiencing or perpetrating IPV is around two to three times higher among people with diagnosed mental health disorders than among those without such disorders.<sup>9</sup> A study with more than 10,000 men across six countries in Asia and the Pacific found that depressive symptoms increased the risk of men's perpetration of physical, sexual, and emotional IPV, even after adjusting for childhood exposure to violence.<sup>10</sup> Yet there is inadequate attention to the pathway between poor mental health and the risk for subsequent IPV.<sup>11,12</sup> This is a significant gap since common mental health problems (which include depression, anxiety, trauma-related symptoms, and PTSD) are extremely prevalent at the global level.<sup>13</sup>

**Although still limited, evidence suggests that efforts to improve mental health can reduce the prevalence of IPV.**<sup>14</sup> For instance, a study among US women with histories of trauma found that cognitive behavioural therapy reduced their risk of PTSD and depression, which in turn, lowered their risk of experiencing future IPV.<sup>15</sup> **Efforts to alleviate common mental health problems can, thus, be a critical IPV prevention strategy.** Indeed, addressing poor mental health is a key strategy identified in the World Health Organization and UN Women's [RESPECT framework](#) to reduce violence against women under the '[Services Ensured](#)' strategy. The [INSPIRE framework](#) similarly includes addressing poor mental health as a key strategy to prevent violence against children under 'Response and Support Services' ('helping children heal, recover, and access justice').

### A NOTE ON TERMINOLOGY

In this review, we prioritise the terms 'common mental health problems' and 'poor mental health'. This terminology reflects the current shift away from an individualised, medical approach to mental health,<sup>16</sup> including 'mental disorder' or 'mental illnesses', and towards common expressions or symptoms of mental distress. This terminology also appreciates the more psychosocial aspects of mental health and forms of social distress, which tend to be especially pressing in low- and middle-income settings and among women and girls.<sup>17</sup> We only use the term 'mental health disorder' where the evidence is referencing a clinical diagnosis.



## WHAT ARE COMMON MENTAL HEALTH PROBLEMS?

According to the World Health Organization, common mental health problems include depression, anxiety disorders, trauma-related symptoms, and PTSD.<sup>18</sup>

### depression

Is characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. People with depression may have multiple physical complaints with no apparent physical cause. Depression can be long-lasting or recurrent, substantially impairing people's ability to function at work or school and to cope with daily life. At its most severe, depression can lead to suicide.

### anxiety

Is an emotion characterised by feelings of tension and recurring worried thoughts or concerns. People with generalised anxiety disorders may avoid certain situations out of worry. They may also have a range of physical symptoms, including restlessness, easily feeling tired, increased blood pressure, tense muscles, sweating, trembling, dizziness, irritability, trouble concentrating or sleeping, or a rapid heartbeat.

