



The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy

Sian Oram, Helen L Fisher, Helen Minnis, Soraya Seedat, Sylvia Walby, Kelsey Hegarty, Khadj Rouf, Caroline Angénieux, Felicity Callard, Prabha S Chandra, Seena Fazel, Claudia Garcia-Moreno, Marion Henderson, Emma Howarth, Harriet L MacMillan, Laura K Murray, Sajaratulnisah Othman, Dan Robotham, Marta B Rondon, Angela Sweeney, Danny Taggart, Louise M Howard

Executive summary

Part 1: Introduction

Intimate partner violence (IPV) is the most common form of violence worldwide and contributes substantially to the global burden of mental health problems. The *Lancet Psychiatry* Commission on intimate partner violence and mental health met to consider progress in reducing the prevalence of IPV and associated mental health harms, and to establish a roadmap for strengthening responses across mental health services, research, and policy. Mental health care is delivered predominantly through primary care globally, but the relationship between IPV and severe mental health problems, and how best to address IPV within secondary mental health care, have been neglected. We therefore focus mainly on the changes needed to address IPV within secondary mental health care. Our focus on mental health is pragmatic rather than exclusionary, and we also recognise the need for broader change across multiple disciplines, systems, and institutions.

Part 2: Evidence for associations between IPV and mental health problems

IPV is a gendered problem. Most victims of IPV are women—globally, an estimated 27% of women and girls aged 15 years or older have experienced physical or sexual IPV—but high rates of IPV are also experienced by other groups, including sexual and gender minorities, people with disabilities, migrants, and people from marginalised ethnic or Indigenous groups. The relationship between IPV and mental health is complex. Exposure to IPV in childhood or adulthood increases the likelihood of developing a range of mental health problems, suicidal ideation, and attempting suicide. The presence of mental health problems also makes individuals more vulnerable to experiencing IPV. Children who are exposed to IPV are at high risk of additional forms of abuse and neglect, and experiencing abuse or being exposed to IPV in childhood greatly increases the risk of both experiencing and perpetrating IPV as an adult. People with diagnosed mental health problems are more likely to commit IPV than those without mental health diagnoses, although absolute rates of IPV perpetration are low. This relationship seems to be partly mediated through substance misuse, with an increased incidence of violence when mental health problems and substance misuse co-occur. Research in this area is controversial:

mechanisms still need to be elucidated, and there are concerns about the potentially stigmatising consequences of examining the role of mental health problems in the perpetration of IPV, as well as concerns that diagnoses such as borderline personality disorder pathologise women's responses to violence and oppression. However, associations between mental health problems and experiencing or perpetrating IPV appear to occur across the life course and relate to both the onset and the course of mental health problems.

Part 3: IPV across the life course

Although IPV is endemic, it is not inevitable. Evidence points to several targets for prevention and intervention in individuals, families, communities, and societies. Some are stage specific, such as parenting programmes to reduce child abuse and neglect, or school-based programmes to address violence-supportive norms and behaviours; others span several stages, or are relevant across the life course, such as the prevention and treatment of substance misuse, and support for secondary or higher education for women.

Part 4: Measurement of IPV

Measurement of the frequency, severity, and context of IPV, its co-occurrence with other forms of violence, and its effects on mental health is challenging but important. Although substantial strides have been made in assessment methods for IPV, more needs to be done to advance measurement and to harmonise data collection via collaboration across sectors. Administrative data are fragmented and inconsistent between fields, professions, and practitioners. The development of IPV measures should involve people with lived experience of IPV and of mental health problems to ensure that the measures generated are relevant, feasible, and valid.

Part 5: Transformation of the mental health system to address IPV

Survivors should be fundamental to the development and assessment of support services at every level, from grassroots survivor-led services to statutory mental health services. Mental health systems and providers can make a crucial difference in IPV survivors' path to healing, but too often the opportunity to do so is unfulfilled, and some survivors experience mental health services as harmful and retraumatising. Survivors and providers

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Section of Women's Mental Health (S Oram PhD, Prof L M Howard PhD) and **Service User Research Enterprise** (A Sweeney PhD), **Health Service and Population Research Department, and Social, Genetic & Developmental Psychiatry Centre** (Prof H L Fisher PhD), **Institute of Psychiatry, Psychology & Neuroscience, and ESRC Centre for Society and Mental Health** (Prof H L Fisher), **King's College London, London, UK; Institute of Health and Wellbeing** (Prof H Minnis MD) and **School of Geographical & Earth Sciences** (Prof F Callard PhD), **University of Glasgow, Glasgow, UK; Department of Psychiatry, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa** (Prof S Seedat MD); **Violence and Society Centre and Department of Sociology, City, University of London, London, UK** (Prof S Walby PhD); **Royal Women's Hospital and Department of General Practice, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, Melbourne, VIC, Australia** (Prof K Hegarty PhD); **Northamptonshire Healthcare NHS Foundation Trust, Northampton, UK** (K Rouf DCLinPsy); **Survivor, UK** (C Angénieux); **Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India** (Prof P S Chandra MD); **Department of Psychiatry, University of Oxford, Oxford, UK** (Prof S Fazel MD); **Department of Sexual and Reproductive Health and Research, WHO, Geneva, Switzerland** (C Garcia-Moreno MD); **School**

of Social Work and Social Policy, University of Strathclyde, Glasgow, UK (Prof M Henderson PhD); Department of Psychological Sciences, University of East London, London, UK (E Howarth PhD); Institute of Child Health, University College London, London, UK (E Howarth); Department of Psychiatry and Behavioural Neurosciences and Department of Pediatrics, McMaster University, Hamilton, ON, Canada (Prof H L MacMillan MD); Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (L K Murray PhD); Faculty of Medicine, Universiti Malaya, Kuala Lumpur, Malaysia (Prof S Othman PhD); The McPin Foundation, London, UK (D Robotham PhD); Instituto Nacional Materno Perinatal, Lima, Peru (M B Rondon MD); School of Health and Social Care, University of Essex, Colchester, UK (D Taggart DClinPsy)

Correspondence to: Prof Helen L Fisher, Social, Genetic & Developmental Psychiatry Centre, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London SE5 8AF, UK helen.2.fisher@kcl.ac.uk

Key messages

- Exposure to intimate partner violence (IPV), whether in adulthood or in childhood, increases the likelihood of developing a range of mental health problems, and those with mental health problems are at greater risk of exposure to IPV. These associations appear to occur across the lifespan, are rooted in gender and other intersecting inequalities, and relate to both the onset and course of mental health problems.
- Reducing IPV is very likely to improve mental health outcomes, irrespective of whether exposure occurs directly in adulthood, indirectly in childhood, or both.
- Some people with mental health problems are more likely to commit IPV compared with people without mental health problems, although absolute rates are low and people with mental health problems are more likely to experience than to commit IPV. Treatment studies have shown that reductions in alcohol use are associated with reductions in IPV generally, and reductions in IPV severity particularly, with implications for both provision of mental health services and social policy.
- IPV causes early exposure to stress, including in utero, which results in difficulties coping with stressors during the life course, increased risk of mental health problems, and neurodevelopmental impairments that contribute to intergenerational transmission of violence. Preconception interventions might reduce the risk of intergenerational transmission of violence and improve mental health outcomes.
- Severe parental stress (eg, caused by IPV, poverty, or food insecurity) increases the risk of children experiencing maltreatment, including exposure to parental IPV. Reducing parental stress, whatever the cause, might help to reduce the prevalence of violence in the population.
- 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.
- Universal screening for IPV is not recommended, but because mental health problems might be associated with or worsened by violence, all mental health service users, especially women and gender and sexual minorities, should be asked about experiences of violence, including IPV, within the context of a mental health assessment. Assessments should be done in private by trained practitioners who work within a clear referral network.
- WHO's LIVES principles for first-line response to IPV can help providers to recognise and respond to IPV. Responders should listen with empathy and without judgement, enquire about needs and concerns, validate experiences, enhance safety, and support people by connecting them to information, services, and social support.
- Children and adolescents with emotional and behavioural problems should be assessed for exposure to IPV. They might need specific interventions together with or separately from their caregivers, but this need should be established based on a thorough 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.
- The risk of IPV seems to be highest in societies that are most unequal in terms of gender relations and where violence against women is an accepted norm. There is a growing evidence base suggesting that gender transformative interventions can effectively prevent IPV.

alike have called for urgent reform to enable pathways to safety, healing, health, and wellbeing for those experiencing IPV, including through the coproduction of trauma-informed approaches to care. All mental health professionals should have a good understanding of the gendered nature and dynamics of IPV, the effects of IPV on mental health, and the intersections of both IPV and mental health with other forms of oppression including racism, transphobia, ableism, and poverty. Mental health professionals should be enabled to respond appropriately through training and continuous learning, and should be able to count on organisational infrastructure and support. Because mental health services can be difficult to access as a result of poor availability and financial or

logistic constraints (especially in marginalised populations and for people in low-income and middle-income countries), efforts to integrate mental health care into primary health care, to strengthen training of lay workers, and to provide grassroots and user-led alternatives to mental health services are essential.

Part 6: Addressing gender inequality and societal responses to IPV

Primary prevention should sit alongside work to strengthen mental health service responses to IPV and should be informed by an intersectional approach that recognises that IPV interlocks with gendered and other forms of oppression. Structural factors that need to be

addressed include access to education, employment, and poverty-reduction strategies, laws and policies that discriminate against women (eg, those surrounding divorce, child custody, property ownership, and inheritance) and other groups at risk of IPV (including people in same-sex relationships and gender minorities), the implementation and enforcement of anti-violence legislation, and policies to reduce harmful alcohol consumption. Moreover, to prevent IPV, societies should consider how violence-supportive norms are located and how institutional and public structures condone or reinforce these norms. The risk of IPV is highest in societies that are most unequal in their gender relations and in which the use of violence generally, and the use of violence against women specifically, are accepted norms. The importance of context and wider societal issues in IPV has been particularly apparent during the COVID-19 pandemic, which has resulted in a steep increase in reports of IPV internationally. The mental health consequences of these increased rates of IPV, and potentially the reduced opportunities to escape and access support, are not yet apparent but will be important to investigate, alongside the mental health consequences of COVID-19 itself.

Part 1: Definition of IPV

Introduction

Intimate partner violence (IPV) is a public health crisis that has catastrophic effects on individuals, families, and communities. It is the form of violence most commonly experienced by women globally and is associated with physical, mental, sexual, and reproductive health problems, and death (due to homicide and suicide). IPV refers to any behaviour perpetrated against a current or former intimate partner that causes physical, psychological, or sexual harm, including physical violence, emotional abuse, sexual violence, and controlling and coercive behaviours (panel 1). Technology is increasingly used to facilitate abuse, including through abuse on social media and other online platforms, the installation of stalkerware on personal devices, and manipulation of smart meters, locks, and cameras.^{1,2}

IPV and gender

The burden of IPV falls overwhelmingly on women and girls. Although women can be violent towards their partners (of any gender), IPV is mostly committed by men against women. Globally, an estimated 27% of ever-partnered women aged 15 years or older report having experienced physical or sexual IPV in their lifetime;³ prevalence is high worldwide, but is highest in low-income countries. Age-disaggregated data show that women often experience IPV from an early age: 24% of ever-partnered 15–19-year-old girls report having experienced physical or sexual IPV.³ Data also show that exposure to IPV continues throughout the life course: although some studies suggest that prevalence declines with increasing age, finer analysis of exposure by type of

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

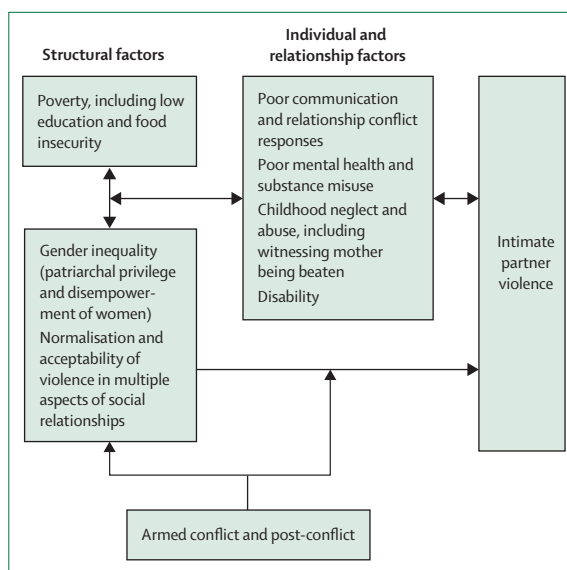


Figure 1: Drivers of intimate partner violence
Reproduced from Gibbs et al.¹⁵

IPV shows that this decrease is limited to physical violence, with rates of non-physical abuse remaining stable across age groups.⁴ Research also suggests that transgender people are at a two-to-three times higher risk of physical and sexual IPV than cisgender individuals,⁵ and that the prevalence of IPV might be higher in gay men and lesbians than in heterosexual people.⁶ Other axes of discrimination and marginalisation, such as Indigeneity,^{7,8} migrant status,⁹ disability,^{10,11} and poverty,^{12–14} are also associated with increased risk of IPV.

Underlying mechanisms of IPV

Several theoretical models seek to explain IPV. Prominent for the past 25 years has been the ecological model, which

proposes that violence results from factors operating at the individual, relationship, community, and societal levels. 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.¹⁵ Proponents of this updated model argue that gender inequality, the normalisation and acceptability of violence in social relationships, and poverty drive men's perpetration of, and women's risk of experiencing, IPV (figure 1). Additionally, gender inequality and poverty increase the likelihood of individual and relationship factors (eg, poor mental health, substance misuse, childhood neglect and abuse, poor communication and relationship conflict responses) that also increase risk of IPV. In this model, disability is suggested to exacerbate risk factors, and individual and structural factors are intensified during conflict and post-conflict periods.¹⁵

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.^{16,17} 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,¹⁷ although the evidence for associations between such attitudes and IPV is mixed.¹⁸ Social norms provide for both the reproduction and maintenance of attitudes regarding gender equity, gender power imbalances, and the acceptability of violence within interpersonal relationships. The relative importance of community versus individual attitudes, however, varies contextually, including in relation to other risk factors such as poverty and trauma.¹⁵ Poverty increases IPV both indirectly (ie, by increasing the likelihood of experiencing other risk factors for IPV, including poor educational outcomes,¹⁹ childhood abuse and neglect,^{14,20} and poor mental health and substance misuse in adulthood) and directly (ie, by increasing exposure to stressors, such as food insecurity, which contribute to increased conflict within households).^{21,22}

As highlighted by the ecological model, experience of maltreatment and exposure to IPV in childhood are strongly associated with both experiencing and committing IPV.²³ 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.^{23–25} 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,^{26,27} and

mental health problems and substance misuse increase the risk of experiencing IPV. The risk of committing IPV is higher among men who report harmful use of alcohol and drugs than among those who do not report such use, and among men who have a diagnosis of one of a range of mental health disorders than among those with no such diagnoses.²⁸

IPV occurs along a continuum of severity (both in terms of frequency and types of acts) and as combinations of forms of violence (physical, sexual, emotional, controlling behaviours). Some researchers in high-income countries draw a distinction between so-called intimate terrorism (in which violence is a mechanism to reinforce control over a partner)²⁹ and situational violence (in which violence is a physical reaction to anger or frustration but is not motivated by control), with the former arguably requiring more substantial interventions than the latter.³⁰ Another approach describes violence as occurring along a continuum of escalation (in terms of frequency, severity, and combinations of violence used),³¹ with different intervention points and tailored responses to patterns of abuse required to address different points on the continuum.

