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Physical and Mental Well-being, as Well as a Sexual Partner A Literature Review on Violence Against Women

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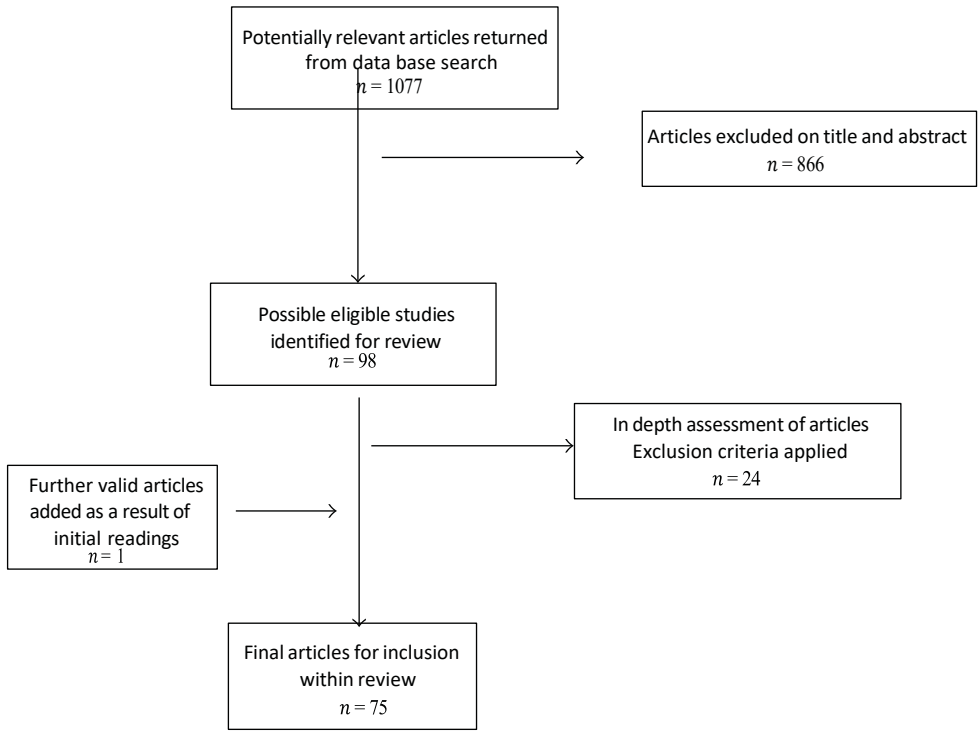
Abstract

Countless research in both domestic and foreign literature have shown that women's physical and mental health suffer when they are victims of intimate partner violence (IPV). The literature on this subject is reviewed in this study. Original research investigations and secondary assessments of primary data sources are both included in the 75 publications that make up this review. Quantitative and qualitative studies from developed and developing nations are included in the evaluated research articles published between 2006 and 2012. Depression, post-traumatic stress disorder (PTSD), anxiety, self-harm, and sleep difficulties were among the mental health concerns linked to intimate partner violence (IPV), however the frequency of IPV varies among cultural contexts. Using reliable instruments, these effects were noted in the majority of research. There was an association between IPV and a host of physical health issues, such as impaired functional capacity, somatic illnesses, chronic diseases, pain, gynaecological issues, and an elevated risk of sexually transmitted infections. A history of sexual assault or violent acts was shown to be linked to an elevated risk of HIV. Discussion centers on how the study's results relate to methodological concerns, their clinical relevance, and potential avenues for further research.

1. Introduction

No country is immune to the pervasive public health and social issue that is intimate partner violence (IPV). Within an intimate relationship, IPV is defined as "behaviour that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" according to a 2010 study by the World Health Organization [1, page 11]. Any intimate partner or spouse, present or past, might be considered violent under this criteria. The potential acute and chronic health implications of intimate partner violence (IPV) are becoming more recognised and understood, going beyond the physical trauma cases observed in acute care hospital emergency departments and primary care settings. Over the last 20 years, researchers from several fields have begun to examine the links between intimate partner violence (IPV) and many aspects of physical and mental health. This is shown by the growing number of research publications addressing the psychological effects and factors that contribute to intimate partner violence (IPV), such as post-traumatic stress disorder (PTSD) and similar disorders.