### PTSD

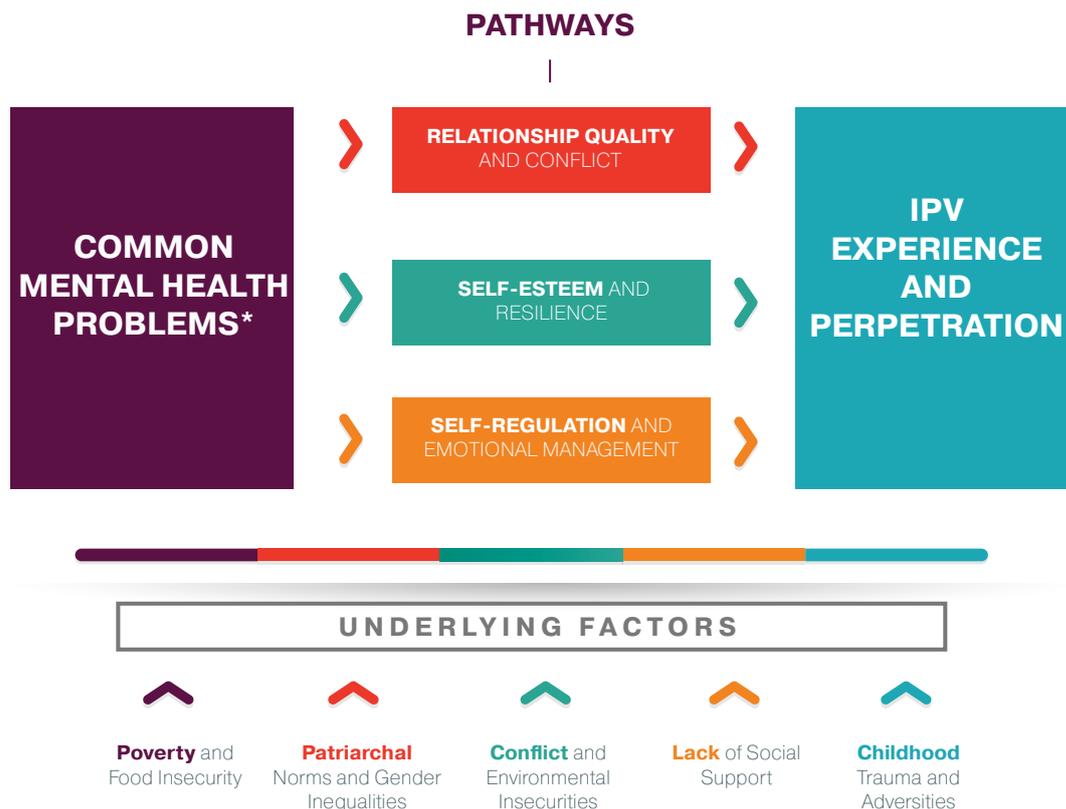
Includes psychological symptoms (e.g., negative changes in mood) and physical symptoms (e.g., shaking and sweating) that can follow particularly threatening or distressing events. Not all people who go through traumatic events subsequently develop PTSD. PTSD includes three primary symptom groups: re-experiencing the traumatic event (through unwanted remembering, such as flashbacks or nightmares); behavioural and cognitive avoidance and numbing (avoiding similar places, activities, or sensations that set off memories of the event or emotionally shutting down to evade feelings); and hyperarousal (the sensation of always being on alert and overreacting to sensory stimuli, such as loud noises).



## CONTROVERSY

Historically, discussing poor mental health as a risk factor for perpetrating and/or experiencing IPV has been controversial, especially among feminist groups. In the 1960s and early 1970s, women's experiences of IPV in the United States were often pathologised as a form of masochism by medical institutions along with popular culture — a framing that was used to blame the survivor of IPV and delegitimise women's experiences. There have also been more recent concerns that emphasising the links between poor mental health and IPV perpetration risks individualising a fundamentally societal problem and avoids holding perpetrators accountable for their actions. Likewise, it could potentially stigmatise people with mental health problems and create barriers to their seeking care.<sup>19</sup> While mental health problems can increase the likelihood of IPV occurring, the link is by no means inevitable. Mental distress and its accompanying symptoms are only one of multiple, overlapping risk factors that contribute to the likelihood of IPV occurring. **Minimising or denying the links between mental distress and violence, however, misses an opportunity to intervene effectively to reduce the negative consequences of both problems.**<sup>20</sup>

# STRUCTURAL FACTORS UNDERLYING POOR MENTAL HEALTH



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

So, how does poor mental health lead to IPV? The above diagram lays out the various pathways through which common mental health problems can lead to both perpetration and experiences of IPV. It also outlines the various structural factors that contribute to poor mental health, some of which are also significant drivers of IPV. In the following sections, we review the evidence that supports each structural factor and the pathways hypothesised to link depression, anxiety, and trauma to the risk of experiencing or perpetrating IPV.

## ▶ POVERTY AND FOOD INSECURITY

Poverty can exacerbate poor mental health for women and men,<sup>21</sup> including through the negative impact of daily stressors<sup>22</sup> and major income losses.<sup>23</sup> Food insecurity has been found to be a significant driver of anxiety and depression.<sup>24</sup> For example, a study of South African men found that food insecurity and childhood trauma led to men’s substance misuse and poor mental health, which in turn, increased their risk of perpetrating IPV.<sup>25</sup> Inadequate and overcrowded housing increases the risks of exposure to pollution, temperature extremes, and challenging sleep environments — stressors that can lead to poor mental health.<sup>26</sup> Poverty is also associated with worse physical health; greater exposure to violence, crime, and other traumas; and lower social status, all of which

can significantly affect mental health.<sup>27</sup> Poverty experienced in utero and in childhood increases the likelihood of poor nutrition and other stressors, which can lead to impaired cognitive development and mental health problems in adulthood.<sup>28</sup> Poverty and food insecurity is a particular mental health risk for women and a key risk factor for their exposure to IPV.<sup>29</sup> In many settings, social and normative expectations on men to be the family 'breadwinner' exacerbate the negative mental health consequences among men facing insecure livelihoods and food insecurity.<sup>30</sup>