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.³² 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.³² The effects of abuse seem to be cumulative: analyses³³ 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.³³ These effects persist long after abuse has stopped.³³ Children are also harmed by exposure to IPV, which increases their risk of anxiety, depression, and poor behavioural and educational outcomes compared with their unexposed peers.^{34–37} Studies in low-income settings have shown that children exposed to IPV are less likely to be immunised against infectious diseases,³⁸ have increased risk of diarrhoeal and other diseases,^{39,40} and have higher rates of child mortality⁴¹ than children who are not exposed to IPV.

Commission aims

Stopping cycles of violence and abuse could decrease the prevalence of mental health problems by as much

Panel 2: Methodology and approach used in preparing this Commission

This Commission was instigated by the Violence Abuse and Mental Health Network, an interdisciplinary research network funded by UK Research and Innovation that aims to understand, prevent, and reduce the impact of domestic abuse and sexual violence on mental health. The Commission brings together experts with different ways of thinking about violence, abuse, and mental health—some with lived experience of these issues, others with expertise from the work they do—through the provision of engagement, capacity building, and funding opportunities.

The initial consultation meeting for this Commission took place in June, 2019, at which individuals from various backgrounds with interests or expertise in intimate partner violence and mental health met to discuss progress and remaining challenges in the field, and to establish a roadmap for strengthening responses across mental health services, research, and policy. Commission authors span a range of disciplines, including applied health research, behavioural science, child and adolescent psychiatry, epidemiology, forensic psychiatry, general psychiatry, neuroscience, paediatrics, primary care, psychology, public health, service user research, and sociology, and include survivor-researchers and survivor-practitioners. This Commission presents a synthesis of evidence—academic, clinical, and experiential—considered important by the authors, a group of international experts (from Australia, Canada, India, Malaysia, Peru, South Africa, Switzerland, the UK, and the USA).

We have used evidence from systematic reviews, when appropriate, and have also drawn on conceptual work across a range of disciplines. We have done database searches to identify the most recent evidence as required, and considered guidelines produced by national and international bodies. Some of the topics addressed are under-researched and we draw attention to the strength of evidence (acknowledging that what is considered strong evidence varies across disciplines) and key knowledge gaps throughout. Quotes from survivors from Australia and the UK who are participants in research or are involved in research advisory or co-production work are included throughout.

People who identify as survivors of IPV were involved in all stages of the Commission's work. Several Commission authors were recruited partly because of their expertise in clinical or academic aspects of IPV and partly because of having some form of lived experience of IPV. Based on feedback from several authors, some who identified as survivors and some who did not, several strengths and limitations of the Commission's involvement strategy were identified. A significant strength was that survivor colleagues were involved in all stages of the Commission's work and contributed as authors with professional expertise in addition to lived experience. This strength was also linked to a limitation of the approach, namely that the survivors involved were mostly contributing in professional capacities and so were not able to speak to the range of life experiences that many victims of IPV face, including the full range of forms of social and economic marginalisation. Although the Commission's scope is international, and despite our best efforts, there were no survivor authors from low-income or middle-income countries. Several survivor authors felt that their contributions were welcomed, and felt fully included in all aspects of the Commission's work. However, there was also feedback from some survivor authors that there was little scope for all Commission authors to be openly reflective about their motivations for participation in this work, which meant that the burden for self-disclosure fell disproportionately on those with lived experience. This feedback ties in with a broader hope expressed by several survivor authors: that the work started by the Commission in making space for survivor perspectives can be developed further in future initiatives, particularly with regard to devising the optimal structures and methods to enable knowledge to be meaningfully co-produced. IPV and other forms of violence can be better understood and ameliorated through scientific enquiry. However, stigma around the topic and a culture that privileges analytic distance in academic circles can create false binaries between experts and survivors that privilege particular forms of knowing.

For the Violence Abuse and Mental Health Network see <http://www.vamhn.co.uk>

as a quarter.⁴² This *Lancet Psychiatry* Commission on intimate partner violence and mental health aimed to consider evidence to identify and reduce the risk of IPV and its related harms, and to establish a roadmap for future work across mental health services, research, and policy (panel 2). We have drawn on the best available evidence, and have identified areas where evidence is incomplete or of poor quality. Overall, most evidence comes from high-income countries, with fewer data available from low-income and middle-income countries. Furthermore, although IPV, as an expression of power inequality, interacts with age, class, disability, ethnicity, gender, sex, Indigeneity,

migrant status, religion, and sexuality, too few studies of IPV and mental health take an intersectional approach.

Part 2: Evidence for associations between IPV and mental health problems

Introduction

In this section, we explore the evidence for associations between IPV and mental health problems. We summarise what is known about the bidirectional relation between IPV and mental health problems—ie, IPV as both a predictor of future mental health problems and a possible consequence of such problems. We also explore how

diagnostic categories for mental illness have been used in people who have experienced IPV.

IPV as a risk factor for the development of mental health problems

IPV is associated with the occurrence of a range of mental health problems with varying degrees of severity and differing effects on individuals' functioning.^{43–45} Anxiety, depression, substance use disorder, post-traumatic stress disorder (PTSD), personality disorders, psychosis, self-harm, and suicidality are all more common among people who have experienced IPV than those who have not.⁴⁶ Although not all people exposed to IPV go on to have mental health problems, associations between IPV and poor mental health have been reported in women⁴⁷ and men⁴⁸ (and specifically in transgender women and men^{5,49}) and non-binary people,^{5,49} and across the lifespan—from childhood³⁶ through to adolescence⁵⁰ and old age⁵¹—as well as during and after pregnancy.⁵² Some research⁵³ has suggested that individuals who experience IPV are likely to have more persistent mental health problems than those who have not experienced IPV. Women are more likely to be victims of IPV than men,³² and a larger proportion of women than men experience mental health problems related to IPV (assuming causality).⁵⁴ Therefore it is important to disaggregate data on associations between IPV and mental health outcomes by sex and gender.

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.^{55,56} Evidence is also emerging for the adverse mental health effects of technology-enabled IPV.⁵⁷ Different types of IPV commonly co-occur (as do different mental health problems), and thus focusing on associations for specific types of IPV is probably unhelpful. Moreover, individuals exposed to more than one type of IPV might be at greater risk of poor mental health outcomes than those who experience only one type of IPV,⁵⁸ particularly when the abuse experienced includes sexual IPV.³³ Chronic exposure to IPV is associated with more severe mental health problems,⁴⁶ although this link might be at least partly dependent on the type of IPV experienced.⁵⁹

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.^{46,60,61} For example, a study⁶¹ done across several low-income and middle-income countries found that experience of IPV was an independent risk factor for suicide attempts. The mental health effects of IPV might be even greater in societies that have larger gender inequalities, where accessing support or escaping harmful relationships might be more difficult. Indeed, the complex relationships between IPV and mental ill health can be neither understood nor addressed without

acknowledging the profound and interlocking effects of heteropatriarchy (the dominance of heterosexual and patriarchal norms in society) and other forms of oppression, including racism,⁶² transphobia,⁶³ ableism, and poverty.^{15,64}

Children who experienced IPV in early life are more likely to have mental health problems than those who did not experience IPV.^{36,65,66} Violence in childhood can take many forms, including being exposed to or experiencing physical, sexual, or emotional abuse or neglect. Children who are exposed to violence between adults in their lives are at increased risk of developing mental health problems in childhood and adolescence³⁶ and in adulthood compared with people who were not exposed to such violence.⁶⁵ For example, Dube and colleagues⁶⁶ identified a positively graded risk for self-reported adult substance misuse and depressed affect as the frequency of exposure to IPV during childhood increased in a US-based sample. Many adults who commit IPV are also violent, abusive, and neglectful towards their children,^{67,68} and children who experience this direct maltreatment are at increased risk of developing a wide range of mental health problems.⁶⁹ It is important to consider the multiple risk factors for this violence, such as poverty, mental health problems in caregivers, low educational achievement, alcohol and drug misuse, having been maltreated as a child, and family breakdown or violence between other family members.⁷⁰

A history of child maltreatment (or exposure to IPV) increases the risk of experiencing IPV in adulthood.^{71,72} Childhood exposure to abuse and neglect could be compounded by experiences of IPV in adulthood, and this harmful combination might further increase the likelihood of developing mental health problems. Longitudinal studies involving comprehensive prospective assessments are needed to disentangle the associations between these factors. One such study,⁷³ in a sample of women based in the UK, showed that IPV in adulthood doubled the risk of experiencing a new onset of depressive disorder compared with those who had not experienced IPV in adulthood independent of exposure to physical abuse in childhood. When women had experienced both IPV in adulthood and childhood physical abuse the risk of developing depression was even greater.⁷⁴ More research, including survivor-led studies, is needed to understand these associations. Irrespective, it remains clear that reducing IPV (whether exposure occurs directly as an adult or indirectly in childhood, or both) is likely to improve mental health outcomes.

The extant body of research on the associations between IPV and mental health problems has several limitations that restrict the conclusions that can be drawn. First, much research in this area is cross-sectional, and thus whether the mental health problems developed after exposure to IPV or were present beforehand is unclear (although some longitudinal

studies^{26,73–75} have been done). Second, many studies do not control for potential confounders, such as history of childhood maltreatment, shared genetic vulnerabilities, or previous psychopathology or behavioural problems (although there are exceptions⁷⁶). Third, the specificity of findings about IPV and mental ill health is difficult to ascertain because most studies focus on a single type of IPV or group all types of IPV together (Gibbs and colleagues' work¹⁵ is a notable exception). More in-depth investigations that take into account survivor perspectives on the usefulness of such grouping of different types of IPV are required. Fourth, the prevalence of exposure to IPV is difficult to measure accurately because of the potential for non-disclosure (especially among men⁷⁷ and those who are part of marginalised groups⁷⁸) as a result of shame, fear of being judged or discriminated against, fear of retaliation, not being aware of available services, or people not recognising that what they experienced constituted IPV. These difficulties probably result in an underestimation of the degree of association between IPV and mental health problems. Finally, the generalisability of findings about IPV and mental ill health is restricted because very few studies take an intersectional approach to data collection and analysis, particularly in relation to experiences of IPV in non-heterosexual relationships or when the adults involved have disabilities, are transgender, or come from marginalised ethnic or Indigenous groups, different social classes, or geographical locations. Moreover, although the literature from different parts of the world suggests similar associations between IPV and mental ill health globally,⁴⁶ the generalisability of findings across regions is likely to be limited by contextual factors that might differ between and within countries—eg, cultural beliefs about partnerships, levels of violence within the wider community, poverty, natural disasters, health crises (including pandemics),⁷⁹ war, displacement, other traumatic experiences.

Mental health problems as a risk factor for experiencing IPV

People who are experiencing mental health problems are at increased risk of experiencing IPV. A meta-analysis⁸⁰ 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. Although evidence is sparse, estimates suggest that the frequency of IPV exposure is around two-to-three times higher among people with mental health disorders than among those without mental health disorders.⁸¹ Similarly, a systematic review²⁶ of longitudinal studies showed that women with depressive symptoms were at increased risk of experiencing IPV for the first time compared with women with no depressive symptoms. This increased risk could be a result of abusive partners inflicting violence when individuals with mental health problems are assumed to be less able to protect

Panel 3: A survivor's account of how her childhood experiences affected her adult relationships

"Personally, to survive my childhood, I learned to doubt my own experiences to maintain the adults in the light of caring individuals. It was safer to question my behaviours than theirs. I couldn't control them, but I could control myself, so I thought I must be wrong in thinking or doing such and such since they said so. I used that same strategy when in a relationship with my abusive partner. The pattern of self-doubt carried on in my adulthood and still makes me more vulnerable to intimate partner violence. In my life, I have had more experiences of disempowerment than empowerment, so whenever the former shows up, it has more weight. It is a lifetime's work to shift the balance. For the cycle of abuse to stop, one has to have more positive healthy relational experiences than abusive ones to create the new norm."

Caroline

themselves (eg, during certain psychotic states involving disinhibition or preoccupation with one's own thoughts). As discussed previously, experiences of violence during childhood could give rise to both the development of mental health problems and revictimisation via IPV in adulthood,⁷¹ and thus these early experiences could actually be driving the associations between mental health disorders and recent experiences of IPV. People who have been abused or neglected in childhood might not have a sense of what a healthy or non-abusive relationship looks like. Their self-worth might also have been eroded to the extent that they think that they deserve to be mistreated. Moreover, their experiences of the minimisation of violence—possibly as a means of coping, or because of the normalisation or endorsement of violence within their family or the wider society they live in—might lead them to minimise the abuse (panel 3).

Mental health problems as a risk factor for perpetrating IPV

In a systematic review⁸² of mainly cross-sectional studies the risk of IPV perpetration was higher in individuals diagnosed with depression, generalised anxiety disorder, and panic disorder than in those without such diagnoses (odds ratios were in the range of 2–3). Depression and anxiety were associated with perpetration of IPV in a Swedish population-based and sibling-controlled longitudinal study,²⁸ in which increased risks for diagnoses of schizophrenia spectrum disorders, bipolar disorder, and attention-deficit hyperactivity disorder among IPV perpetrators compared with non-perpetrators were also reported. No association was found between autism and IPV perpetration. The association between diagnoses of schizophrenia spectrum disorders and IPV perpetration was not present when people with schizophrenia spectrum disorders were compared with siblings who

did not have such a diagnosis,²⁸ suggesting that the link is confounded by familial factors (ie, genetic and early environmental factors shared by individuals with schizophrenia and their siblings). Risk of IPV perpetration was most strongly associated with alcohol and drug use problems, and comorbid substance misuse increased risk in all diagnostic groups.²⁸ Although the strength of the association with mental health problems might be lower for perpetration of IPV than for other forms of violence, these findings correspond with evidence that having a diagnosis of substance use disorder, schizophrenia spectrum disorder, bipolar disorder, or personality disorder increases the risk of perpetrating violence more generally.⁸³

The connection between substance use and IPV perpetration is complex, and the environmental, situational, social, economic, and cultural contexts of this link should be carefully considered. Substances have different effects that depend on an individual's physiology, psychology, and gender, and the environments in which the substances are consumed. That said, evidence suggests that the psychophysiological effects of alcohol use directly increase the risk of committing IPV.⁸⁴ Studies^{28,85–87} from low-income, middle-income, and high-income countries support an association between alcohol and IPV, although the magnitude of the association (and moderators thereof) are inconsistent. This variability in associations might be due to multiple contextual factors (eg, relationships, culture, gender roles, history of dispossession, experiences of discrimination) or methodological limitations (eg, poor measurement, non-representative or non-comparable samples). The complexities of the interaction between substance use and perpetration of IPV make the pathways behind the association difficult to establish. For example, alcohol might affect neurochemical systems that lead to aggressive behaviour, or alcohol might reduce effective communication, causing discord and eventually violence. Of course, mental health problems such as PTSD or depression could account for both substance use and aggressive behaviour. More research is needed to clarify these relationships and possible causal, mediating, and moderating pathways. However, given the consistent findings of a moderate effect size for the association between alcohol use and perpetration of IPV (even after adjustment for familial factors),^{28,85} it is important to study these associations further. A treatment study⁸⁸ in Zambia showed that reduced alcohol use was related to reductions in the incidence of IPV.