International agencies have started to fund research studies on IPV from the time that the United Nations General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1993 [2]. This is because international agencies recognise IPV as a global human rights issue that affects women across cultures [3-7]. The issue of intimate partner violence (IPV) has evolved from a legal and judicial system concern affecting individuals and families to a social problem that requires widespread acknowledgement and action. There is mounting evidence that the effects of intimate partner violence (IPV) may not end with the occurrence of abuse but may linger for a long time after it has stopped. Even narrowing the focus to health concerns, the mountain of literature on intimate partner violence (IPV) may lead to misunderstandings about



FIURE 1: Literature review selection process.

deducing the most probable links between IPV and its effects. Researchers have additional challenges while trying to evaluate the health of this group, further complicating matters. There is a lack of generalisability since studies often only use convenience samples (from shelters, clinics, etc.) and because there is worry about underreporting when community samples are included. Also, results from different research don't always add up because of how IPV is measured. This review study aims to summarise the current evidence on IPV and health by surveying recent studies. In order to draw conclusions on the trends and patterns of IPV's health effects and their correlates, this review compiles research from a variety of sources.

2. Selection Methods

Literature searches of three major online databases (Scopus, SAGE premier, and ProQuest) were undertaken, covering works written and published between January 2006 and June 2012. During this time frame, we were able to include the most current research in the area while still keeping the amount of reviewed literature reasonable. Using both "domestic violence" and "intimate partner violence" in the search criteria helped to avoid accidentally excluding studies that used a little different language for IPV. Domestic and intimate partner violence were used interchangeably with "physical health" and "mental health" since this article explores the correlation between the two. To accommodate every conceivable permutation of these search parameters, the Boolean operators "AND" and "OR" were included. In each database, we searched the title, abstract, and keyword lists. In Figure 1 we can see the steps involved in evaluating publications. Articles were first evaluated for relevance to this study by looking at the title and abstract. Then, after this, complete research papers for potential

TABLE 1: Settings and range of IPV prevalence for reviewed studies.

Setting	Studies (nn n nn)		Reported lifetime prevalence of IPV
	Number	%	Range (%)
Population studies	23	30.6	0.98–70.9
Domestic violence shelter[1]	14	18.7	100
Community sample	13	17.3	11.4–44
Primary healthcare	10	13.3	21.3–39
Mental health setting[2]	5	6.7	46.7–75.9
Emergency department	4	5.3	33.3–54
Health maintenance organisation (HMO)	2	2.7	34–46.4
Education setting	2	2.7	23–78.8
Court system	2	2.7	100

[1] Includes three comparative studies that recruited a sample of abused women from domestic violence shelters and a sample of nonabused women from the general community.

[2]One study from each of the following settings: psychiatric inpatient, psychiatric outpatient, substance abuse clinic, university-based research clinic for mental health problems following IPV, □psychiatric patients□ not specified whether inpatient or outpatient.

inclusion in the review, were accessed in order to conduct a more thorough evaluation of their relevance.

In determining relevant studies for this review, the following inclusion criteria were used.

(i) The article reported on an original study, either from primary research or original secondary data analysis.

(ii) Physical and/or mental health consequences or corre-lates of intimate partner violence were the main foci of the research.

(iii) The research focused on intimate partner violence against women, experienced at any point in adult-hood, except during the antenatal or immediate postnatal period.

(iv) The violence defined within the study was restricted to violence against women from a current or previous intimate partner.

(v) The full text of the research article had to be available in English.

(vi) The article had been published in a peer reviewed journal between January 2006 and June 2012.