## ▶ PATRIARCHAL NORMS AND GENDER INEQUALITIES

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Globally, women are more likely than men to experience common mental health problems, including depression and anxiety,<sup>31</sup> with women living in low- and middle-income countries especially vulnerable.<sup>32</sup> The higher rates of poor mental health among women, particularly depression, can be partially explained by gender-based inequalities that disadvantage women and by their higher likelihood of exposure to gender-based violence (GBV), including IPV.<sup>33</sup> At the same time, dominant constructions of masculinity typically hinder men's willingness to seek help for emotional problems, and the mental health services that do exist are often not regarded as 'male-friendly' or oriented to men's health needs.<sup>34</sup> Men are more likely primed to cope with psychological distress by using strategies that affirm widely held social expectations that men should dominate women, including through sexual promiscuity and physical or psychological violence.<sup>35</sup>

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, income, immigrant status, disability, and more. For instance, there are significant correlations between disability and poor mental health outcomes, including anxiety and depression.<sup>36</sup> A recent review identified how LGBTQI+ individuals are particularly prone to emotional distress, depression and anxiety, PTSD, suicidal ideation, and self-harm, as well as high rates of alcohol and substance use.<sup>37</sup> This was often attributed to common experiences of violence and related challenges, including childhood neglect and abuse and IPV.

## ▶ CONFLICT AND ENVIRONMENTAL INSECURITIES

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Environmental insecurities can have long-term impacts on people's mental health and sense of well-being, which speaks to the importance of not individualising risk factors for poor mental health.<sup>38</sup> Exposure to conflict, post-conflict, and high-violence settings, as well as stress from displacement, creates multiple forms of trauma and increases the risk of severe mental health problems<sup>39</sup> and GBV.<sup>40</sup> A study conducted in the occupied Palestinian territories found that one of main pathways between experiences of occupation-related violence and IPV was through depressive symptoms for men and

women.<sup>41</sup> Refugees and internally displaced persons (IDPS) often experience a range of adversities (e.g., GBV perpetrated by fighting forces, torture, abduction, disappearance of family members) as well as ongoing stressors (e.g., poverty, IPV and other forms of violence in refugee camps, lack of access to health care, post-migration living difficulties) that occur in the period preceding displacement, during displacement, and in the post-migration environment.<sup>42</sup> As a result, refugees and IDPs are particularly vulnerable to psychological distress and anxiety that can impair daily functioning.<sup>43</sup> These risks may be offset by protective factors, including positive coping strategies, being surrounded by supportive peers, and having access to strong justice mechanisms and psychosocial support programmes.<sup>44</sup> Climate change and extreme natural disasters (e.g., floods, hurricanes, wildfires) can also have a profound impact on mental health and be a trigger of traumatic stress.<sup>45</sup> Extreme events can disrupt access to resources or social support or lead to abrupt relocation, all of which are risk factors for worsened mental health.<sup>46</sup> The devastation and anxieties related to the COVID-19 pandemic — including millions of deaths, economic strife, and curbs on social interaction — have been linked to increased rates of IPV, compounded trauma, and poor mental health.<sup>47</sup>

### ▶ LACK OF SOCIAL SUPPORT

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Across populations, a lack of social support (both emotional and practical) is a risk factor for poor mental health, including depression.<sup>48</sup> Reduced access to social safety nets — including food banks, income support, or family or friends who can offer loans — increases the likelihood of people developing mental health problems.<sup>49</sup> People living with disabilities are at increased risk of poor mental health due to marginalisation and a lack of social support.<sup>50,51</sup> A lack of social support from neighbours or community has also been identified as a significant risk factor for IPV.<sup>52</sup> Conversely, strong social support can be a protective factor for mental health and well-being, including through having stress-buffering effects.<sup>53</sup> For instance, one study in the United States found that women who experienced IPV and had high social support were significantly less likely to report depression and anxiety compared to women who experienced IPV and had low social support.<sup>54</sup>