It is important to note that the vast majority of people with mental health problems are not violent, and that people with many mental health problems are more likely to experience than to commit IPV. Furthermore, the odds of people with mental health problems perpetrating IPV are lower than those for people without mental health problems who have other historical factors (eg, a history of experiencing IPV), and at least equivalent

to those for people affected by relationship factors (eg, marital discord). This suggests that a multifactorial approach is required to understand why individuals commit IPV. From a dimensional perspective, psychological traits such as anger, hostility, and jealousy, have strong associations with IPV and might be more prevalent in some individuals with mental health problems.⁸³

More research is needed to explain the increased risks of committing IPV among some individuals who are experiencing mental health problems. Mechanisms might include symptoms directly leading to violence, such as paranoia, hostility, and anger. Additionally, mental health problems increase the likelihood of substance misuse, and specifically alcohol misuse, which in turn can increase the risk of committing IPV. Other important potential explanations include familial confounding, in that there are shared genetic and early environmental risks for mental health disorders, substance misuse, and violence.^{28,89} A final possibility is that these heightened risk associations are due to higher rates of detection and arrest of people with mental health problems who perpetrate IPV.⁹⁰ There is not always a clear distinction between committing and experiencing IPV, with some individuals experiencing both.⁹¹ People who both experience and commit violence have been suggested to have the greatest risk of developing mental health disorders.⁹²

Research that addresses the link between mental health problems and IPV needs to be attentive to the wider frameworks that are used to contextualise and explain these relationships so as not to embed simplistic assumptions about victimhood or pathologise particular groups of people. Linking mental health problems with committing or experiencing IPV has the potential to perpetuate discriminatory behaviours: in particular, the conflation of mental health problems and violence contributes to the stigmatisation of, and discrimination against, people with mental health problems, and creates barriers to help-seeking.^{93–95} It is crucial, therefore, to better communicate what is meant by the term risk and how risk translates into actual numbers of individuals who either perpetrate or experience IPV. Despite increased relative risks, the absolute risks are not high, and thus only some people with mental health problems will perpetrate IPV (table 1). However, it is important for clinicians to acknowledge that there is an association between mental health problems and violent behaviour, and the effective treatment of groups at high risk of perpetrating IPV should be a priority for mental health services.⁹⁶

Minimisation or denial of any links between mental health disorders and IPV will probably lead to worse risk assessments and treatments to address modifiable risk factors,⁹⁷ and might maintain or even increase IPV rates, leading to further stigma. To clarify the association between mental health disorders and IPV, high-quality epidemiological studies are needed that

	Absolute lifetime rates of committing IPV (IQR)	Odds ratio of committing IPV (95% CI)
No diagnosis of mental health problems	4% (3–7)	N/A
Alcohol use disorder	..	7.0 (6.6–7.5)*
Depression	18% (15–22)	2.9 (2.7–3.2)†
Drug use disorder	..	7.7 (7.2–8.3)*
Generalised anxiety disorder	20% (19–23)	3.2 (2.5–4.4)
Personality disorder	..	4.3 (3.8–4.9)*
Post-traumatic stress disorder	22% (18–28)	1.8 (1.0–3.2)
Panic disorder	14% (13–19)	2.5 (1.7–3.6)

Data are from Oram et al.⁸² unless otherwise specified. Odds ratios show the odds of committing IPV compared with the general population. Estimates for drug and alcohol use disorders are based on hazard ratios adjusted for sociodemographic factors. IPV=intimate partner violence. N/A=not applicable. *Data are modified from Yu et al.²⁸ †Data are modified from Yu et al.⁸³ and Fazel et al.⁸³

Table 1: Absolute rates and relative risks of men with and without mental health problems committing IPV

have large, representative samples, longitudinal designs (such that the timing of mental health problems and IPV can be ascertained), and validated methods to identify both mental health disorders and IPV, including adjustment for probable confounders (such as familial factors).

Mental illness diagnostic categories and IPV

Diagnostic categories for mental health problems in the ICD and DSM classification systems are commonly used by practitioners to describe symptom clusters with the aim of clarifying causal relationships, prognoses, and treatments. However, they can also add to stigma and create a siloed view of the nature of mental health symptoms. Furthermore, several diagnoses (including those associated with both experiencing and committing IPV—eg, borderline personality disorder,^{98,99} substance use disorders,¹⁰⁰ antisocial personality disorder¹⁰¹) can be highly gendered or racialised, which can produce and reinforce stigma. These diagnoses, some argue, might reveal more about societal and cultural assumptions about gender, violence, and trauma than about actual mental health problems.¹⁰² For example, Shaw and Proctor¹⁰³ have argued that the diagnosis of borderline personality disorder pathologises women's responses to violence and other forms of oppression.

Diagnoses can also produce an incomplete picture of individuals who have experienced IPV and present to services with comorbidities. For example, psychotic symptoms can occur in people with severe PTSD resulting from IPV, which can lead to difficulties in establishing a diagnosis, misdiagnosis, or practitioners focusing on one set of symptoms for treatment rather than considering all of a person's experiences.¹⁰⁴ Indeed, whenever a mental health condition is diagnosed, the risk is that an incomplete picture is produced that does

Panel 4: A survivor's account of an abusive partner labelling her as mentally unwell

"I have experienced a violent partner accusing me of being mentally unwell. They used a few different methods: instilling fear, by lying and telling me that other people thought I was 'crazy', 'bipolar', 'schizophrenic'; disarming the appropriate fight-flight response by accusing me of being a pathological liar in order to create a shield for themselves; and shifting their shame towards me. He spat on my face. The smell of his bloody, unhygienic spit made me gag and seek the toilet to throw up. He then used my eating disorder (anorexia-bulimia) against me to belittle and shame me further. This deflected me from being able to shame his abusive behaviours.

Through my partner's accusation of mental illness, he made me understand that no one would believe me regarding his abuse because society reduces people with mental illnesses as disconnected from the collective reality. I feared that if I shared my experience of abuse, I would be automatically discredited and disbelieved on the grounds of poor mental health, so I kept quiet. I didn't want to trade the gaslighting of my partner for the gaslighting of a more powerful system, the psychiatric system, where whatever I said would be used as proof of me lacking mental capacity. He could only weaponise mental illness because of the stigma attached to it. It worked. It was as powerful a tactic as his physical abuse."

Caroline

not take into account comorbidities, environmental factors, traumatic events, or other circumstances.

Additionally, diagnoses and mental health labels can be misused by abusive partners. For instance, people who commit IPV have been reported to label their victimised partner as mentally unwell to excuse their behaviour or as a means of psychological abuse or control (panel 4).

Key knowledge gaps

Many gaps remain in understanding the relationship between IPV and mental ill health, and research is crucial to improve services, interventions, and outcomes for people who experience IPV and those who commit IPV. If there is a causal relationship between the two, then the biopsychosocial mechanisms through which IPV leads to the development and maintenance of mental health problems require thorough investigation to inform preventive interventions. The extent to which other factors (eg, poverty, exposure to other forms of violence) contribute to the relationship between IPV and mental health problems requires clarification. Improved understanding of the factors across multiple levels (individual, family, relationships, and social, cultural, economic, and political structures) that might protect IPV survivors from adverse mental health

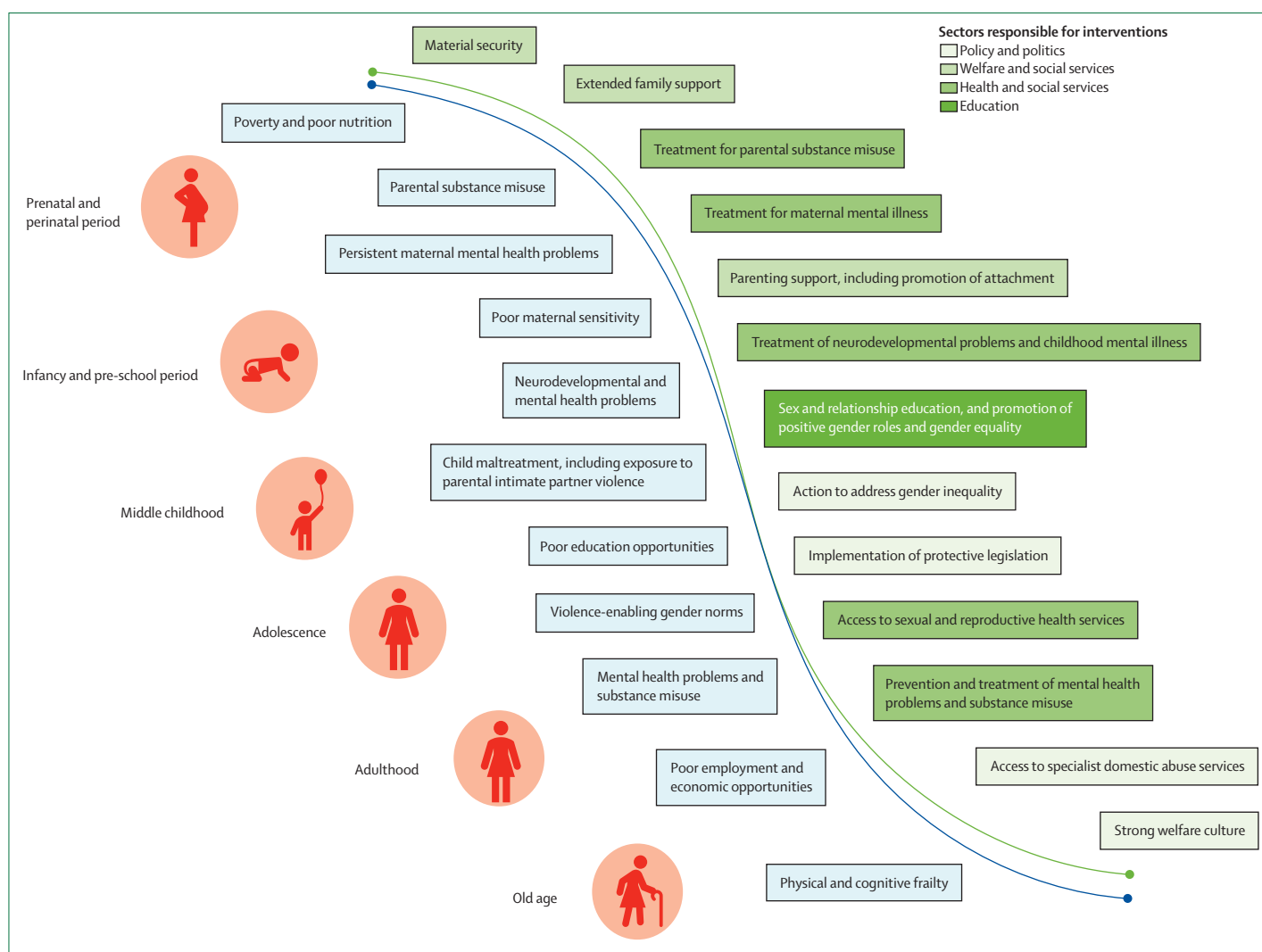


Figure 2: Risk factors for intimate partner violence and targets for intervention across the lifespan

consequences could also facilitate prevention. Furthermore, it is important to understand potential risk factors among those who commit IPV (eg, substance misuse) to identify and assess treatments that could reduce the incidence of IPV.

Research is also needed on understudied groups, including those who are undocumented, Indigenous, disabled, sexual and gender minorities, and all other groups that are marginalised or discriminated against. The use of qualitative methods might be particularly helpful in improving understanding of experiences of IPV in these understudied groups. The association of IPV with other mental health problems, such as eating disorders and sleeping disorders, should be studied.

Research into IPV and mental ill health should consider the wider context in which IPV occurs—in relation to both other manifestations and experiences of violence and abuse and broader societal and political

structures—through the adoption of intersectional, multi-level, and cross-national approaches. Greater integration of psychiatry and the social sciences could help to support such research. Finally, it is imperative that future studies are designed and conducted in collaboration with survivors (or wholly survivor-led) to ensure that the perspectives of those with lived experience of IPV are central to the research.

Part 3: IPV across the life course

Introduction

IPV occurs across the life course (figure 2). In Part 3, we consider the developmental mechanisms that make IPV more or less likely to occur and suggest targets for prevention and intervention. Most studies have been done in high-income countries, but we present evidence from low-income and middle-income countries when possible.

The perinatal period

IPV during pregnancy can be a precursor for the intergenerational transmission of mental health problems and the propensity to poorer general health, and thus might contribute to both individual and global burdens of mental and physical health problems.¹⁰⁵ Evidence from animal, clinical, and brain imaging studies of trauma-exposed individuals suggests that exposure to traumatic stress in early life, including the intrauterine period, has serious consequences for mental¹⁰⁶ and physical¹⁰⁷ health, and epidemiological evidence shows that both people who experience IPV and those who commit IPV are more likely to have been born to women who were abused during and after pregnancy compared with people who have not experienced or committed IPV.^{23,108,109}

Although there is conflicting evidence about whether IPV increases or decreases during pregnancy,¹¹⁰ unplanned pregnancy in particular is associated with IPV (potentially reflecting reproductive coercion),¹¹¹ and IPV during pregnancy increases the risk of mortality in pregnancy.^{112,113} According to an analysis¹¹⁴ of WHO estimates from 19 countries between 1998 and 2007, the global prevalence of IPV during pregnancy was between 2·0% (as reported in Australia, Cambodia, Denmark, and the Philippines) and 13·5% (reported in Uganda) among ever-pregnant ever-partnered women. Prevalence was highest in Latin America and Africa, but substantial within-country and inter-country variation was noted.¹¹⁴ A review¹¹⁵ of IPV during pregnancy in low-income and middle-income countries reported prevalences of 2–35% for physical violence, 9–40% for sexual violence, and 22–65% for psychological violence, but more high-quality research is needed. The children of women who experience IPV in the perinatal period have an increased risk of developing common and severe mental health problems and non-communicable diseases.¹⁰⁷ Women experiencing IPV during pregnancy have increased odds of experiencing obstetric complications, including emergency caesarean sections, instrumental delivery, pre-eclampsia, eclampsia, and untoward obstetric outcomes (prematurity and small-for-gestational-age babies),¹¹⁶ all of which are in turn risk factors for mental health problems, neurodevelopmental problems, and cognitive deficits in their offspring.^{117–20} Children who develop mental health problems are also more likely to be at risk of experiencing (and committing) abuse both in childhood and in adulthood, which could affect subsequent generations.^{23,82}

Several other mechanisms might link IPV in the perinatal period with childhood mental health problems in the offspring. Systematic reviews of studies in low-income, middle-income, and high-income countries consistently find associations between IPV during pregnancy or the post-partum period and perinatal mental health problems in mothers,^{74,75,121} including substance misuse.^{122–125} The association between perinatal

mental health problems and substance misuse and a range of childhood adverse mental health and behavioural outcomes in the offspring is well established.^{74,75,121,126,127} A review¹²⁸ of the mechanisms involved is beyond the scope of this report, but these include the effects of stress in utero and the quality of the mother–infant relationship, which can be impaired by postnatal depression in particular but also by other adversities.¹²⁸ Stress in utero, including that caused by mental health problems and IPV during pregnancy, does not inevitably lead to adverse outcomes in childhood, but is moderated by maternal sensitivity towards the child, poverty, persistent symptoms of mental health problems, and postnatal IPV.¹²⁶

Traumatic stress exposes fetuses and infants to high concentrations of cortisol, resulting in the activation of psychophysiological systems, which can lead to underlying difficulties in adaptation and mental health problems in later life.¹¹⁶ Anxiety, depression, ADHD, and conduct disorder are more frequent in children born to mothers who experienced IPV during pregnancy than among those born to mothers who did not experience IPV during pregnancy.¹¹⁶ Chronic activation of the corticolimbic circuit in the fetus impairs regulation of subcortical (amygdala and hippocampal) activation by the prefrontal cortex, and greater stress exposure is associated with smaller grey matter volume,¹⁰⁷ both of which can lead to less efficient modulation of impulses and anxiety and greater vulnerability to new stimuli. These changes in fetal and infant brain structure are compounded by epigenetic changes, which affect regulation of gene expression. Epigenetic changes are associated with IPV,¹²⁹ and this association can be compounded by environmental and nutritional factors (such as the greater food insecurity often linked to IPV).¹¹⁶ Almost 40% of mothers who report IPV during pregnancy experience symptoms of post-partum depression,¹³⁰ which could potentially result in epigenetic changes that in turn could lead to mental (emotional regulation and cognitive development) and physical impairments in the infant.¹³¹ Research is required to characterise the role of cortisol and the neuroendocrine, epigenetic, and genetic regulation of the hypothalamic–pituitary–adrenal axis, and to establish whether the stress of IPV causes damage via pathological responses in the mother (eg, depression, PTSD) or via direct antenatal effects of maternal stress hormones on the fetus.¹³²

Studies of intergenerational violence transmission¹³³ have a high degree of methodological variability.¹³⁴ They tend to rely heavily on measuring discrete acts of physical violence only, and seldom include measurement of the context and purpose of violent acts or of coercive control.¹³⁵ It is therefore difficult to draw any firm conclusions from these studies.