This review only included studies that stratified their findings by gender, so that the health consequences of partner violence on women could be clearly recognised. Studies that reported on the health impacts of intimate relationship violence for both men and women were also included. Included in the exclusion criteria were studies that concentrated on women with particular health conditions (such as HIV-positive women) or who had experienced additional traumatic events (such as military veterans), as well as samples in which intimate partner violence (IPV) happened during pregnancy or the immediate postnatal period. Since this review did not aim to include teenage abuse or health economics, we also did not include studies that focused on high school students or adolescents.

Figure 1 shows that 1077 items were returned from the first database search using the given keywords. Using the aforementioned inclusion and exclusion criteria, these papers were evaluated based on their abstracts and titles. After removing 866 items in this round of the assessment, 211 articles remained for further consideration. Each of these studies had its full-text articles retrieved so that a more in-depth evaluation of their significance could be conducted. A further reduction of the number of publications for evaluation occurred when the defined inclusion and exclusion criteria were applied, resulting in 98 studies. Relevant results were extracted and summarised after reading and analysing each of these research. This procedure resulted in the removal of 24 articles from the review and the insertion of 1 paper. In the end, 75 papers were considered for inclusion in this review, and their results provide its foundation.

3. Findings

Setting of Reviewed Studies and IPV Prevalence. Table 1 summarises the study settings for the papers that were examined. A little over a third of the studies surveyed the general public, while over 20% gathered information from shelters for victims of domestic abuse. Medical research was conducted in several contexts, including primary care (13.3%), mental health (6.7%), emergency rooms (5.3%), and health maintenance organisations (2.7%).

The studies' reported lifetime prevalence of intimate partner violence varied greatly, as seen in Table 1. The prevalence varied from 0.98 percent in population studies to 70.9 percent in community samples, whereas it was 11.4 percent to 44.1 percent in population studies. A sample of undergraduate university students [12] found the greatest frequency of relationship violence at 78.8 percent. According to the reports, there was a 100% prevalence rate in research that enlisted women from domestic violence shelters or crisis centers for women who had suffered intimate partner abuse. who were seeking judicial protection orders from violent spouses.

The results of research carried out in industrialised nations were published in 55 of the 75 publications that were assessed, while the results from developing countries were provided in the remaining 20. The great majority of the investigations ($Zn\ Z\ nn$) relied on quantitative methods, while three used qualitative approaches and reporting, and two utilised a mix of the two.

4. Health Outcomes

The effects of intimate partner violence on mental health have been the primary focus of research. Out of the 75 papers that were examined, 38 (or 50%) focused only on mental health concerns, 24 (32%), on physical and mental health results independently, 9 (13%), on physical health outcomes alone, and 4 5%, on sleep disorders explicitly. Mental health outcomes (e.g., depression, PTSD, anxiety, suicidality, self-harm), self-perceived mental health (SMH), psychological distress (PSD), and the effect of intimate partner violence (IPV) on sleep quality (and sleep disorders) are described in this section in a sequential fashion. The effects of intimate partner violence on functional health, self-perceived impact on physical health, and chronic health issues are discussed in the second portion of the review, which focuses on physical health outcomes.

Section 4.1: Results for Mental Health. There were 66 research that addressed mental health issues in connection to intimate partner violence among the publications that were included in the review. Tabulated in Table 2 are the many mental health issues discussed in the articles that were evaluated.

Depression (4.1.1). Of the mental health issues related to intimate partner abuse, 42 out of the 153 papers examined reported on depression [10, 13–53]. The research conducted by Vos et al. [46] revealed that depression accounted for 34.7% of the overall IPV illness burden, highlighting the significant relative relevance of depression in relation to its effects on health as a consequence of IPV. Compared to the 27.3% caused by anxiety, 10.7% by suicide, and just 0.6% by physical injuries caused by IPV, this is a very small fraction of the illness load [46]. Of the women residing in shelters studied by Helfrich et al. [25], 51.4% had suffered from serious depressive disorder in the previous twelve months. As a comparison, just 2.4% of American women reported suffering from depression in the last year [25].