### ▶ CHILDHOOD TRAUMA AND ADVERSITIES

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Adverse childhood experiences, including exposure to and experiencing violence, have a profound impact on children's mental health development.<sup>55</sup> Early trauma can alter the developing brain by interfering with normal neurodevelopment, which can predispose a child to subsequent anxiety and depression.<sup>56</sup> Early trauma can also influence the development of avoidance and arousal symptoms,<sup>57</sup> which can be risk factors for perpetrating IPV. Evidence suggests that the more severe the violence experienced by children, the more significant the potential mental health impacts.<sup>58</sup> A study conducted in South Africa found that child abuse significantly increased the likelihood of child survivors



developing PTSD symptoms and depression, and that such mental health consequences increased the subsequent risks of IPV victimisation among women in adulthood.<sup>59</sup> These findings suggest that interventions to reduce child abuse or address its mental health effects may have the potential to reduce subsequent exposure to IPV.<sup>60</sup>

## **PATHWAYS** BETWEEN POOR MENTAL HEALTH AND EXPERIENCES AND THE PERPETRATION OF IPV

### ▶ RELATIONSHIP QUALITY AND CONFLICT

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One pathway through which mental health problems can increase the risk of experiencing and perpetrating IPV is decreased relationship quality and eroding constructive conflict management.<sup>61</sup> Depression, for example, has been found to be significantly associated with lower intimacy, reduced relationship satisfaction,<sup>62</sup> and experiences of IPV.<sup>63</sup> Symptoms of depression (such as feeling worthless, unmotivated, hopeless, and sad) may impact an individual's ability to negotiate disagreements, manage triggers of IPV and relationship stress, or leave abusive relationships.<sup>64</sup> Feelings of depression often make women less interested in sexual intimacy, which can be a source of relationship discord and increase the risk of their exposure to forced sex.<sup>65</sup> Depression can also lead to cognitive distortions of risk, which can impact an individual's ability to detect potentially abusive relationships.<sup>66</sup> Trauma is likewise associated with shame, guilt, and self-blame, which can lead to difficulties with trust and intimacy in relationships.<sup>67</sup> Romantic jealousy — which can be more prevalent in individuals with common mental health problems<sup>68</sup> — has been demonstrated to undermine the quality of intimate relationships and be a significant risk factor for IPV.<sup>69,70</sup>

### ▶ SELF-ESTEEM AND RESILIENCE

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A second pathway between common mental health problems and the risk of experiencing or perpetrating IPV is through the erosion of self-esteem, self-efficacy, and resilience.<sup>71</sup> Mental distress and experiences of trauma can undermine people's self-worth to the extent that they believe they deserve to be mistreated or do not identify when they are being mistreated.<sup>72</sup> Individuals with poor self-esteem may also be less able to protect themselves and leave abusive relationships.<sup>73</sup> In terms of IPV perpetration, individuals with lower self-esteem are more prone to interpret ambiguous social cues as personal rejections<sup>74</sup> and to experience a heightened sense of threat, which can mean that real or perceived criticism from intimate partners seems more threatening and can trigger a negative response, including violence.<sup>75</sup> Conversely, individuals with higher self-esteem are less likely to interpret a partner's behaviour as threatening and more likely able to engage in sacrifice and compromise within intimate partnerships, facilitating non-violent communication.<sup>76</sup> Self-esteem, resilience, and stress management are protective factors for maintaining mental well-being and preventing IPV and, thus, should be included as objectives for both mental health and IPV prevention interventions.<sup>77</sup>

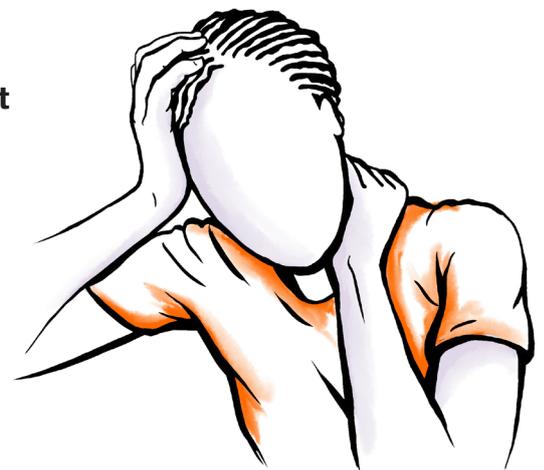
A final pathway through which common mental health problems can influence the risk of IPV is by affecting an individual's ability to manage their emotions. Anger, hostility, irritability, and agitation — symptoms related to poor mental health — have all been identified as risk factors for the perpetration of IPV.<sup>78</sup> Traumatic experiences and depression have been shown to influence a person's ability to regulate emotions and impulses, including managing emotional reactivity (e.g., explosive anger).<sup>79</sup> In addition, poor mental health can reinforce riskier methods for coping with stress and negative emotions, such as substance abuse, which in turn can heighten the risk of exposure to IPV.