Infancy and the preschool period

IPV more than doubles the risk that a child will display substantially aggressive behaviour by age 4 years.¹³⁶ Most

infants and young children use aggression to express frustration and demands.¹³⁷ Aggression peaks during the second year of life and then usually diminishes, but it persists in some children.^{137,138} Exposure to IPV seems to be particularly associated with the development of traits such as feeling no remorse, uncaring behaviours, and an inability to express emotion, which are subsequently associated with persistent aggression.¹³⁹ The potential mechanisms underlying these associations involve both the child's temperament and the family environment. The more maltreatment a child experiences (including exposure to IPV), the more persistent their aggressive behaviour.¹⁴⁰ At a population level, childhood exposure to IPV or experiences of physical or sexual abuse double the risk of committing IPV in men and of experiencing IPV in women.²³ Research is needed to understand protective factors in individuals with these childhood experiences who do not subsequently commit or experience IPV.

Severe parental stress greatly increases the risk of children experiencing abuse of all kinds, including exposure to IPV.¹⁴¹ Parental stresses—such as unemployment, poverty, food insecurity, and postnatal depression—might therefore increase the risk of child abuse or exposure to IPV.¹⁴² Children who experience abuse or neglect, or who are exposed to IPV, are much more likely than their peers without such experiences to have complex, overlapping neurodevelopmental problems.¹⁴³ Longitudinal research^{144,145} shows that these neurodevelopmental problems tend to be noted before abuse and neglect in the lifecycle, which has led to controversy about the causal role of early childhood adversity.¹⁴⁶ These findings, in combination with behavioural genetic evidence,¹⁴³ suggest that neurodevelopmental symptoms in children and adults can increase parental stress¹⁴⁷ and potentially IPV.¹⁴⁸

Children with neurodevelopmental disorders, such as autism spectrum disorder and ADHD, can be stressful to care for,¹⁴⁹ and children with autism are at higher risk of being abused and neglected than children who are neurotypical.¹⁵⁰ That is not to imply that the child is in any way responsible: no child should ever be subjected to maltreatment. Understanding and management of neurodevelopmental disorders in children and adults is therefore an important target for the prevention of family stress and IPV. Neurodevelopmental disorders are lifelong, highly heritable conditions,¹⁵¹ and emerging evidence suggests that adults with ADHD are more prone to committing IPV than those without ADHD.¹⁴⁸ Adults with neurodevelopmental disorders who have children with neurodevelopmental disorders might find parenting particularly stressful.¹⁵²

Middle childhood and adolescence

During middle childhood (age 5–12 years roughly), children are growing in autonomy and are increasingly exposed to influences outside the home, such as peers and school. Unsurprisingly, being exposed to IPV at

home can be detrimental to children's performance at school and can be reflected in their behaviour. Potential knock-on effects include the child being labelled as difficult or underperforming educationally,^{153,154} although conversely children experiencing abuse might also strive for perfection and present as model pupils. Children exposed to IPV at home are deprived of many of the benefits of education, including the possibility of social mobility.¹⁵⁵ However, middle childhood affords an opportunity for schools to modulate factors that reduce the risk of IPV being experienced or perpetrated in adolescence. Schools need to be a safe space for children and should purposively create an ethos that promotes gender equality and respectful relationships, thereby potentially influencing values, attitudes, and behaviour related to IPV.¹⁵⁶

Adolescence is a period of transitions, from the relative security of a small primary school to a larger secondary school with new peers, to the onset of puberty, which might be accompanied by the amplification of gender-restrictive norms, particularly for girls,¹⁵⁷ and the intensification of pressure to conform to gender roles. Many people experience their first sexual relationships during adolescence, become increasingly independent of parents, and become potentially more influenced by peers and intimate partners. IPV is common in adolescent dating relationships: WHO estimates that globally around 24% of ever-partnered adolescent girls have experienced physical or sexual violence, or both, from an intimate partner.³ The predictors of experiencing IPV in adolescence are also predictors of other adverse outcomes, such as substance misuse, poor educational outcomes, risky sex, and adolescent pregnancy (and early parenthood).¹⁵⁵

IPV in adulthood

The highest lifetime prevalence of physical or sexual IPV, or both, for women is between 25 and 44 years.³ The highest prevalence in the past 12 months (16%) is in adolescent girls and young women (aged 15–24 years).³ IPV prevalence is higher in low-income and middle-income countries than in high-income countries, and the difference is starkest when considering prevalence in the past 12 months.³ 31% of women and girls aged 15 years or older surveyed worldwide reported lifetime physical or sexual IPV or sexual violence from a non-partner, and 6% reported sexual violence from a non-partner. Coercive control, controlling behaviours, and emotional abuse are less well measured and understood, but their importance has been highlighted by the #MeToo campaign (and its many national and regional adaptations).¹⁵⁸ Individual risk factors, such as previous exposure to trauma and violence, poor education, and younger age, interact with factors operating at the level of the relationship, community, and society.¹⁵⁹ The absence of proper sexual and reproductive health services, including modern contraception, abortion, and timely and quality antenatal

and delivery care (including proper attention to emotional changes), compounds the violence experienced by women during their reproductive years.

IPV can be part of a complex range of abuses experienced both inside and outside the home. Education and work outside the home can be hampered by sexual harassment (unwanted behaviour of a sexual nature), which causes severe losses in productivity, slows or stops women's advancement, and is associated with mental health problems.¹⁶⁰ Unsafe public spaces,¹⁶¹ lax implementation of protective legislation, delays in interventions to change societal views about women's rights and liberties (including sexual expressions), and the absence of criminal recourse are macro-level factors that contribute to the perpetuation of IPV during adulthood.

IPV in older adults

IPV in older adults (ie, aged 65 years or older) might reflect a long-standing abusive relationship with both partners growing old together, but can also be a new experience, including after changes in a partner's behaviour in the context of age-related pathologies such as Alzheimer's disease, stroke, or depression, or after the establishment of a new relationship.^{162,163} Frailty and dependence due to declining physical ability and cognitive function increase vulnerability to IPV, as do retirement, children leaving home, and menopause.⁴ Intimate partner homicide-suicide, although rare in the general population, is more common among older adults than among younger adults.¹⁶⁴ News and police reports frequently highlight untreated depression in the perpetrator.¹⁶⁵

IPV is associated with mental health problems in older women, including depression, anxiety, psychological distress, and substance misuse,^{166–168} which might be exacerbated by prolonged exposure to violence.⁴ Older women who have experienced prolonged and ongoing IPV report frustration, anger, helplessness, hopelessness, isolation, and low self-esteem, and women whose experiences of abuse have ended might continue to experience psychological distress.¹⁶⁷

In older adults, IPV is often treated as a subset of elder abuse, which typically considers abuse from an ageing and disease-based, rather than a relational, perspective.¹⁶⁹ Such an approach overlooks the particular experiences and needs of older adults, and also ignores the significance of gendered power within abusive relationships in later life.^{167,170} Differences in both gender socialisation and in attitudes towards service use might mean that older women are less likely than younger women to self-identify as victims of IPV, or to seek help for experiences of IPV. Older women might also be more accepting of men's use of controlling and abusive behaviours,¹⁷¹ and are likely to have grown up in an era in which mental health problems and use of mental health services were more stigmatised. Women's refugees and other specialist

services might not be appropriate to older women's needs (eg, an absence of provision for women with disability and mobility requirements). Other obstacles to help-seeking include poor physical and mental health, financial issues, poor social networks, and family worries.⁴ Older adults might also experience loss of hope for change as a result of long-term exposure to IPV and might fear loneliness.¹⁴⁹

Part 4: Measurement of IPV

Introduction

In this section, we focus on the measurement of IPV in mental health care. Accurate measurement is essential for assessment of the prevalence, incidence, risk, and severity of IPV and related mental health problems, and of the effectiveness and cost-effectiveness of interventions to prevent or reduce these problems.

Overview of IPV measurement

Numerous assessment tools and research instruments have been developed over the past three decades.^{172,173} Specialised cross-national and national survey initiatives have captured data for IPV exposures—including data for the type, severity, and timing of abuse and the relationship to the person committing violence—and health outcomes (eg, the WHO Multi-Country Study on Women's Health and Domestic Violence,^{32,174} the US National Intimate Partner and Sexual Violence Survey,¹⁷⁵ the Crime Survey for England and Wales,¹⁷⁶ the Australian Personal Safety Survey¹⁷⁷).

Despite this progress, IPV is often not included as an exposure or an outcome in mental health research. Challenges in measuring IPV include the absence of consensus on how types of IPV, which can vary by severity and frequency, combine into a pattern of behaviour to represent an individual's experience. There are also questions about the equivalency of measurement in diverse populations and subpopulations and across geographical, cultural, and language boundaries. Although both DSM-5¹⁷⁸ and ICD-11¹⁷⁹ include codes for data collection regarding IPV, to our knowledge these codes are not routinely used in clinical practice.

Tools developed for health-care settings

A range of self-report questionnaires have been developed to measure IPV, most of which have focused on IPV victimisation.¹⁸⁰ The following measures have been used to establish the prevalence of IPV, as criterion standards when assessing brief IPV assessment tools, and as outcome measures in intervention studies: the Conflict Tactics Scale (CTS, 18 items),¹⁸¹ the Revised Conflict Tactics Scale (CTS-2, 78 items),¹⁸² a subsequent short form of the CTS-2 (20 items),¹⁸³ and the Composite Abuse Scale.^{184–86} Brief self-report questionnaires or screening tools have been developed for use in clinical and research settings. The accuracy of these measures varies widely, with sensitivities for IPV in women ranging from

47% to 94% and specificities ranging from 38% to 95%.¹⁸⁷ Although screening tools for IPV are being used in health-care settings in some jurisdictions, three trials assessing IPV screening of women did not show a reduction in the occurrence of IPV or improvements in health outcomes.¹⁸⁷

Brief instruments have been developed for screening for IPV perpetration, as summarised by Davis and colleagues.¹⁸⁸ Whether the use of such tools is associated with improved outcomes for service users is unknown. Although risk assessment of the potential for perpetrating violence is routine within mental health assessments, it has tended not to focus on identification of risk specific to partners or ex-partners. Tools have also been developed to provide risk stratification for future IPV assault and intimate partner homicide. Such tools need to have very good predictive validity (ie, to identify individuals who are expected to assault or kill their intimate partners and those who are not). Graham and colleagues¹⁸⁹ identified 43 studies that collectively examined 18 different assessment tools for IPV or intimate partner homicide. Only a few—the Ontario Domestic Assault Risk Assessment,¹⁹⁰ Danger Assessment (20-item Revised Version),¹⁹¹ Domestic Violence Screening Instrument Revised,¹⁹¹ and the Kingston Screening Instrument for Domestic Violence¹⁹²—had available data for internal consistency, interrater reliability, and validity (predictive, construct, and concurrent). Differences in measurement of validity, outcomes, and length of time between administration of the tools and measurement of outcomes make synthesis of study findings challenging. Use of structured risk assessment tools in forensic settings might enhance the comprehensiveness, objectivity, and defensibility of expert opinion, and could be triangulated with other information on risk.¹⁹³ However, the validity of these tools in predicting outcomes is mostly weak to moderate (if reported), so these tools need refinement, such as better designs for development, internal and external validation, and inclusion of a wider range of performance measures (including calibration). Such tools should be simple and scalable, and should support clinical and professional decision making.

Measurement of IPV in research settings

When measuring any aspect of IPV—victimisation, perpetration, or risk—it is important to consider the types of violence, the context, and the extent to which the perspectives of people with lived experience are incorporated. Tools have been criticised^{47,194–96} for measuring conflict tactics as opposed to coercive tactics or normative use of violence¹⁹⁷ and concentrating mainly on physical abuse, with little measurement of sexual abuse and verbal aggression and no acknowledgment of social isolation and harassment.¹⁹⁶ There is concern that not focusing on characteristics of IPV such as severity and repetition could result in an apparent gender symmetry in

experiencing and committing IPV.^{196,197} Gender equivalence in the perpetration of violence is often the result of inclusion of isolated minor incidents only, even though qualitative data suggest that self-defence is a common reason why women hit their partners.^{196,198} Similar criticisms have been made of measures used to assess intergenerational and family violence.^{133,134}

To address these measurement limitations, Walby and colleagues^{176,199} use a nuanced measurement framework with finely graded distinctions in the severity and frequency of violence and coercion that also includes the consequences of these experiences for victims. They argue that counting repetitions in addition to the number of victims is important to build a multifaceted picture of IPV, including an understanding of how the effects of IPV differ by gender. If only the number of victims is counted, then the gender profile of IPV is distorted to appear nearly gender symmetrical. If the repetition of violent acts is included in the measure, a more accurate gender profile of IPV emerges, with acts of violence by men against women much more frequent and more severe than those by women against men. Furthermore, when repetitions are counted, increases in IPV during economic crises become apparent, increases that are obscured when only the number of victims is counted.¹⁷⁶ Information about frequency and severity is essential to generate an accurate gender profile of IPV victimisation and perpetration, which is necessary to inform policy about the provision of targeted services.¹⁷⁶

Some forms of abuse, including controlling and coercive behaviours, might be better identified by patterns and frequency over time than by repetition. The Composite Abuse Scale and the Composite Abuse Scale-Short Form provide a multi-dimensional measure of IPV and calculate the patterns and severity of abuse for an individual.^{184–86} The WHO instrument is used widely in low-income and middle-income countries. Designed for prevalence surveys (but also used in clinical research), it captures physical, sexual, and psychological abuse, and the frequency and duration of abuse in the past 12 months and during adult lifetime. It also measures some of the effects of IPV, including, for example, injuries, living in fear, and effects on mental health.¹⁷⁴

Measurement of mental ill health in IPV research

Measurement of mental ill health should be embedded in research on IPV. Depression, anxiety, PTSD, and substance misuse have been the most measured mental health outcomes in observational and interventional studies, largely through self-report measures. Clinician-administered semi-structured interviews to confirm psychiatric diagnoses have seldom been incorporated into studies.⁴⁷ More often, screening measures that assess symptoms rather than diagnosable disorders are used. The timeframe of measurement varies widely between studies, from past week to past year. Many studies do not specify any timeframe, which is likely to affect estimates

of the associations between IPV and mental health problems. Consensus on short, standardised measures that can be integrated into IPV research to measure, at a minimum, depression, anxiety, PTSD, and substance misuse, is urgently needed.