Of all the research that looked at the correlation between IPV history and depression, only one—in 2008, by Fedovskiy et al. [23]—found no significant connection. The results of this study of Latinas from the United States who participated in primary care indicated that there was a statistically significant (P $n\ n.PP$) increased risk of major depressive disorder among women who reported a history of intimate partner violence (OR 1.68) compared to those who did not report such a history.

Fedovskiy et al.[23] point out that their nonsignificant result runs counter to what other research have discovered and speculate that the high prevalence of major depressive illness in their sample could be a confounding factor hiding any real effects.

Significant correlations between IPV history and depres-sive symptoms were consistently documented in all the remaining examined investigations. There was an association between the intensity or persistence of violence and more severe depression symptoms, according to many research [13, 14, 16, 17, 40, 50]. Martinez-Torteya et al. [32] found the opposite to be true; they found that women's subjective assessments of the "stressfulness" of an IPV episode, rather than more "objective" metrics like frequency and intensity, were more strongly associated with depressive symptoms. Physical, sexual, and psychological/emotional abuse are the most prevalent forms of IPV, however other studies have reported on IPV as a whole or on specific types of violence. Multiple forms of abuse were associated with a higher risk of depression and a worsening of its symptoms [19, 21, 27, 37]. When asked about their experiences with abuse, women often mentioned more than one kind of violence, according to the majority of research. Pico-Alfonso et al. [37] discovered that psychological IPV was just as detrimental as physical IPV in terms of depressive symptoms in their research sample of Spanish women, among the studies that reported on depression and presented data on separate abuse categories. Among Chinese women surveyed by Wong et al. [10], psychological abuse was the strongest predictor of IPV-related depression. This research indicated that depressive symptoms were much greater in correlation with psychological abuse than physical abuse, although no such correlation was seen in regard to the frequency of physical abuse [10].

In a study conducted by Chen et al. [19] on Hispanic women in the United States, they found that women who had been sexually abused by an intimate partner had a significantly higher risk of developing depression (42.60, 95% CI: 2.39-758.61) compared to nonabused women and women with a history of physical (OR 10.28, 95% CI: 1.54-68.77) or psychological (OR 5.83, 95% CI: 2.11-16.16) abuse. The findings should be interpreted with care since the 95% CI for sexual abuse and physical abuse shows huge swings, which are caused by the limited number of responders in each category. Zlotnick et al. [49] examined the mental health recovery patterns of women who had experienced intimate partner violence (IPV) over a five-year period in a research conducted in the United States. After comparing women with and without IPV over the course of 5 years, they found that those who reported IPV at the beginning of the research continued to have higher rates of depression, functional impairment, poor self-esteem, and life satisfaction. According to their findings, there is little indication that women who stay in violent relationships have more psychological challenges than those who leave. Therefore, they deduced that IPV puts women at risk for many mental health issues in the long run,

TABLE 2: Reported mental health conditions following IPV (✓: statistically significant; ns: observed, but not statistically significant).

First author Year Reference number	Depression	PTSD	Anxiety	[1]Suicide/self-harm	Sleep disorders	[2]Poor self-perceived mental health
Alsaker, 2006 [63]						✓
Alsaker, 2008 [64]						✓
Ansara, 2011 [13]	✓		✓		✓	✓
Avdibegović, 2006 [14]	✓		✓			
Ayub, 2009 [51]	✓		✓			
Beck, 2011 [54]		✓				
Becker, 2010 [55]		✓				
Blasco-Ros, 2010 [15]	✓	✓	✓			
Bonomi, 2006 [16]	✓					✓