## WHAT WORKS TO IMPROVE MENTAL HEALTH

So, what does the evidence suggest for programmes designed to reduce IPV? First, it suggests that **efforts to improve mental health and well-being can and should be considered as part of a comprehensive strategy to prevent abuse. It also suggests that programmes addressing the structural drivers of poor mental health may positively affect levels of IPV, and vice versa.** Indeed, numerous IPV prevention programmes have found positive impacts on women and men's mental well-being, despite not being explicitly designed to do so.<sup>81,82,83</sup> The reverse is also true: programmes that improve mental health have been shown to reduce IPV.<sup>84,85,86</sup>

**Most existing efforts to improve mental health work at the individual level, focusing on clinical diagnosis and the provision of therapies and/or medication.** However, almost half the world's population lives in countries where, on average, there is only one psychiatrist for every 200,000 or more people, and other mental health care providers trained in the use of psychosocial interventions are even scarcer.<sup>87</sup> The sheer breadth of the problem and the extreme shortage of mental health professionals means that **violence practitioners must make common cause with the field of global mental health, which is seeking to identify strategies to expand access to mental health support, including those that can be implemented by laypeople rather than trained psychologists.**<sup>88</sup>

**This section presents some strategies demonstrated to be effective at improving mental health at different levels of the social ecology: individual, relationship, and community levels.** It is important to recognise the limitations of the existing evidence base, which is skewed to manualised interventions that are conceptualised within an individualised or clinical framework, even if delivered by laypeople. This can partly be explained by the fact that such interventions lend themselves more easily to randomised controlled trials.<sup>89</sup> The current evidence base gives less attention to broader psychosocial support interventions



(including community mobilisation and organising used to support healing) and interventions involving movement, music, and other expressive mediums.<sup>90,91</sup> It is warranted to continue exploring the contribution of approaches beyond the mainstream evidence base and, particularly, identify how feminist and women's rights organisations are working to strengthen emotional well-being and resilience, self-care, and healing from trauma.<sup>92</sup>

**The final sub-section discusses potential structural solutions that address the underlying drivers of both poor mental health and IPV.** The highlighted examples have not necessarily been evaluated in terms of influencing IPV; however, based on the pathways previously noted, we have reason to believe such efforts could address major risk factors of IPV.

## INDIVIDUAL-LEVEL STRATEGIES TO IMPROVE MENTAL HEALTH

There is strong evidence that brief psychosocial interventions offered by lay providers in low- and middle-income countries can successfully reduce depression, anxiety, trauma-related symptoms, and the likelihood of experiencing IPV.<sup>93</sup> For instance, the Healthy Activity Programme is a lay counsellor-delivered brief psychological treatment for moderate to severe depression.<sup>94</sup> An evaluation in India found that women who received the Healthy Activity Programme were nearly 50 percent less likely to report IPV at the end of treatment than women in usual care. The programme also had strong effects on reduced symptoms of depression and the severity of symptoms, reduced suicidal thoughts and attempts, and improved daily functioning.<sup>95</sup>

### **Problem-Solving Therapy**

Problem-solving therapy is another brief, individual-level strategy that is particularly promising for low-resource contexts, as it does not require extensive training or complex skills.<sup>96</sup> It assumes that depression and anxiety symptoms are often caused by everyday problems and aims to teach people better ways to cope by setting goals, having a greater sense of control, and minimising feelings of incompetence and distress.<sup>97</sup> Several studies from low- and middle-income countries suggest that problem-solving therapy can be effective in alleviating depression, anxiety, and psychological distress.<sup>98</sup>

#### **PROGRAMME EXAMPLE**

In Zimbabwe, a particularly creative application of problem-solving therapy is the **'Friendship Bench'**, in which grandmothers and other lay counsellors are trained to provide supportive counselling to community members who approach the Bench for support. Lay counsellors offer six scripted sessions of individual problem-solving support and invite participants to attend an optional six-session peer support group.<sup>99</sup> A randomised controlled trial demonstrated that the Friendship Bench reduced depression and suicidal ideation by 80 percent and fostered a 60 percent improvement in quality of life.<sup>100</sup> Evidence suggests the programme works by helping people more accurately assess their problem, focus on one problem at a time, and develop self-awareness of internal factors that they can control and factors that are external.<sup>101</sup>