Survivor priorities and perspectives on measurement in research

Measures administered in research settings often reflect researchers' beliefs about what constitute good outcomes. These beliefs might not be shared by, or be meaningful for, people with experience of IPV or mental health problems.^{200,201} Many survivors of IPV have criticised the dominance of the biomedical model of mental disorders, which emphasises symptoms but not why these symptoms are experienced.²⁰² When developing measures, thought is needed about which definitions of successful outcomes are privileged.

Whereas clinical trials tend to measure a narrow set of health outcomes, people who use, deliver, and fund interventions often emphasise outcomes relating to function (eg, quality of life) and wellbeing (eg, self-efficacy) in addition to—or sometimes instead of—improvements in health.²⁰³ This mismatch between what is prioritised by survivors and what is measured in trials and other interventional studies might be due to the notion that outcomes valued by survivors (and other groups), such as empowerment and self-esteem, represent intermediate or surrogate endpoints—a step in the causal pathway between the exposure and the final outcome of interest, which is commonly recurrence or severity of abuse or a health outcome.²⁰⁴ To ensure that evidence produced by intervention studies is relevant, studies need to measure outcomes reflecting the priorities and expectations of survivors.²⁰⁵ Systematic monitoring of harms in IPV intervention trials is also needed, because potential iatrogenic effects have been reported.^{206–08}

Methods developed by mental health service user researchers to generate reliable and valid outcome measures from the perspectives of service users^{200,209} could be adopted by researchers working with IPV survivors. The model involves using participatory qualitative and psychometric methods to explore survivors' experiences and perspectives and translate them into psychometrically robust outcome measures.²¹⁰

Cross-cultural issues in measurement

How IPV is conceptualised in any culture will crucially affect recognition, risk assessment, and linkage to care. Cultural norms might determine what can be measured in research or clinical settings. For example, disclosure of sexual IPV might be culturally sanctioned, which could limit measurement of how such abuse affects mental and physical health and its use as an intervention outcome.^{211–213} Cultural norms might also determine how questions are asked, with implications for the

translation and adaptation of tools between countries and regions. Measurement of psychological abuse, and differentiation of such abuse from controlling behaviours, could prove challenging across different cultures. In WHO's Multi-Country Study on Domestic Violence and Women's Health,¹⁷⁴ rates of psychological abuse between countries varied substantially and there was no cross-cultural consensus on the items constituting psychological abuse, and thus prevalence estimates were not published. The authors revisited the data to identify meaningful thresholds that affect health outcomes and recommended the use of a continuum approach (ie, a simple three-level intensity-based index) to advance cross-cultural measurement, which recognised that emotional violence and controlling behaviours can mean different things in different cultures.²¹⁴

Heise and colleagues²¹⁴ recommend the enrichment of cross-cultural measurement through qualitative studies to understand how women experience different forms of violence, how they rate the severity and emotional consequences of these acts, and how violent acts can have different meanings in different cultures. To understand some of the cultural nuances in measurement, they recommend complementing qualitative investigation with quantitative studies to establish different ideal cutoffs on measures of IPV and mental health across countries and populations, and extending such investigations to clinical populations and women seeking help from social services. It is also important to understand the cultural context in which people are being asked to disclose abuse, including whether legal protections exist for those who have experienced or are experiencing IPV and potential adverse consequences of disclosure.

In low-literacy contexts, and in some cultural groups, measurement of IPV and mental health might need to be interviewer-led rather than self-administered. Survivors with low literacy might have difficulty comprehending items on a questionnaire or scale.²¹⁵ The use of audio computer-assisted self-interviews to facilitate disclosure among women with low literacy has had mixed results.²¹⁶ High rates of disclosure of IPV in face-to-face interviews in one study were suggested to be due to the presence of a non-judgemental and empathic interviewer and the perceived likelihood of therapeutic benefits and referral for further support and care.²¹⁷

Improving cross-sector coordination in data collection

Improvement of coordination and cooperation in data collection on IPV and other forms of violence is important because multiple agencies (eg, health services, specialist services, criminal justice, welfare services) need to act to reduce and end violence.²¹⁸ It is also crucial that researchers and policy makers gather data aligned with their specific remit. Definitions of IPV, and operationalisation of definitions of IPV, differ across and within disciplines and

sectors. Some variation is due to the different priorities of agencies, which is appropriate, but some variation is merely historical and serves little useful purpose. When the conceptualisation and measurement of violence cannot be fully aligned across fields, they should at least be translatable. Drawing attention to the legitimacy generated by international legal instruments (eg, those used by UN agencies, even though WHO, the UN Office on Drugs and Crime, UN Women, and the UN Statistics Commission have some differences in approach) could facilitate progress on this matter. Use of core minimum information within and across sectors would both facilitate cooperation and deepen understanding.^{199,219} Data for sex and gender should be collected as standard throughout measurement.²²⁰

Greater coordination would also enable big-data analyses. Data mining of electronic health records, for example, will allow for finer analysis of the associations between IPV and mental health problems (if information about IPV is recorded),²²¹ temporal identification of mental health sequelae, and identification of high-risk women, men, and gender minorities for targeted preventive interventions,²²² thereby supporting improvements in the clinical response to IPV.^{223,224} Similarly, the application of machine-learning models to administrative data records of IPV samples could help to identify high-risk women, men, and gender minorities for targeted preventive interventions, based on risk models' predictions of sexual violence victimisation in other high-risk non-IPV samples.²²²

Mainstreaming IPV within mental health research

Despite the long-standing association of IPV with mental ill health, and evidence that psychological treatments for anxiety might be particularly effective in women who have experienced IPV,²²⁵ IPV too often remains unmeasured in mental health research. Traditionally, observational mental health research has either excluded IPV or included only one or two questions about it, an oversight that has impeded investigation of causal associations and mechanisms. As new population cohorts are established, it is essential that comprehensive measurement of IPV is a consideration.

Future trials of mental health interventions should measure IPV as a potential moderator of treatment response. Information should be gathered about the sex and gender of people experiencing and committing IPV, and outcome data should be routinely disaggregated by sex and other variables, including gender, disability, and migrant status.²²⁶ Heterogeneity in outcomes—measured across trials for people who experience IPV, either as adult victims or as children living with abuse, or those who commit abuse—has hampered the process of gaining a comprehensive picture of the effectiveness of interventions for IPV in different populations and in different environments, and has made comparison of different interventions in the same population

difficult.^{201,204,227} The development of core outcome sets as a means of harmonising measurement of outcomes across different studies and, increasingly, contexts is gaining momentum through the Core Outcome Measures in Effectiveness Trials (COMET) initiative.^{228,229} Several core outcome sets have been developed in relation to specific mental health conditions,^{230–32} and a study²³³ is underway in the UK to develop a core outcome set for targeted psychosocial interventions delivered to children and families with experience of domestic abuse. Work is needed to guide decisions on what to measure at the interface between IPV and mental ill health. IPV researchers can look to the mental health field, which is more advanced with respect to the development of core outcome sets and service user leadership, to guide measurement in both research and clinical contexts.

Part 5: Transformation of mental health systems to address IPV

Introduction

In Part 5, we discuss ways to transform how mental health services respond to IPV. We consider service users' experiences of services, and the trauma-informed system-level transformations that are needed to prevent retraumatisation and enhance safe engagement. We then consider specific interventions at individual and system levels, and the research that is now needed to continue improving mental health service responses to IPV.

Challenges of addressing IPV in mental health systems

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.^{234–36} The prevalence of IPV among mental health service users is high,^{81,237} and many more survivors of IPV are unable to access mental health services.²³⁸ The dominance of medical models of mental illness²³⁹ and the standardisation of psychological interventions can lead to the organisation of treatment along diagnostic categories²³⁵ and inattention to people's lived experiences and individual contexts.^{208,235} Thus, mental health services too often concentrate on symptoms that service users affected by IPV might have and what treatment they might need rather than what has happened to them and how they might best be supported (panel 5). These problems are compounded by the fact that many mental health-care providers know little about the dynamics of IPV and how IPV affects mental health (and particularly women's mental health). Furthermore, although the need for survivor-centred and gender-sensitive mental health services has been clearly articulated, such services are rarely provided.^{240,241} Greater focus is needed within mental health services on respectful care and good communication skills based on gender-sensitive and trauma-informed approaches to addressing IPV.^{234,239,242}

Responding to people who are experiencing or have survived IPV

Universal screening for IPV is generally not recommended.²⁴³ However, because mental health problems might be associated with, or worsened by, violence, all patients should be asked about experiences of violence, including IPV, within the context of a mental health assessment. 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,^{235,244–46} including a curriculum for mental health providers developed by the World Psychiatric Association.²⁴⁷ Guidelines developed by WHO include a special focus on mental health responses for non-specialist primary care providers.²³⁴ Although this and other guidance has generally focused on women who experience violence perpetrated by men,²⁴⁵ the principles are mostly relevant to anyone with these experiences, including children and young people, women in same-sex relationships, men, and gender minorities.

Panel 6 summarises good practice principles for recognising and responding safely to people who have experienced IPV. These principles align with LIVES, WHO's recommended first-line response to disclosures of IPV, which recommends listening to the service user with empathy and without judgement, enquiring about and responding to their needs and concerns, validating their experiences and assuring them that they are not to blame, enhancing their safety by discussing a plan to protect them and their children from harm, and helping them to connect to information, services, and social support.²⁴⁴

A meta-synthesis²⁴⁸ that analysed what survivors want from health professionals echoed the LIVES response and reinforced the need for a patient-centred and trauma-informed approach to care. This synthesis also underscored the importance of CARE (ie, choice and control, action and advocacy, recognition and understanding, and emotional connection). Potential harms that might be experienced by survivors when such an approach is not used include retraumatisation and feeling ignored, disrespected, dismissed, silenced, and more afraid.^{248–50} Mental health services that are predicated upon power imbalances and conditions of coercion and control can result in dynamics that resemble those of abusive relationships,^{251,252} causing survivors to feel retraumatised rather than supported.^{253,254} For example, the use of coercive treatment, such as seclusion, restraint, and forced medication, in inpatient settings can cause retraumatisation.²⁵² Less research has been done on the effects of subtler forms of coercion in community settings (eg, how disclosure is managed, pressure to comply with treatment). There is, however, a substantial body of discursive literature by survivors and trauma experts that explores the harms caused by such

Panel 5: A survivor's account of pathologisation by mental health services

"I wish mental health practitioners would stop judging us as survivors and see us for how strong and resilient and courageous we are. I fought the hardest to protect myself and my family from being murdered, and I should be seen as a hero for that—not pathologised by a mental health system that sees me as a problem and a victim."

Cina

approaches. Psychiatrist Judith Herman, for instance, has famously argued that help is always harmful when it takes power away from the survivor, thereby mimicking the original trauma.²³⁶

Adoption of trauma-informed approaches will require a transformation of community, outpatient, and inpatient mental health services.²⁵³ Implementation of trauma-informed approaches through staff training and organisational redesign could help to reduce the use of coercive treatment in both adolescent²⁵⁵ and adult inpatient settings.²⁵⁶ Yet the principles of trauma-informed approaches (table 2) are sometimes highlighted in mental health policies without guidance or evidence to inform the organisational or health-systems change needed for implementation.^{235,242,258} Application of these principles necessitates that both providers and the environment in which mental health care is delivered are sensitive and responsive to the pervasiveness and potential effects of trauma.²⁴⁴ Everyone who interacts with service users, including non-clinical staff, should be trained in the importance of non-discrimination and avoidance of stigma.^{244,245} There needs to be recognition that anyone can have experiences of violence, either currently or in the past, and that interactions with the health-care system can lead to possible revictimisation, retraumatisation, and additional harm.²⁵⁷ Providers need to be aware that a broad range of signs and symptoms can be associated with exposure to IPV.²⁴⁴ For example, service users who repeatedly cancel visits and then seek mental health care after hours from the emergency department might be experiencing IPV. In all instances, it is important that information about a service user's mental health is not collected solely from partners (who might be controlling and abusive). Revictimisation of survivors of IPV can occur at the provider level (eg, via responses to disclosure of IPV that are victim-blaming or judgemental), the team level (eg, service users having to retell their story to multiple team members), and the systems level (eg, triage systems in which service users are asked in front of other service users about their reasons for seeking care, restraining practices on inpatient wards). Therefore, a health-systems approach that integrates actions at the individual, provider, and organisational level is crucial.^{259,260}

Panel 6: Good practice principles for recognising and responding to people who have experienced IPV

Prioritise safety

Safety includes emotional and cultural safety and goes beyond the absence of injury. Service users who are at risk of harm have different support needs compared with service users whose safety is assured. Professional support should never be withheld until a service user is safe or has left a relationship. Focus on increasing the choices available to the service user and remember that risks increase at the point of separation.

Listen with empathy and respond to the service user's needs

Communication should be empathetic and non-judgmental, acknowledge the complexity of IPV, and respect the service user's concerns and decisions. The approach should involve shared decision making, which respects the individual competence of the service user and where they are in terms of recognising violence.

Make the limits of confidentiality clear

Service users should be informed of what to expect, including about mandatory reporting legislation, which might require health-care providers to contact child protection services when a child is being exposed to IPV.

Ensure privacy

Enquiry about IPV should take place in private (ie, not in the presence of a partner, relative, or child beyond infancy) and follow a phased approach, beginning first with the service user's presenting concerns followed by enquiries about wellbeing and relationships, including safety. General open-ended questions that can lead to more specific questions about IPV include "How are things at home?", "How do you and your partner get along?", and "Are you sometimes afraid of your partner?"²⁴⁴

Assess safety

Ongoing enquiries about safety are imperative and should involve working collaboratively with the service user to protect them and any children involved (following safeguarding procedures where appropriate). Questions to ask include "Is it

safe for you to go home?", "What are you afraid might happen?", "What has [the abuser] threatened?", and "What about threats to the children?" Risk indicators for increased severity and risk of harm include separation, obsessive jealousy, control of daily activities, strangulation, sexual assault, escalation of physical violence, and use of weapons.

Ask about children

Children are often exposed to IPV, and it is important to ask about their safety and wellbeing. Survivors are often fearful of disclosing abuse in case their children are removed. Providers should strive to help children stay with the non-abusive parent, and to work with that parent to keep the children safe.

Document enquiry, disclosure, and safety assessments

Records should include a clear statement of who experienced IPV, who committed IPV, information about the frequency and severity of abuse, and any symptoms or injuries observed. Use the service user's words when recording disclosure and ensure that records are kept secure.

Support safety planning

Discuss where the service user would go in an emergency, who they would contact, and what they would take with them.

Share resources and information

Discuss what IPV resources and services are available in the local context or online and assist service users to explore preferences, including their ability and comfort to access specialist IPV services.

Integrate knowledge of IPV into treatment and support

Knowledge integration can be done at all levels of clinical practice—from how providers formulate and diagnose or choose a therapeutic approach, to how they write letters, advocate for service users (eg, letters of support for housing), and interact with service users.