Carbone-López, 2006 [17]	✓					
Chandra, 2009 [18]	✓	✓				
Chen, 2009 [19]	✓					✓
Devries, 2011 [9]				✓		
Edwards, 2009 [68]						✓
Ehrensaft, 2006 [20]	✓		✓			
Ellsberg, 2008 [57]				✓		✓
Escribà-Agüir, 2010 [12]						✓
Eshelman, 2012 [21]	✓	✓		✓		
Fadardi, 2009 [22]	✓		✓			
Fedovskiy, 2008 [23]	ns	✓				
Fortin, 2012 [69]						✓
Hamdan-Mansour, 2012 [24]	✓					
Helfrich, 2008 [25]	✓	✓	✓			
Himelfarb Hurwitz, 2006 [26]	✓			✓		
Houry, 2006 [27]	✓	✓				
Ishida, 2010 [28]	✓		✓	✓		
Kim, 2011 [29]	✓					
Logan, 2007 [30]	✓	✓				
Lowe, 2007 [72]					✓	
Loxton, 2006 [31]	✓		✓			✓
Ludermir, 2008 [50]	✓		✓		✓	
Martinez-Torteya, 2009 [32]	✓	✓				
Naved, 2008 [58]				✓		
Nerøien, 2008 [33]	✓	✓				
Nicolaidis, 2008 [34]	✓					
Nicolaidis, 2009 [35]	✓					
Nur, 2012 [67]						✓
O'Campo, 2006 [36]	✓	✓				
Pico-Alfonso, 2006 [37]	✓	✓	✓	✓		
Rauer, 2010 [11]					✓	
Renner, 2009 [59]				✓		
Roche, 2007 [38]	✓					✓
Sansone, 2007 [61]				✓		

TABLE 2: Continued.

First author Year Reference number	Depression	PTSD	Anxiety	[1]Suicide/self-harm	Sleep disorders	[2]Poor self-perceived mental health
Sato-Dilorenzo, 2007 [39]	✓		✓	✓		
Savas, 2011 [40]	✓		✓			
Scheffer Lindgren, 2008 [41]	✓				✓	
Schei, 2006 [42]	✓					
Schneider, 2009 [43]	✓		✓	✓		
Stene, 2010 [52]	✓					
Straus, 2009 [65]						✓
Theran, 2006 [44]	✓					
Tomasulo, 2007 [66]						✓
Vachher, 2010 [45]	✓			✓		✓

Vives-Cases, 2011 [8]						✓
Vos, 2006 [46]	✓		✓	✓		
Vung, 2009 [47]	✓			✓		
Walker, 2011 [70]					✓	
Wong, 2011 [10]	✓					
Wong, 2011 [62]				✓		
Woods, 2008 [56]		✓				
Woods, 2010 [71]					✓	
Wuest, 2007 [53]	✓		✓			
Yang, 2006 [48]	✓			✓		
Yoshihama, 2009 [60]				✓		✓
Zlotnick, 2006 [49]	✓					✓

[1] Suicide/self-harm: includes suicidal ideation and attempts; acts of deliberate self-harm.

[2]Poor self-perceived mental health: low scores on mental health component of SF-36 and SF-12 instruments; reported psychological distress.

regardless of their decision on the abusive relationship's continuation or termination [49]. Chapter 4.1.1.Insomnia due to stressful events (PTSD). The occurrence of post-traumatic stress disorder (PTSD) in battered women was examined in fourteen papers included in this study [15, 18, 21, 23, 24–56; 25, 27, 30, 32–33, 36–37. The correlation between a history of intimate partner abuse and an elevated prevalence PTSD symptoms and diagnoses was consistently found in all investigations. Following adjustments for socioeconomic background, marital status, and race, O'Campo et al. [36] determined that, in comparison to never-abused women, IPV survivors had a 2.3-fold increased risk of developing post-traumatic stress disorder (PTSD). According to two other studies [23, 33], women who reported a history of intimate partner violence were almost three times more likely to fulfil the criteria for post-traumatic stress disorder (PTSD) than women who did not disclose a history of IPV. There was a large range in reported prevalence rates of PTSD among the studies that were analysed. Out of all the women who reported experiencing IPV, fourteen percent fulfilled the criteria for post-traumatic stress disorder (PTSD), according to an Indian research by Chandra et al. [18]. One study found that 16.2% of women surveyed from domestic abuse shelters in the US suffer from post-traumatic stress disorder.