## Cognitive Processing Therapy/Cognitive Behavioural Therapy

There is also significant evidence that cognitive processing therapy, a form of cognitive behavioural therapy, can help address common mental health problems, including depression and PTSD. This approach teaches individuals strategies to manage distressing or trauma-related thoughts, such as self-blame, using cognitive restructuring techniques.<sup>102</sup> An evaluation of cognitive processing therapy delivered to survivors of GBV in eastern Democratic Republic of the Congo found that the intervention significantly reduced depression, anxiety, and post-traumatic stress, as well as improved participants' daily functioning and social capital.<sup>103</sup>

### PROGRAMME EXAMPLE

In the field of mental health, there is increasing emphasis on broader, more scalable approaches that do not only address single mental health diagnoses.<sup>104</sup> For instance, the Common Elements Treatment Approach (CETA) is an intervention designed to treat depression, anxiety, harmful substance use, trauma, and stress-related disorders. CETA can be provided by trained and supervised laypeople and combines strategies for addressing a range of mental health issues into a single model. Core elements of CETA include engagement and education; cognitive coping/thinking differently; behavioural activation; confronting fears and memories of trauma; safety assessment and planning; harmful substance use intervention; and problem-solving and anxiety management.

CETA has been proven to reduce trauma, depression, anxiety, and harmful substance use, as well as IPV.<sup>105</sup> For instance, trained lay providers in Zambia delivered CETA to couples (in individual sessions) over six to 12 weekly sessions, and a randomised controlled trial demonstrated that CETA significantly reduced depression, PTSD, and IPV among participants.<sup>106</sup> Mechanisms underlying these changes included the use of de-escalation strategies (e.g., 'walking away' and 'staying quiet' to stay safe), reductions in male and/or female alcohol use, and increases in intra-couple trust and understanding that facilitated better communication.<sup>107</sup> Though men and women described acting in ways that challenged gender roles, they also described some of the changes from CETA in ways that unintentionally reinforced inequitable gender norms. For example, 'staying quiet' was identified as a safety strategy for women that also demonstrated respect for one's husband.<sup>108</sup>

Learn more about CETA on the dedicated programme [example page](#) on the Prevention Collaborative Knowledge Hub.

## Mindfulness, Yoga, and Other Body-Focused Approaches

Brief mindfulness interventions (typically around eight sessions) have also been shown to be an effective treatment for people experiencing depression, anxiety, and PTSD.<sup>109</sup> Mindfulness uses meditation to attune users to the present moment, focusing attention on the breath, bodily sensations, sensory perceptions, cognitions, and emotions, while maintaining an accepting and non-judgemental attitude.<sup>110</sup> Mindfulness training can promote awareness and acceptance of what is currently being experienced and

compassion for oneself and others. These skills can help individuals to develop resilience, recover from trauma, and enhance their emotional regulation.<sup>111</sup>

Yoga includes mindfulness, stress management, and meditation, and several studies have documented the potential for yoga-based interventions to achieve positive mental health outcomes.<sup>112</sup> Yoga can be a particularly important tool to support trauma survivors in regaining bodily awareness after the physical dissociation between mind and body that often is a symptom of PTSD, along with regaining a related increase in a sense of autonomy, agency, and trust.<sup>113</sup> For instance, Healing and Resilience after Trauma (HaRT) Yoga is a 12-week psychosocial intervention for women and girls who have experienced human trafficking that was developed and piloted in Kampala, Uganda.<sup>114</sup> It aims to 'create a nurturing environment in which participants can strengthen their inner resilience, build a supportive community, and overcome the psychological effects of trauma'. The group-based programme involves weekly sessions that integrate yoga poses alongside breathwork, visualisations, mindfulness practices, and theme-based discussions. Results from an initial pilot were promising; participants experienced reductions in depression symptoms and improvements in self-rated emotional and physical health.