IPV=intimate partner violence.

Digital technologies are increasingly used in responses to IPV, especially safety decision aids that aim to reduce 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.²⁴⁹ Although evidence is mixed,^{261,262} these online interventions came to the fore during the COVID-19 pandemic, when delivery of some face-to-face support was suspended. Remote care delivery has provided new opportunities but also presents challenges in some areas, including with regards to risk assessment. In some countries, there has been a shift to telephone-delivered safety protocols for IPV situations, with recognition that access might be limited because the perpetrator might be monitoring or own the victim's phone (panel 7). Providers should attempt to establish the location of the service user, check that the call has not

been placed on loudspeaker, and use yes-or-no questions to confirm that the service user is alone and can safely talk. People who are not alone should be advised to hang up and report that it was a wrong number, and informed that they will be called back later. Code words should be established to convey that a situation is no longer safe and that the call should be ended.^{263,264}

Although IPV is associated with increased risk of mental health problems, mental health problems are not an inevitable consequence of exposure to IPV and not all survivors will require psychological interventions. Moreover, there is no single intervention that will suit all survivors. When indicated by assessment, survivors should have access to appropriate therapeutic counselling and peer support (if available) to support long-term healing. Appropriate interventions might include trauma-focused and non-trauma-focused cognitive

	Description	How service users might experience it
Safety	Throughout the organisation, staff and the people they serve feel physically and psychologically safe.	"The most important thing is that I feel safe when getting help."
Trustworthiness and transparency	Organisational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among staff, service users, and family members of those receiving services.	"The trust I had before was so badly betrayed, it is hard for me trust things will be different this time."
Peer support and mutual self-help	These are integral to the organisational and service delivery approach, and are understood to be a key vehicle for building trust, establishing safety, and empowerment.	"Being around other women who have been through what I have been through makes me feel understood."
Collaboration and mutuality	There is true partnering and levelling of power differences between staff and service users and among organisational staff, from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision making. The organisation recognises that everyone has a role in a trauma-informed approach. One does not have to be a therapist to be therapeutic.	"I feel like we are working together, and nobody is taking over yet, which is different."
Empowerment, voice, and choice	Throughout the organisation and among service users, individuals' strengths are recognised, built on, and validated, and new skills are developed as necessary. The organisation aims to strengthen staff, service users', and family members' experience of choice and to recognise that every person's experience is unique and requires an individualised approach. This approach includes a belief in resilience and in the ability of individuals, organisations, and communities to heal and promote recovery from trauma. It builds on what service users, staff, and communities have to offer, rather than responding to perceived deficits.	"I am learning how to speak my mind for the first time in a long time."
Cultural, historical, and gender issues	The organisation actively moves past cultural stereotypes and biases (eg, based on sex, gender identity, gender inequality, sexual orientation, race, ethnicity, age, geography), offers services that are cognisant of gender power differentials and promote service users' autonomy, dignity, and self-determination, leverages the healing value of traditional cultural connections, and recognises and addresses historical trauma.	"I am taken seriously as a whole person here, not just treated as a victim."

Table 2: Guiding principles of trauma-informed care and implementation^{256,257}

behavioural therapies.²⁴⁷ A Cochrane systematic review and meta-analysis²⁰⁸ of 33 randomised controlled trials of integrative interventions (n=11), humanistic interventions (n=9), cognitive behavioural therapy (n=6), third-wave cognitive behavioural therapy (n=4), and other psychologically orientated interventions (n=3) showed that these therapies work to some extent in the context of IPV. 25 of these studies were done in high-income countries (19 in the USA, two in Australia, two in Greece, and one each in Spain and the UK); of the other eight, three were done in Iran and one each was done in China, India, Kenya, Nigeria, and Pakistan. Psychological therapies ranged from two to 50 sessions and were delivered by a variety of staff (social workers, nurses, psychologists, community health workers, family doctors, and researchers). The therapies were associated with a probable reduction in depression (standardised mean difference -0.24 [95% CI -0.47 to -0.01]; based on four trials of 600 women; moderate-certainty evidence) and anxiety (-0.96 [-1.29 to -0.63]; based on four trials of 158 women; low-certainty evidence). However, these studies involved a mix of different therapies provided in widely varying contexts, which limits the comparisons that can be made between them.

A systematic review and meta-analysis²²⁵ of 15 randomised controlled trials from eight low-income and middle-income countries (Kenya, South Africa, Zimbabwe, Uganda, Cambodia, Pakistan, India, and Iraq)

showed that anxiety (difference in standardised mean difference 0.31 [95% CI 0.04 to 0.57]) showed a greater response to intervention among women reporting IPV than among those who did not report IPV.²²⁵ In this review, responses to interventions for PTSD, depression or psychological distress did not differ on the basis of previous exposure to IPV, although all individual studies showed some effect on one of these common mental disorders.²²⁵ Interventions ranged from trauma-informed approaches (cognitive processing, habituating traumatic memories, focusing on traumatic experiences or debriefing) to those with a more practical focus (problem-solving, behavioural activation, or coping skills).

Thus, although psychological therapies can improve the mental health of women experiencing IPV, whether women's need for safety, support, and holistic healing from complex trauma are being addressed remains unclear. Systematic reviews and meta-analyses^{208,265,266} have shown that advocacy interventions (eg, empowerment, safety information, referrals), typically provided by specialist IPV services, can help women in terms of both being safe (ie, reduced abuse) and recovery with improved wellbeing. Greater integration is needed between specialist IPV and mental health services to respond to survivors' needs.²⁵⁸ Innovative models for addressing survivors' needs in an integrated way should be developed, and should include the delivery of psychological therapies by specialist services.²⁶⁷

Panel 7: A survivor's account of using services remotely during the COVID-19 pandemic

"Being able to access my doctor via telehealth during COVID was a life saver for me, as I have been housebound due to my mental health issues since March, 2020. Of course, going in person is much better when doctors are looking after your mental health issues, but that is not always possible.

It took away a lot of the stress and anxiety [due to] worrying if I could actually physically get there. My doctors were patient and sympathetic and nothing was rushed. I have also been accessing my domestic violence counsellor through telehealth (every 2 weeks), and that has been invaluable."

Fiona

More evidence is required to establish the types of intervention that best serve women and infants during pregnancy and the postnatal period.²⁵⁴ A US randomised controlled trial assessing an intervention combining a structured abuse assessment and six empowerment sessions integrated into home visits compared with standard post-partum home visits showed significant reductions in the number of IPV episodes from baseline, which were maintained at 2 years postpartum.^{268,269} Preconception interventions might reduce the risk of intergenerational transmission of violence.⁹⁷ Ideally, such interventions should start in adolescence and should equip women to be in relationships in which they receive support when pregnancies are planned and assist them to resist aspects of reproductive coercion.

Little is known about whether mental health interventions effectively prevent or reduce IPV. A systematic review²⁷⁰ of studies of the effect of mental health treatments on the prevention or reduction of IPV in low-income and middle-income countries identified only seven studies (all of which were done in middle-income rather than low-income countries), but suggested promising initial evidence that interventions for depression reduce the prevalence of IPV. In a trial in Zambia,⁸⁸ a cognitive-behavioural, modular, flexible, multi-problem, transdiagnostic treatment model that was assessed in women who reported moderate or higher levels of IPV and their male partners with hazardous alcohol use significantly reduced the severity and prevalence of IPV, mental health symptoms, and hazardous alcohol use compared with treatment as usual. In view of epidemiological evidence for an association between mental health problems and IPV victimisation, this association might be an important focus for future research and intervention.

Children

Children's exposure to IPV is often recognised because their mothers are identified as experiencing IPV. However, children and adolescents with emotional and

behavioural problems should also be assessed for exposure to IPV.^{37,227} As with adult survivors, it is important to see the child or adolescent alone once they are of an appropriate age and developmental stage to be interviewed (eg, when they are able to speak in sentences).²⁷¹ Open-ended questions such as "How do the people in your family get along?" are useful to begin the discussion. Providers should be sensitive to the struggles that children face in reconciling their feelings about parents in the context of abuse, and should reassure children that they are not alone in their experiences and have permission to talk to providers about what has happened to them.

In countries with child protection systems, child protection workers tend to investigate the possibility of child maltreatment and children's exposure to IPV. Mental health providers should ask about children's exposure to IPV to the extent needed to establish whether there is reason to suspect such experiences. Children should not be subjected to intensive interviews about IPV or other types of maltreatment when child protection workers have a mandate to investigate possible exposure. Collaboration is essential between mental health providers and both child protection services and non-abusive parents in establishing the risk to the child (and to any parent who is a survivor).

Children might need specific interventions delivered either with or separately from their caregivers. However, the need for intervention should be based on thorough assessment, because not all children who are exposed to IPV experience impairment.²⁷² Prevention of children's exposure to IPV before they experience negative outcomes should be a priority. Thus, interventions should focus not only on reducing the impairment associated with IPV but also on preventing exposure from recurring. Providers should work to increase support for parent survivors of IPV as part of their efforts to keep children safe.

A wide range of interventions have been developed to improve mental health outcomes among children exposed to IPV. These interventions vary in terms of their therapeutic strategy, focus, format, and mode of delivery, and whether they are selective or indicated.²²⁷ Although the evidence base is underdeveloped, there is some suggestion that mother-and-child and child-focused therapies (including psychotherapeutic interventions, parenting skills and training, and advocacy plus psychoeducation²²⁷) improve child behavioural and mental health outcomes, although replication is needed. A review²⁷³ suggested that interventions involving mothers and children working both separately and jointly across sessions might be associated with greater improvements across a range of outcomes compared with those that involve working separately only or jointly only. Several shortcomings remain. Although interventions are typically offered on the basis of children's exposure to IPV (rather than on the basis of type or

severity of impairment), it is clear that no one intervention can effectively treat all adverse outcomes associated with exposure to IPV.²²⁷

Furthermore, evidence is lacking for children who are living with ongoing abuse (both those directly experiencing abuse and those living in homes where IPV is occurring). Some evidence suggests that interventions targeting families experiencing or at risk of child maltreatment (which might include but not explicitly target families experiencing IPV), such as home visitation and parenting programmes, can improve child outcomes.²⁷⁴ However, the benefits of these broad interventions might be attenuated in families experiencing IPV,²⁷⁵ perhaps because IPV is backgrounded relative to other adversities such as parental mental health and substance use,²⁷⁶ or because parents traumatised by IPV need help to address their own experiences before being able to engage effectively in child-focused interventions.^{277,278} Children experiencing mental health problems for which evidence-based interventions are available (eg, depression), should be offered treatment, but the provider should be knowledgeable about the effects of trauma and be able to assess whether the child is experiencing ongoing exposure to IPV or other types of maltreatment. Cohen and colleagues²⁷⁹ offer some practical strategies for the delivery of trauma-focused cognitive behavioural therapy to children living with abuse, including the implementation of safety modules at the beginning rather than the end of treatment (focusing on sharing the child's awareness and experiences of IPV and addressing maladaptive cognition rather than mastering past memories of trauma) and working to help the child discriminate between real dangers and generalised fears.

Perpetrators of IPV

Efforts to reduce IPV need to address perpetrators' use of abusive behaviours, and should support mental health-care providers to identify and respond to the perpetration of IPV^{280,281} by drawing on lessons learned from efforts to improve responses to IPV victimisation.^{282,283} Good practice guidelines are available to improve health-care responses to the use of IPV, including specific guidelines for service users with mental health or drug and alcohol problems.²⁸² Key principles include that health-care providers have a duty of care not only to service users who perpetrate IPV, but also to the current and former partners and to the children of such service users (panel 8). The role of the health-care provider is to help the service user within the context of a multi-agency support network, in which maintaining the safety of those affected by abuse is a priority. When asking about the use of IPV, health-care providers should be aware that people who commit IPV often deny or minimise behaviour, and therefore inquiries might have to be persistent and probing. When asking about a history of violence, health-care providers should ask specifically

Panel 8: A survivor's account of the importance of services for people who commit intimate partner violence

"I would like to see less wait times and an increase in access to services for perpetrators. Wait times may cost lives; the quicker we can work to change the behaviour, the quicker we can lower the risk for victims and future victims."

Jasmine

about violence towards partners, ex-partners, family members, and any children involved, and document any disclosures.

Responses should include an acknowledgment of disclosure, and should reassure perpetrators that help is available while also conveying that abusive behaviour is unacceptable. Working with people who commit IPV requires a consistent message that IPV is unacceptable, a belief that change is possible and desirable, and the demonstration of empathy without collusion. Part of the aim of treatment should be to enable service users to take responsibility and admit accountability for their abusive behaviours. Motivational interviewing approaches to engage people who commit IPV before specialist referral to behaviour-change programmes have been associated with increases in attendance, compliance, and completion of programmes.^{284,285} Motivational interviewing techniques²⁸⁶ enable people (who vary in terms of readiness to change) to weigh up their situation and options, and to form action plans that meet their personal priorities and are tailored to their stage of change (pre-contemplation, contemplation, preparation, action, and maintenance).

Providers working with perpetrators with mental health problems should establish whether there are potentially modifiable clinical risk factors for IPV that could be addressed, but should emphasise that neither mental illness nor substance misuse are excuses for violent behaviour. Potentially modifiable risk factors include emotional dysregulation, overvalued jealousy and paranoia, delusions or hallucinations that might lead to violence, irritability (eg, in depression, or PTSD-related hyper-arousal and hyper-reactivity), impulsivity, substance misuse, and alcohol misuse.²⁸⁷ Clinical responses might include talking therapies for underlying traumas and emotional regulation, antipsychotics for delusional beliefs and command hallucinations, and interventions for substance or alcohol misuse. In a systematic review and meta-analysis²⁸⁸ of randomised controlled trials, reductions in violence were noted in people treated with antipsychotic drugs whose psychotic symptoms decreased, which suggests that some psychotic symptoms might have a role in the perpetration of violence.²⁸⁸ This evidence related to all violent outcomes, which were mainly non-domestic assaults, but could be generalisable to IPV.

Interventions for people who commit IPV typically follow one of three treatment modalities: cognitive behavioural, feminist, or psychodynamic therapy.^{289,290} Evidence is scarce for the effectiveness of these interventions in reducing violence both among people who commit IPV generally and among people who commit IPV and have mental health problems specifically.^{245,291} This evidence deficit should be addressed as a matter of priority. Cognitive behavioural and motivational interviewing therapies delivered in conjunction with alcohol treatment programmes have been identified as promising interventions in high-income and low-income settings but more rigorous assessment is needed.^{88,291,292}

It is essential to acknowledge the complexity of IPV. Not all people experiencing IPV want to separate from their abusive partner, and some people who do separate remain in contact (eg, in the context of a co-parenting relationship). There is little evidence to inform safe practice for professionals working with individuals in this context.^{293,294} Relationship-level interventions have proven effective when grounded in gender theory.^{295–97} A systematic review²⁹⁴ of six randomised controlled trials of couples therapies showed some efficacy. However, health-care providers should be aware that couples' interventions might be dangerous in relationships in which one partner is afraid of the other.²⁹⁴ When violence is normative or situational, working with couples to improve communication and conflict-resolution skills as potential mediators of IPV might be promising. The use of a couples curriculum that aimed to support equitable, non-violent relationships in Rwanda and Nepal improved communication and conflict-resolution skills and led to an increased sense of unity and shared power among couples.²⁹⁸ These findings suggest the value of couples programmes within the context of an enabling environment with highly trained facilitators.