in their study [25]. However, Woods et al. [56] found that 92.4% of women in a comparable sample of battered women from crisis shelters and the general population in the USA satisfied the criteria for a clinical diagnosis of PTSD. Another research including women from an HMO in the US indicated that among those with a history of IPV, 30.9% had symptoms that were compatible with PTSD, as opposed to 13.7% of women without an IPV history [36].

More severe and long-lasting maltreatment was associated with increased PTSD symptoms in women, mirroring the pattern in depression [18, 27, 56]. Multiple forms of maltreatment were also associated with increased PTSD symptoms [21, 27]. The percentage likelihood of suffering symptoms of post-traumatic stress disorder (PTSD) increased with the number of abuse types encountered, according to Houry et al. [27]. Compared to women without a history of abuse, those who had endured three forms of abuse were almost nine times more likely to develop post-traumatic stress disorder. only over double the risk of developing PTSD was seen in women who had experienced only one kind of abuse compared to those who had not [27]. Alonso Pico et al.

According to [37], the prevalence of PTSD alone was low in their research; rather, the majority of women showed signs of both PTSD and depression. Several other PTSD research also seem to support this [15, 18, 23, 36]. Fedovskiy et al. [23] makes note of this correlation between PTSD and depression by reporting that women with PTSD had a tenfold increased risk of also having high depression scores (CES-D scores of >15). The authors of the study propose that the co-occurrence of PTSD and major depressive disorder in their sample might be due to overlapping symptoms, particularly those involving anhedonia, sleep disruption, and concentration issues.

Chapter 4.1.2.Feeling anxious. The presence of IPV is often linked to feelings of anxiety. One hundred and sixteen studies [13–15, 20, 22, 25, 28, 31, 37, 39, 40, 43, 46] were included in this meta-analysis of anxiety. 50, 51, 53], while it was mentioned with other prevalent mental diseases, namely depression, in none of these investigations. According to Vos et al. [46], who studied the burden of illness related with IPV, anxiety accounted for 27.3% of the total and was the second most significant cause, behind only depression. Helfrich et al. [25] found that among women surveyed from a domestic abuse shelter in the United States, 77% had experienced anxiety in the last year. This is in contrast to the 6.1% female national average recorded in a health survey.

There was a significant correlation between a history of intimate partner violence and elevated anxiety levels in women, according to all sixteen research that examined anxiety. This correlation persisted even after controlling for age, education level, and wealth [22, 40, 43]. The intensity of state anxiety was greater in abused women with depressive symptoms, according to Pico-Alfonso et al. [37], who found a correlation between the two conditions. Anxiety symptoms were found to be more severe among women who had suffered more frequent, intense, or severe maltreatment, suggesting a dose-response relationship [13, 40, 50]. Section 4.1.3.Suicide and Self-Harm. In regard to a history of intimate partner violence, six studies reported on suicide attempts [9, 26, 39, 43, 45, 57] and twelve studies reported on suicidal ideation or thoughts [21, 26, 28, 37, 43, 45, 47, 48, 57-60]. All of these studies found that women who had experienced abuse at some point in their lives were more likely to have suicidal thoughts and to have attempted suicide.

Three reports[9,57,58] detailed the findings from the World Health Organization's multinational research on suicidal thoughts and behaviours among women and issues of domestic abuse. Devries et al. [9] focused on suicide attempts and found a statistically significant association between IPV and suicide attempts across all thirteen research locations in all nine nations. Among women who had been victims of physical or sexual violence, or both, Ellsberg et al. [57] found that those who had attempted suicide were nearly four times as likely and those who had thought about suicide three times as likely. This was based on a pooled analysis across all fifteen sites in ten countries. compared to women who had never been victims of intimate relationship abuse, to have attempted suicide at least once. Abused women were seven times more likely to have suicidal thoughts than nonabused women in this research population [26], and the reported adjusted odds ratios from a study of South Asian immigrant women residing in the US were even higher.