There is a growing evidence base for other body-focused approaches to improving mental health, including dance and movement therapy<sup>115</sup> and somatic experiencing-based programmes. Somatic experiencing is a body-centred approach designed to reduce the effects of trauma and chronic stress.<sup>116</sup> It aims to increase conscious awareness and help individuals regain regulatory capacity of their bodies and central nervous systems. A six-week somatic experiencing programme offered in groups to refugee women in Turkey was significantly effective in decreasing post-traumatic stress and increasing mindfulness and social support levels.<sup>117</sup>

## RELATIONSHIP AND COMMUNITY-LEVEL STRATEGIES TO IMPROVE MENTAL HEALTH

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At a relationship and community level, interventions focused on enhancing social support are a common mechanism for improving mental health. Strengthening support from peers or family, or through community-based networks, can equip individuals to develop better strategies to cope with distress and anxiety.<sup>118</sup> Indeed, diverse communities worldwide have practised collective rituals as a source of healing. In many collective cultures where healing after trauma is understood as a shared experience, individual therapies are not necessarily acceptable or effective.<sup>119</sup> A particular value of group-based programmes can be the process of 'mutual aid', whereby participants draw upon their own experiences and needs to help their fellow group members. They, in turn, can learn from and be empowered by assisting others.<sup>120</sup>



## PROGRAMME EXAMPLE

The Living Peace project is a 15-week intervention developed by Promundo and the Institut Supérieur du Lac in the eastern Democratic Republic of the Congo. It uses community psychosocial support groups to help men and their partners develop positive coping strategies after traumatic experiences, build social cohesion, and restore violence-free relationships in post-conflict and high-violence settings. Living Peace uses group therapeutic principles to create an environment in which participants feel safe sharing traumatic experiences and personal problems.<sup>121</sup> This group-oriented approach is contextually appropriate in the Congolese culture, where individual psychosocial well-being strongly depends on the quality of social relations.<sup>122</sup> A qualitative evaluation of this programme found that it helped men cope more effectively and in nonviolent ways with stress, loss, and anger. It also led to an improvement in their conflict management skills and a reduction in their self-reported use of IPV.<sup>123</sup> Families that reported limited changes in the husband's behaviour linked this to alcohol abuse and/or to severe psychosocial distress that was beyond what this project could address.<sup>124</sup>



Many violence prevention initiatives incorporate social support as a strategy, including through curriculum-based models that train facilitators to create safe spaces and build group rapport. For instance, the [Indashyikirwa couples curriculum](#) in Rwanda (implemented by CARE Rwanda, Rwanda Men's Resource Centre, and Rwanda Women's Network) was designed to equip couples to build nonviolent, equitable, and higher-quality relationships. The curriculum incorporates elements of cognitive behavioural therapy to support couples in becoming aware of how negative thoughts trigger negative feelings and actions, as well as how to choose more helpful thoughts. A rigorous mixed-methods evaluation of the Indashyikirwa couples curriculum found it reduced the odds of women and men reporting IPV by 55 and 47 percent respectively at both 12 and 24 months; it also significantly reduced the odds of both women and men reporting trauma and symptoms of depression.<sup>125</sup> Gender-transformative interventions, including Indashyikirwa, have been developed to help communities confront the harmful effects of restrictive gender attitudes and norms. These can be helpful in addressing not only inequitable norms that underlie IPV but also the negative influences of such norms and attitudes on mental health and well-being.<sup>126</sup>

Schools offer an important community-level platform to improve mental health and build self-esteem and skills of youth and adolescents around emotional regulation and anger management. For instance, the school-based Right to Play programme 'uses the power of sport and play to empower boys and girls to reduce peer violence, improve mental health, and change social norms in support of gender equality and non-violence'. An evaluation of the Right to Play intervention in Pakistan found significant reductions in girls' and boys' depressive symptoms and experiences of peer violence over a 24-month study period.<sup>127</sup> Schools can also provide an important platform to care for children with symptoms of common mental health problems.<sup>128</sup>

## STRUCTURAL-LEVEL STRATEGIES TO IMPROVE MENTAL HEALTH

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While integrating individual- and group-level psychosocial strategies into violence prevention programming is an important way to address the link between mental distress and IPV, another way is to go straight to the structural drivers of both problems. There is a wealth of evidence, for example, suggesting that cash transfers and broader anti-poverty programmes can significantly reduce anxiety and depression, as well as reduce IPV.<sup>129,130,131</sup> One review found that different economic interventions — including conditional and unconditional cash transfers, poverty graduation programmes, asset transfers, housing vouchers, and health insurance provisions — can all improve the psychological well-being and mental health of recipients, although improvements are most robustly documented with unconditional cash transfers.<sup>132</sup> There is also evidence that income-based interventions that help move people out of poverty can be as effective in improving mental health as other common individual-level interventions, including cognitive behavioural therapy and antidepressants.<sup>133</sup> Some studies in low-income settings have suggested a larger positive impact on mental health through cash transfers compared to psychotherapy interventions alone.<sup>134</sup> Additionally, there is evidence that income losses have a particularly detrimental impact on mental health, especially among those living close to the poverty line, which suggests the importance of income and welfare policies that provide an adequate financial safety net for the most socio-economically disadvantaged.<sup>135</sup> The field of global mental health is increasingly emphasising the importance of efforts to address social distress arising from structural factors, including economic difficulties, social isolation, poor access to health care or education, and sub-standard housing.<sup>136</sup>