System-level interventions

Providers need to be supported in the delivery of mental health care to people affected by IPV through undergraduate and in-service training, organisational support and supervision, and reflective practice. Training without reinforcement, referral pathways, and organisational change seems to be insufficient. A Cochrane review²⁹⁹ of randomised and quasi-randomised controlled trials of domestic violence educational interventions for health-care professionals suggested that there is some, albeit weak, evidence that training can contribute to improved attitudes and knowledge about IPV. Evidence for improvements in actual responses—including the use of safety planning identification, and documentation of IPV—was weak and inconsistent, and the sustained effect of training on these outcomes was uncertain.²⁹⁹

A cluster randomised trial³⁰⁰ done in primary care in the UK showed that training provided to all staff at general practice surgeries by domestic violence advocates from specialist third-sector organisations, a computerised

prompt to remind clinicians to ask about IPV when service users presented with indicators of abuse (such as depression), and a referral pathway for those needing IPV advocacy or counselling, improved rates of identification and referral for support for women experiencing IPV compared with practices in which none of these interventions were implemented. Evidence suggests that this model of intervention is sustainable, scalable, and likely to be cost-effective.^{301,302} Similar findings, with improved rates of identification and improvements in mental health and decreased abuse, have been reported in pilot interventions modified for secondary mental health-care services in the UK.³⁰³ However, a cluster trial in the Netherlands showed no improvement in rates of identification of people experiencing IPV despite changes in knowledge and attitudes after training.³⁰⁴ This lack of improvement was possibly because the training was not delivered in the context of an integrated intervention or referral pathway with the domestic violence sector.³⁰⁴ Cluster trials of systemic integrated interventions in mental health settings in the UK and other countries are therefore urgently needed to support commissioning of such interventions.

Even if identification of people experiencing IPV is improved, no system-level intervention trials have shown improvements in mental health outcomes for people experiencing IPV. Training alone is unlikely to address problems such as the inadequacy of generic risk assessment in the identification of risk of IPV severity and intimate partner homicide or filicide, unclear information-sharing requirements and protocols, and the absence of a broad organisational commitment to addressing IPV. The establishment of links between health-care providers and specialist domestic violence services is important.³⁰⁵ Research is needed to establish how best to improve actual outcomes, including clear measurement of the fidelity of integration of co-located third-sector services within secondary care.

The importance of organisational support was highlighted in a systematic review³⁰⁶ of 47 qualitative studies of how health practitioners are enabled to address IPV. Providers who collaborated within a team and worked within a health organisational system that was supportive were more likely to want to participate in identifying and responding to IPV compared with those who worked in unsupportive environments.³⁰⁶ An important factor was that providers had tried a service-user-centred approach and received positive feedback from service users: as a result of this feedback, providers trusted that health care was an appropriate setting in which to address IPV. The review also showed increased engagement among providers who had a personal commitment to addressing IPV, either because of personal experiences or because of a commitment to human rights, child rights, or feminism, areas which were not often addressed in training. Many providers will have experienced IPV, and

support should include training for managers in how to support such providers. Health-care professionals are often erroneously considered not to be traumatised themselves, and although they can benefit from this misconception by appearing well adjusted, it also denies an important part of their experience, which can enhance their practice if used carefully.^{307,308} A 2019 study³⁰⁹ showed that providers with their own personal experience of IPV were more likely to attend training and provide more effective care for survivors than those with no personal experience of IPV.

Supervision and reflective practice are useful when working with people experiencing IPV, which can be challenging. Panel 9 lists some questions that providers might wish to consider as part of regular reflective practice and that might help to enhance trauma-informed approaches to IPV.²⁹⁷

Improving organisation of mental health services to support families experiencing IPV

The readiness of mental health services to address IPV varies substantially, from little or no acknowledgment of the underlying role of IPV in mental health problems through to recognition of the need for individualised, survivor-centred, and trauma-informed approaches to IPV and for the appropriate infrastructure to support these responses (panel 10).³¹¹ Improving organisations' understanding of the interrelationships between IPV and mental health problems, and the need for trauma-informed approaches to care, is essential. Although many mental health services reference trauma-informed approaches, in practice little attention is paid to addressing the system-wide changes that are needed²⁷⁰—eg, strengthening of leadership and governance, provision of care in environments that are private and safe (ie, 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).²⁵⁹ At an individual level, there is often poor recognition that, even within the context of trauma-informed approaches, tailored responses to the specific type of violence and abuse experienced might be required.²⁵⁴ Enabling change requires a focus on building relationships across teams and services for a shared understanding of mental health and IPV frameworks,³¹² supported by clinical champions.²⁵⁸ Reflection on the organisation—including through consideration of survivor voices, clinical audits, staff input and feedback, environmental and workflow patterns, and assessment of the culture, values and beliefs within the mental health service—can identify the transformations needed.³¹³ Mental health practitioners might need to reflect on, for example, how their use of power and privilege when applying their own frameworks to assessments of individuals can disrupt the interactions between

Panel 9: Reflective questions for practitioners

- What kinds of power and privilege do I have? How do these shape my life and world view?
- Have I considered how experiencing trauma and violence might have contributed to the development of the presenting complaint or reason for referral?
- How does the service user's experience of coercive and controlling behaviours constrict their lives (or their children's lives) and their ability to do what they want to do, including their ability to engage in any mental health care plans?
- What do I know about safety strategies the service user has previously tried, how these strategies worked, if services were helpful, their partner's reactions, and what (if any) access they have to financial, family, social and cultural supports?
- Are the service user and their family experiencing systemic barriers (eg, no stable housing, little access to money and transport, poverty, language barriers, dismissive or racist responses from services)? How is this affecting them and their children and family's safety and wellbeing?
- Who is working with the service user's partner? What strategies are in place to support their partner and to address their use of violence?
- In view of all of these factors, what actions can I take as a safety ally, as part of the treatment plan?
- How and with whom will I review whether what I am doing is supporting safety for the service user, their children, and their family?

Adapted from Short and colleagues.³¹⁰

Panel 10: A survivor's perspective on survivor involvement

"I may not have the years of family violence training you do. I may not have a PhD, but I have lived it, I have survived it. I don't want to be viewed as someone who is damaged or traumatised. I want to be viewed as someone who has something of value and importance to contribute."

Jasmine

practitioners and survivors. Arbitrary uses of power and inflexibility within services can cause iatrogenic harm, such as limiting the accessibility of services.

An important omission from some definitions of trauma-informed approaches to care is that services are co-produced with and led by service users—survivors themselves are instrumental in bringing about change (panel 11). Similar to the early development of the recovery movement, in which mental health service users played an active role in advocating for change and redesigning services,³¹⁴ the development and embedding of trauma-informed approaches often has survivors working as clinicians, researchers, peer workers,

Panel 11: Readiness of mental health services to address IPV

None

No acknowledgment of the underlying role of IPV and sexual violence in mental health problems in policy or practice.

Low

Policy and practice documents discuss generic trauma-informed care but do not specify the role of IPV or sexual violence in mental health problems, and the organisation does not train staff specifically in these areas.

Medium

Policy and practice documents include discussion of IPV, gender, and safety issues. Training includes identification and response to IPV, trauma-informed care principles, gender, and safety issues.

Moderate

A change process has implemented IPV policy and practice, and staff are trained on IPV, gender trauma, and safety issues. The organisation recognises that everyone has a role in addressing IPV through a trauma-informed approach.

High

Throughout the organisation and among the clients served, individuals' strengths are recognised and partnerships are strong. The organisation aims to share power, encourage choice, and recognise that every person's experience requires an individualised approach to addressing IPV.

IPV=intimate partner violence.

and trainers to communicate what trauma-informed approaches are and why they are needed.³⁰⁸ Survivor involvement in service development should not require survivors to do large amounts of emotional labour drawing from their experiences. Instead, involvement should be empowering and liberating, creative and joyful, and should amplify the voices of survivors and promote self-care,³¹⁵ including by facilitating access to trauma-informed peer support.³¹⁶

Globally, however, many countries have few (if any) health-care professionals trained in mental health,³¹⁷ let alone in trauma-informed or survivor-centred approaches to care. 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.³¹⁷ It is imperative that overall access to, and quality of, mental health services is strengthened. Efforts to integrate mental health care into primary health care and to enhance the mental health-care skills of primary care providers, such as the Mental Health Gap Action Programme,³¹⁸ are essential, and should include efforts to improve identification of, and responses to, IPV.

WHO has done randomised controlled trials in low-income and middle-income settings of several interventions to reduce symptoms of common mental health disorders that can be delivered by trained and supervised non-specialists. For example, Problem Management Plus is a brief, transdiagnostic psychological intervention comprising problem management and other strategies that can be delivered individually or in groups. It has been formally tested in violence-affected communities (including women with a history of domestic violence) in Kenya and Pakistan, where it effectively reduced depression and anxiety symptoms and improved daily functioning (ie, ability to communicate, get around, care for oneself, complete work or household chores, and participate in society) compared with enhanced daily care.^{319,320} Self-Help Plus is an innovative, facilitator-guided, group-based, transdiagnostic stress-management intervention that uses pre-recorded audio and an illustrated self-help guide to communicate stress-management techniques to groups of up to 30 people. It both prevented the onset of mental disorders and resulted in meaningful reductions in psychological distress at 3 months compared with enhanced usual care among South Sudanese female refugees, including those who had experienced IPV.^{321,322}

Key knowledge gaps

High-quality evidence is needed to improve mental health interventions and service responses to IPV. Little research has been done to assess interventions for mental health service users who experience IPV. Trials in other settings suggest that useful interventions are likely to be strengths-focused, develop cognitive and emotional skills to address trauma-related symptoms, and include psychoeducation about IPV and attention to safety.²⁸³ Too little is known about how mental health services should assess, identify, and respond to service users who commit IPV, how to intervene to reduce risk, and whether and how culturally appropriate mental health interventions might help to reduce IPV. Future interventions could target modifiable risk factors (eg, medication for persecutory delusions, psychological interventions, treatment of comorbid alcohol and substance misuse) in combination with action to ensure the safety of potential victims among mental health service users for whom the use of abusive behaviours appears linked to these factors. Evidence is insufficient for how best to prevent children's re-exposure to IPV³²³ and for interventions that are safe, appropriate, and effective for children who live with ongoing abuse. Few studies of interventions delivered to adults who have experienced or who use IPV quantify the effects of reduced IPV on children's health and wellbeing.³²⁴ In all research on IPV, studies need to be done with greater rigour. Studies often have inadequate sample sizes, high attrition, or no meaningful controls (or no control group at all), do not include information on long-term

outcomes, or do not examine mediators and moderators sufficiently. Longitudinal research into the cumulative effects of different forms of violence across the life course is also needed and could help to identify opportunities for early intervention.

Trauma-informed approaches provide an opportunity to strengthen mental health service responses to IPV, but their implementation and sustainability should be studied. Future research into increasing access to high-quality mental health care to address IPV should include studies on the effectiveness of scalable psychological interventions and on different ways of delivering high-quality mental health services. Interventions and research that are co-designed with survivors are more likely to meet the needs of those with lived experience than those designed without survivor involvement.³²⁵ Survivor involvement is therefore needed in service development and assessment, including through research studies that are themselves trauma informed and survivor led. Such studies could involve testing increases in the mental health capacity of primary care providers, using lay providers, using mobile and wireless technologies to deliver psychological interventions, and increased integration of mental health and IPV services.

Part 6: Addressing gender inequality and societal responses to IPV

Introduction

In part 6, we aim to examine the relationship between gender inequality and IPV. We also discuss the pervasiveness of gender stereotypes across society, and the importance of survivor-led social movements in challenging all forms of violence against women and girls.

The causes of IPV are many, but gender inequality is a root cause. Gender inequality manifests at all levels, from relationships and the family to economics, politics, and civil society, and to how institutions respond to matters at a structural level.³²⁶ The risk of IPV appears to be highest in societies that are most unequal in terms of gender relations and where the use of violence against women is an accepted norm. Within mental health, disciplines such as psychiatry and psychology have their own norms that, if unexamined, risk replicating the misuse of power against people, particularly women and others who are discriminated against, who have experienced IPV. By changing gender norms and cultures of violence, and with the support and engagement of multiple systems—including mental health systems—it is possible to transform practices to promote gender equality, improve rights for women and other marginalised groups, and reduce IPV.

Gender inequality and IPV

Violence is both a cause and consequence of inequality in society. Inequalities drive violence against all disadvantaged people, including women and girls.³²⁷ Gender

inequality intersects with other disadvantages based on social class, ethnicity, religion, sexuality, gender identity, citizenship, disability, and age. The intersection of these inequalities is associated with complex patterns of violence and resistance to violence. IPV is thus part of a complex range of abusive experiences for women and disadvantaged or marginalised groups.

Although historically and cross-culturally the extent of gender inequality and violence varies across societies, the gendered inequalities that underpin IPV are present in all social systems and social institutions. IPV can be decreased by reducing gendered economic, political, and civic inequalities, and multiple institutions are relevant to efforts to prevent IPV. For example, gendered economic inequalities are correlated with increased prevalence of IPV,^{328,329} gendered inequalities in ownership of land and other property increase the prevalence of IPV,³³⁰ and women with less access to employment and home ownership are more likely both to experience any IPV and to experience more frequent and more severe IPV than employed women and women who own homes.^{31,199} Similarly, gendered inequalities in politics and civil society are associated with increased rates of IPV: countries with higher proportions of women in parliament have lower rates of femicide than those with lower proportions of female elected officials,³³¹ IPV is less acceptable in countries in which women contribute to the development of cultural institutions and to public debate,³³² and countries with strong feminist movements have more robust policies to prevent violence against women than those where feminist movements are less strong.³³³ Gendered welfare provision, including but not limited to specialised violence-against-women services, also reduces IPV³³⁴ by decreasing the vulnerability of potential victims and increasing resilience. Greater access to public housing increases victims' capacity to leave violent partners, and women who rent from public authorities report lower rates of IPV than those who rent privately.^{31,199}

The pervasiveness of gender-stereotyped and violence-supportive norms

Norms and beliefs supporting violence against women and girls are common and include male dominance and privilege, male rights to assert power over women, use by men of physical discipline to correct female behaviour and ward off future transgressions, use of certain types of violence in conflict, and the positioning of sexual intercourse as a man's right with a romantic partner, male sexual activity (and sometimes rape) as a marker of masculinity, and female provocation as a justification for violence.³³⁵ Men's gender-inequitable attitudes and hypermasculine behaviours are not consistently related to perpetration of IPV, and men's perpetration of IPV can vary substantially at the individual level even in highly patriarchal and gender-inequitable contexts.^{15,18} However, research done in a population-based sample of South

African men points to the clustering of violent behaviours and the performance of heterosexual masculinities, with the most violent men expressing hypermasculine attitudes and behaviours.¹⁷ Men's endorsement of sexist, heteropatriarchal, or sexually hostile attitudes is an important predictor of committing IPV.¹⁵ Research on cognitive distortions in offenders has also highlighted themes such as victim-blaming and male entitlement to use violence.³³⁶ Women and girls might be expected to tolerate violence to preserve the family unit or be held responsible for men's sexual urges. Although such norms might be more prominent in some cultures than others, such patterns are never a justification for othering or racism: sexist or misogynistic views about virginity, female sexuality, and motherhood are present in every culture and social class. Even within one society, there are many subcultures or microcultures in which violence might be culturally endorsed—especially if these social groups are male dominated and characterised by gender-restrictive norms (eg, college fraternities, the military, sports settings).³³⁷ Research suggests that very violent men are often strongly influenced by their peers.³³⁸

Gender-stereotyped and violence-supportive norms and attitudes permeate social ecology, and are woven into language, popular culture, mass communication, and institutions. This pervasiveness can lead to misleading and harmful social norms being repeated, reinforced, and psychosocially embedded, shaping attitudes, social scripts, expectations, and life chances. Historical representations of women as passive and incidental still rebound in contemporary life, and gender-based violence remains part of mainstream culture and media, with the continued use of tropes about love being linked to violence (eg, *Twilight*), representations of women as sexual objects (eg, "Blurred Lines"), depictions of women as being ambiguous about sexual consent (eg, *Poldark*), portrayals of women being harmed for transgressing social norms (eg, *The Godfather*), and the voyeuristic use of violence against women in film (eg, *Fatal Attraction*). Women continue to be sexually commodified in advertising, music videos, and elsewhere, with an increasing and harmful proliferation of sexualised images of girls.³³⁹ Young people are also increasingly exposed to violent pornography, which is associated with gender-based violence and distorted perceptions of sexual relationships.^{337,340} There are disturbing trends of media portrayals of alcohol, gun culture, hypermasculinity, restrictive gender norms, and the normative use of force to resolve problems—all risk factors associated with IPV³⁴¹—as glamorous, aspirational, or entertaining.