Vachher and Sharma [45] found that among urban Indian women, 22.3% had considered suicide at some point, 12.0% had such thoughts during the previous month, and 3.4% had actually attempted suicide. Women who had been victims of intimate partner abuse were statistically more likely to have suicidal thoughts and behaviours than women who had never been victims of such violence [45]. From a population-based research of women from Paraguay, Ishida et al. [28] examined the impact of various forms of violence on suicide thoughts. Psychological abuse was not a significant risk factor for suicidal thoughts among abuse victims who had experienced physical or sexual assault in the previous year, but emotional abuse was. When looking at abuse that occurred more than a year ago, the most detrimental impact was from sexual violence, suggesting that sexual abuse was more harmful and had a longer-lasting impact than the other two types of abuse [28]. In contrast, Naved and Akhtar [58] published findings from Bangladesh that spouse sexual assault was not linked to suicidal thoughts in either rural or urban research locations. Victims of intimate partner violence in China viewed self-harm as a way to release the painful emotions brought on by the abuse, or as a last resort to end their lives when they felt they had no choice but to endure the violence any longer, according to a qualitative study of this phenomenon [62]. Section 4.1.4.of the prevalence and health impact of IPV, commissioned by the WHO in 1997. It involved the collection of data from over 24,000 women at fifteen sites in ten countries: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania [4]. Memory loss, problems with concentra-tion, and dizziness were screened for in the World Health Organization questionnaires. Memory loss and problems with concentration were significantly associated with lifetime experiences of partner violence across all study sites in the WHO multi-country study [57] as well as in Japan [60] and Vietnam [47]. Dizziness was also reported as a condition associated with IPV history across several individual studies [33, 56, 57] along with reported neurological complaints [43].

5. Discussion

By determining which aspects of health are most strongly associated with IPV experiences across diverse populations, cultures, and age groups, this review contributes to the existing knowledge. Depression, post-traumatic stress disorder (PTSD), anxiety, suicidal thoughts, self-harm, insomnia, pain, respiratory issues, musculoskeletal issues, cardiovascular disorders, diabetes, and gastrointestinal symptoms are among the many psychological and physical symptoms and illnesses that women who have lived with violent partners are more likely to experience than other women. This is according to a systematic review and synthesis of the relevant literature. Another interesting finding is that there seems to be a dose-response connection between IPV and symptoms including depression, PTSD, anxiety, and suicidal thoughts; that is, the severity and frequency of IPV seem to be inversely proportional.

Health consequences and IPV prevalence may be seen in a broader context thanks to the publications included from various locations. The fact that several community and population-based studies consistently found substantial health issues, despite the fact that clinical settings are anticipated to report increased rates of health problems due to the participants' characteristics, demonstrates that the findings may be applied to a broader population. Researchers also found that IPV was more common

in healthcare settings compared to general populations. Nonetheless, IPV rates in many population-based research were as high as, or even higher than, those in the clinical samples. This was particularly true for studies conducted in impoverished nations and reported by the World Health Organization. Therefore, it is reasonable to assume that the studies included in the review cover a broad variety of IPV circumstances, providing a picture of IPV that goes beyond the limitations imposed by specific research settings. The inclusion of studies that used population, shelter, and clinical samples from diverse cultures and variations in IPV and health issue measurement methods do not change the consistent results that IPV is a significant human rights and health concern. reach the same conclusions [4, 5].

There is strong evidence to support the idea that having a history of intimate partner violence (IPV) is associated with poor mental health outcomes, which may continue even after the violence has stopped, as both longitudinal and cross-sectional studies have shown similar trends in health outcomes.

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