### IMPLICATIONS FOR PRACTICE

A range of strategies have had a demonstrably positive impact on mental health, and they could be better integrated into existing IPV prevention programmes. Several implications to consider when integrating such strategies into IPV prevention programmes include:

▶ **Ensure high-quality training and support for providers:** Although the strategies and programmes highlighted here can all be implemented by lay providers, it is critical to ensure they receive quality training, supervision, and support. For instance, CETA providers receive an intensive 10-day training followed by six months of coaching and ongoing support.

▶ **Address stigma and ensure safety:** Stigma around mental health problems exists in nearly every setting. Interventions to improve mental health should consider how to address such stigma and how to increase community acceptance of efforts to support people experiencing mental health challenges. The framing of such work can be highly significant. For instance, the Friendship

Bench intervention in Zimbabwe was originally termed the Mental Health Bench; organisers changed the name when they realised that the shame associated with the phrase for mental health was slowing community uptake. In some cases, people who seek mental health care or services may suffer from increased stigma or discrimination, and it is important to monitor for safety and any risks to individuals participating in such interventions.

- ▶ **Raise awareness and establish referral processes:** The violence prevention community should foster wider awareness among practitioners of the relationships between mental health and IPV. It is important that practitioners understand the symptoms of depression and anxiety and the terms used in different settings to express these symptoms. Frontline staff need to be trained on how to respond to mental distress in order to understand the limits of their capacities and where and how to refer people for more support. Many participants in IPV prevention programmes may have mental health problems or be suffering from past trauma, especially if the project works with survivors of IPV and/or in impoverished, humanitarian, conflict, or post-conflict settings.

- ▶ **Contextualise risk factors and build on coping and resilience strategies rooted in existing community systems and expertise:** As with programming to prevent IPV, it is important to consider the major risk factors and pathways to common mental health problems in a particular setting across multiple levels of the socio-ecological model. Formative research can help

identify areas of mental health that are relevant within a local context and key risk factors for common mental health problems.<sup>137</sup> Where possible, interventions should build upon local coping strategies or rituals that already exist to support positive mental health and coping.

- ▶ **Measure both IPV and common mental health symptoms:** Given the strong synergies, it is important to measure IPV as part of evaluations of mental health interventions and to measure mental health symptoms as part of evaluations of violence prevention programmes. This could help us better understand the pathways between poor mental health and IPV and help bridge these two often disparate fields.
- ▶ **Be inclusive and eliminate barriers to participation:** To ensure ‘no one is left behind’, it is imperative that programmes consider accessibility and identify and address any barriers to engagement. For instance, people living with disabilities typically face stigma, discrimination, and additional barriers to accessing health and social services,<sup>138</sup> as well as IPV prevention programmes.<sup>139</sup> Efforts need to be made to ensure all target participants can access programming to prevent IPV and address their mental health needs.<sup>140</sup>
- ▶ **Recognise the need for specialised support:** Some mental health problems require specialised support or medication beyond what can be offered by lay providers. It can be valuable to have diagnostic tools to identify mental health problems that are beyond the scope of what your intervention can address. Close collaboration with existing mental health services or professionals is recommended, although access to professional mental health services may

be extremely challenging or impossible in some settings.

- ▶ **Explore opportunities to bring a more consistent gendered lens to strategies to improve mental health:** Considering more explicitly how to integrate gender-sensitive

and transformative approaches within promising mental health interventions is warranted. 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.



## CONCLUSION

While some IPV prevention programmes have been shown to improve mental health without including specific content to do so, great opportunities exist to harness improving mental health as a significant IPV prevention strategy. Moreover, the effectiveness of IPV prevention interventions may be compromised due to inadequate attention to poor mental health, an important risk factor for IPV. Alternatively, efforts to improve mental health may be ineffective in the absence of efforts to prevent IPV. Interventions that incorporate elements to address both IPV and poor mental health may enhance the magnitude, cost-effectiveness, and sustainability of impacts on both outcomes.<sup>141</sup>

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