Cultural and institutional responses to IPV are often gender biased. Media reporting of IPV, including of intimate partner homicide, is frequently sensationalist or victim-blaming, or otherwise justifies the violence.³⁴² There is often too much focus on the negative consequences experienced by people who commit IPV, rather than the effects upon the people who have been

subjected to such violence. This erasure is amplified for those who are not stereotypically expected to be affected by IPV, such as men, gender minorities, people in same-sex relationships, older adults, people with disabilities, and people from marginalised ethnic or Indigenous groups, which in turn contributes to a failure to recognise and help these groups as victims of violence. Although there have been incremental gains in legislation to protect victims of IPV, conviction rates remain poor and the use of harmful stereotypes in courts is highly concerning.³⁴³ Furthermore, research has shown that the legal system does not consider how IPV increases vulnerability to suicide among victims or the risk of being murdered, with implications for the response of health and legal services in the identification and protection of victims and for the conviction of perpetrators.³⁴⁴

Gender-stereotyped norms within psychiatry and psychology

Disciplines such as psychiatry and psychology are not immune to structural inequalities or social norms and have not always examined their own practices or histories. Historians and social scientists claim, however, that these disciplines have roots in practices that minimised or denied violence,³⁴⁵ pathologised difference (particularly around racial heritage),^{346,347} and reinforced classism and patriarchal norms rather than seeing social oppression as pathogenic.³⁴⁸ Mental health systems have perpetuated stereotypes and, at times, been used as an instrument of social and political control (eg, to detain political prisoners and unmarried mothers in institutions, conversion therapy for homosexuality). Although no branch of medicine sits outside its cultural milieu, mental health research and practice have arguably been particularly vulnerable at times to exploitation by social and political power structures, with negative consequences for both service users and the profession.

Although many people benefit from using mental health services, it is essential to acknowledge this painful ancestry and to reflect on how harmful norms continue to shape responses to people who have experienced trauma and abuse. There are contemporary debates about aspects of mental health practice that variously interface between protection and coercive control. Although uncomfortable, these debates warrant serious attention, as services can repeat and perpetrate serious harms.³⁴⁹ Furthermore, traditional models of mental health problems might endorse victim-blaming and pathologise ways of responding to victims of violence (eg, by positioning traumatised victims of violence as mentally ill and thereby positioning their disclosures as potentially unreliable). This view of victims has often intersected with the legal system, where narratives about unreliable testimony can be used to discredit victims.³⁵⁰

In the wake of influential contemporary social movements, such as #BlackLivesMatter, #TimesUp,

#MeToo, and #EveryonesProblem, it is timely for mental health services to reflect upon and change organisational and professional cultures. Social movements voicing the concerns and demands of people who are often excluded from power have a long history in precipitating change. There is an urgent need for structural and societal shifts towards recognising and responding to IPV, for the development of richer and textured psychosocial perspectives, and for mental health services to realise their role in sociocultural change regarding violence. Although the primary institution focused on by this Commission is mental health services, we recognise that these changes need to occur across institutions. For example, the UK Domestic Abuse Act (2021) incorporates a more sophisticated understanding of coercive control but much more needs to be done to enhance public, police, and judiciary understandings of the nature and effects of this and other forms of abuse.

Promoting social change

Ecological perspectives on violence prevention allow for consideration of how social structures can mobilise and collaborate for change across cultures and contexts. In short, this change involves everyone coming together in collective effort. Health, criminal justice, security, faith, education, and civil society need to cooperate to promote sustainable social change, shifting the cultural consensus away from violence-supportive norms and towards gender equality.³⁵¹ IPV needs to be prioritised through all stages of the system, from strategic decisions and designing services with survivor input, to improving public understanding of IPV and how to stop it, and the micro-interactions that practitioners have with clients (which need to have a basis of empathy, belief, and psychosocial support, and to include referral to other services).

Mental health and other services have to adopt a clear, unequivocal stance that violence is unacceptable and need to work together to reduce the social determinants of health inequality and to improve gender and race equality indicators, such as women's income, educational attainment, occupational status, labour market participation, and equal pay. Oram and colleagues,²⁴⁵ for example, suggest roles for mental health professionals in the promotion and protection of women's right to live free from IPV and other forms of gender-based violence. They argue that mental health professionals should go beyond traditional forms of intervention to raise awareness of the effects of violence on mental health, challenge cultural norms within mental health services and wider society, identify and respond to violence experienced and committed by users of mental health services, and advocate for the funding of specialist services. Advocates should also consider whether and how changes in the wider policy environment might contribute to reductions in IPV. Increasing the price of alcohol has, for example, been endorsed by WHO as

the most cost-effective and targeted public health intervention to reduce alcohol-related harm (including IPV).³⁵²

Gender-transformative interventions: a promising evidence base

To prevent IPV, it is essential to reduce factors that increase the risk of IPV (eg, poverty, gender inequality, child maltreatment, scarcity of services) and to increase those that protect from IPV (eg, secondary education, economic empowerment). RESPECT Women, a framework for preventing violence against women, was developed by WHO and UN Women in 2019 and has been endorsed by 12 other UN agencies and bilateral partners.³⁵³ It aims to convey in a simple way a process for, and the evidence for, prevention to policy makers. RESPECT Women identifies seven strategies (which collectively spell out "RESPECT"): relationship skills strengthened, empowerment of women (economically, socially, and psychologically), services ensured (including health, legal or judicial, and social welfare services), poverty reduced, environments made safe (including schools, workplaces, and public spaces), child and adolescent abuse prevented, and transformed attitudes, beliefs, and norms. The quality of the evidence for each of these seven strategies is summarised in the framework and specific programmatic examples are provided, with a focus on low-income and middle-income countries.³⁵⁴ An important strategy of RESPECT Women is the transformation of gender attitudes, beliefs, and norms.

A wide spectrum of gender-transformative interventions aims to prevent IPV, ranging from small-scale interventions with groups of individual men to interventions designed to transform social norms.^{296,355–58} Rigorous assessments are lacking, but some evidence suggests that gender-transformative interventions (ie, those that explicitly address the norms, behaviours, and relations associated with masculinity rather than only specific behaviours or attitudes of individual men and boys) can have an important role in prevention of violence.^{358,359} Successful programmes to transform norms are delivered by trained and well supported staff over sustained periods, are participatory, engage multiple stakeholders, support critical dialogue about gender relationships (eg, by explicitly examining norms and behaviours, including those surrounding gender binaries, gendered power relations, and homophobia³⁶⁰), and improve communication and shared decision making within families.³⁵⁷ Some methods of behaviour and attitude change involve group mobilisation to challenge pluralistic ignorance (ie, when people tend to overestimate group support for harmful attitudes). However, interventions must be appropriately tailored: some men who commit violence will feel entitled to commit violence, that they are able to violate social norms, or that committing violence does not have consequences. Thus, interventions should be context

Panel 12: Key international commitments to ending intimate partner violence and other forms of gender-based violence

- 1945: The UN was established to foster better international collaboration, and has enshrined gender equality in its charter.
- 1976: The UN Development Fund for Women was established to provide technical and financial assistance for programmes and strategies to promote women's human rights, political participation, and economic security.
- 1979: The UN Convention on the Elimination of All Forms of Discrimination against Women was adopted as the most comprehensive international instrument to protect the human rights of women. The Convention legally bound signatory governments to end discrimination against women in public and private life, including the family. It also aimed to achieve equality between women and men, both legally and in everyday life.
- 1993: The UN Declaration on the Elimination of Violence against Women provided a framework for national and international action to address violence against women.
- 1993: The International Conference on Human Rights recognised women's rights as human rights, including the right to live a life free of violence.
- 1994: The International Conference on Population and Development's Programme of Action recognised the importance of women's sexual and reproductive rights as central to everyone's welfare.
- 1994: The Belém do Pará Convention was adopted by the Inter-American Commission of Women of the Organization of American States. It was the first legally binding international treaty to criminalise all forms of violence against women, especially sexual violence.
- 1995: The Declaration and Plan of Action of the Fourth World Conference on Women in Beijing included a chapter on violence against women and a chapter on women and armed conflict.
- 2003: The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) was established by the African Union to guarantee comprehensive rights to women, including the end of female genital mutilation and other traditional practices that are harmful to women.
- 2010: UN Women was established to exclusively champion women's rights, and includes reference to the right to live free of violence and coercion.
- 2011: The Council of Europe's Istanbul Convention committed to improve gender equality and recognised violence against women as both a cause and a consequence of inequality.
- 2015: The Sustainable Development Goals (2015) set the goal of eradicating violence against women and girls globally by 2030.
- 2016: The World Health Assembly endorsed the global plan of action to strengthen the role of the health system to address violence, particularly violence against women and children.
- 2017: The Convention on the Elimination of All Forms of Discrimination against Women launched recommendation number 35 on gender-based violence against women, which updated general recommendation number 19. The updates include expansion of the understanding of violence to include violations of sexual and reproductive rights and defining different levels of liability of states for acts and omissions committed by its agents or those acting under its authority to protect women and girls and to ensure access to remedies for survivors.

specific, constructively engage community leadership structures, police, health services, and social services, be backed by legal and policy shifts, and receive sustained funding. Addressing the precarious funding situation for services that work to prevent IPV and associated harms is essential. Awareness-raising campaigns are unlikely to be effective as standalone interventions.²⁹⁶ Change needs scaffolding across the social infrastructure, with an emphasis on prevention.³⁵⁷ Assessment of a global prevention programme has reaffirmed that poverty, patriarchal privilege, and patriarchal norms are key drivers of violence against women and girls.¹⁵ Longitudinal, high-quality ethnographic research is needed to develop effective and safe interventions to reduce the vulnerabilities caused by poverty and understand the nuances in experiences of inequality, exploitation, and abuse.

Momentum for change: collective determination and action

Understandings of IPV are changing as a result of the collective activism of people traditionally excluded from

power. Over several decades, feminist activism has demanded that IPV is reframed and recognised as a public health issue and that IPV's roots in gender inequality are understood and addressed, thereby forcing a societal shift away from the hidden or tolerated nature of abuse and towards prevention and recognition that violence is not inevitable. Although this fight is ongoing, there are increasing international and regional commitments to end IPV and violence against women more generally (panel 12).

Commitments in words must be matched by action. There is evidence of improvements, including the expansion of legal prohibitions against IPV, but there is still a long way to go.³⁶¹ There is now, for example, legal recognition of coercive control in England and Wales, and the UK Government has committed to ending violence against women and girls. Yet public funding for specialist IPV services in the UK has been reduced, including services for women from racial minorities, which were already underfunded.³⁶² There are concerns that even under the new UK Domestic Abuse Act³⁶³ women with insecure

immigration status will face major barriers to escaping violence and will lack rights and protections under the law.³⁶⁴ At the time of writing, the South African Government is consulting on a bill to amend the Domestic Violence Act of 1998, with plans to extend the definition of domestic violence to include the abuse of an elder or the exposure of a child to a violent domestic environment, and to recognise entry into a victim's workplace without consent as a specific act of abuse (eg, stalking or harassment) that can be presented in court application proceedings.³⁶⁵ However, concerns have been raised that victims might be exposed to retaliatory harm from perpetrators because of a provision that would make it mandatory for adults who become aware of domestic violence to report the violence to either a social worker or the police or risk a fine or imprisonment. Legislative progress in Canada has included amendments to the Divorce Act³⁶⁶ to address family violence, and Justice Canada has developed resources to assist family lawyers who are working with clients experiencing this form of violence. However, there is still an urgent need for health care, social services, and safe housing for people experiencing IPV, particularly in rural and remote areas and in Indigenous communities.

Moreover, the global COVID-19 pandemic has provided sobering evidence of how inequalities and vulnerabilities are magnified during times of social and economic crisis. Evidence suggests that IPV and child maltreatment have increased during the pandemic,^{367,368} and rates might increase further if post-COVID-19 austerity increases as recession forces women and marginalised groups out of the labour market, which would further increase inequalities and render these groups more vulnerable to IPV.³⁶⁹ Post-pandemic planning at the national and international level needs to address existing inequalities and enhance access to prevention and response services for IPV.

Conclusion

Understanding of the associations between IPV and mental ill health, and of how to prevent and respond to IPV and associated mental health harms, has greatly improved in the past decade, but gaps remain. In this Commission, we have appraised the available evidence and made recommendations both to improve this evidence base and to act upon what is already known. Our ambition is to prevent IPV and, in doing so, to decrease the prevalence of mental health problems in society. With scientific effort, coordinated action, and political will, there is not only opportunity for change, but an imperative to do so.

Contributors

LMH developed the original idea for this Commission. FC, PSC, CG-M, SF, HLF, KH, EH, LMH, HM, HLM, LKM, SOr, DR, MBR, KR, SS, AS, DT, and SW attended Commission meetings to discuss structure and content. HLF led the drafting of content on evidence for associations between IPV and mental health, with input from CA, FC, SF, and DR. HM led the drafting of content on IPV across the life course, with input from PSC, MH, SOr, and MBR. SS and SW led the drafting of content

on measurement of IPV, with input from PSC, CG-M, EH, KH, HLM, and AS. KH led the drafting of content on transforming mental health systems to address IPV, with input from CG-M, EH, HLM, LKM, SOr, AS, and DT. KR led the drafting of content on societal norms and IPV, with input from SW. All authors contributed to the first and second drafts of the Commission. SOr and HLF led the revision of the final draft, with contributions from all authors.

Declaration of interests

HLM was a member of the guideline development group for WHO's Clinical and Policy Guidelines on Responding to Intimate Partner Violence and Sexual Violence Against Women and received funds from the Public Health Agency of Canada as project lead for the Violence, Evidence, Guidance, Action project. SOr, LMH, MBR, HLM, and CG-M were members of the steering Committee for the World Psychiatric Association Curriculum on Intimate Partner Violence and Sexual Violence. LMH was a professional member of the NICE guideline on preventing and reducing violence. All other authors declare no competing interests.

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