Chapter 7
Mental Health Consequences of Violence Against Women

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Introduction

Interpersonal violence occurs in both domestic and community situations, and includes acts of violence between people who are known to each other in families (domestic violence) or who are not related to each other (community violence). Domestic and community violence are transgressions of human rights. The World Health Organization defines domestic and community violence as intentional acts which might result in death and/or physical and psychological injuries and are always a misuse of power (Krug et al. 2002).

The Declaration and Platform for Action of the Fourth World Conference on Women, Beijing, 1995, defined gender-based violence as acts that *(. . .) result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life* (United Nations Entity for Gender Equality and the Empowerment of Women 1995). The United Nations Declaration on the "Elimination of Violence Against Women" (United Nations 1993) defines any act of violence against women in their families, the general community or perpetrated by the state as gender-based violence.

Millions of lives of women are lost by suicide, homicide, war and terrorism each year (World Health Organization 2002); however, this only represents one element of the consequences of gender-based violence. There are enormous economic losses due to injuries, medical treatment, law enforcement and reduced work productivity,

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but one of the most serious consequences is the major adverse effects on the physical and mental health of the victims of violence (World Health Organization 2002). It is a public health concern across borders and observable in all nations (World Health Organization 2002). Women are more likely than men to be subjected to most forms of violence across the lifespan and some forms of violence only occur among women (World Health Organization 2002). Gender-based violence is a very well established risk factor for mental health problems including depression, post-traumatic stress disorder and suicidal behaviours among girls and women across the life span (Astbury and Cabral de Mello 2000), as illustrated in the following examples.

Gender-based violence occurs in all societies, but especially in cultures in which women have low status and their rights are not respected.

Female Foeticide

Violent transgressions of the human rights of females begin prior to birth. Since the early 1980s – when ultrasound technologies, which could be used to determine foetal sex were first available – selective abortion of female foetuses has increased. It occurs predominantly in countries with a strong culturally determined family preference for sons rather than daughters, including China, India, Korea and Pakistan (Miller 2001). It is regarded as one of the leading causes of 'missing girls' or disproportions of males to females in the population. In India, it has been established that female foetuses conceived in families, which already have 1 or 2 female children, are most at risk of female foeticide (Jha et al. 2006). In China, Attané (2009) found in an investigation of the country's sex imbalance that the discriminatory practices of sex-selective abortion, and neglect leading to deaths of female babies, were the main contributors. These were related to responses to extreme poverty and pressure on couples to adhere to traditional values. In a case-control psychological autopsy study of young people who had committed suicide in a rural region of China, Zhang and Ma (2012) found adverse life events related to family relationships or health/hospital events in the previous year were apparent in the recent lives of at least half the women. Although the specific reasons were not investigated, young women who had committed suicide were significantly more likely than those in the control group to have had an abortion, possibly not as a matter of personal choice, in the previous year.

Childhood Abuse

One of the most common forms of violence experienced by girls is childhood abuse or maltreatment, which is defined by the WHO Consultation on Child Abuse Prevention as *all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in*

actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (World Health Organization 1999). Childhood abuse is generally considered in 4 classifications: physical abuse, psychological or emotional abuse, sexual abuse, and neglect (World Health Organization 2002). Witnessing interpersonal violence between adult caregivers is also regarded as additional form of child maltreatment (Gilbert et al. 2009).

The prevalence of child maltreatment differs considerably between and within countries (Krug et al. 2002). Different methods of ascertainment include self-report surveys of children who are old enough to describe their experiences, population–based surveys of parents about their use of harsh physical punishments, recalled abuse in surveys of adults, case reports and formal records of children referred to child protection authorities. These yield different estimates of the extent and severity of this problem (Gilbert et al. 2009; Krug et al. 2002). Official statistics are in general found to underestimate true prevalence, whereas self-reported data are considered to provide a more accurate indication, but are governed by the precision of sampling strategies used and the recruitment fractions achieved (Gilbert et al. 2009). In high-income countries it has been estimated that between 3.7 and 16.3 % of children experience severe physical abuse and up to 10.0 % neglect or emotional abuse annually. Between 5.0 and 10.0 % of girls (double the 5.0 % of boys) experience penetrative sexual abuse during childhood. In resource-constrained settings the situation is much worse. Data from the population-based World Studies of Abuse in the Family Environment (WorldSAFE) surveys conducted in Chile, Egypt, India and the Philippines suggested that 4.0–36.0 % of their children had experienced severe and 29.0–75.0 % moderate physical abuse in the form of harsh punishment (Krug et al. 2002) in the previous 6 months. In Africa, examinations of 30,510 students aged 13–15 years from schools in Namibia, Swaziland, Uganda, Zambia and Zimbabwe revealed that different proportions of students reported having experienced physical abuse, ranging from 27.0 % in Swaziland to 50.0 % in Namibia (Briere et al. 2009). The same high prevalence of physical abuse as in Namibia was recorded in a separate study in Viet Nam (Nguyen et al. 2010). Much of this abuse was the use of corporal punishments in schools and institutions. Although banned in some countries such as Israel, Sweden, Namibia, South Africa, Zimbabwe, Uganda, New Zealand, The Republic of Korea and Thailand, it remains legal in others (Krug et al. 2002).

Childhood prevalence rates of sexual abuse varies widely across, as well as within countries, depending on the definitions used (Krug et al. 2002), ranging from 15.0 to 30.0 % in population-based samples from Australia, New Zealand, Canada and the USA (Gilbert et al. 2009); to 33.0 % (both genders included) in Zambia (Brown et al. 2009). Females are more likely to report childhood sexual abuse than males in most of the world's regions, with prevalence ranging from 7.1 to 67.7 % in some South East Asia Regions (Andrews et al. 2004). Most studies have found an elevated risk of sexual abuse among girls, compared to boys (Brown et al. 2009; Gilbert et al. 2009; Krug et al. 2002). Different forms of childhood abuse and neglect of basic needs often co-occur and can become chronic with abuse being

repeated (Gilbert et al. 2009). Children in institutional care are especially vulnerable to abuse.

Child maltreatment is multifactorial determined, not just by individual caregiver or family characteristics, but also by those of the local community and wider society (Krug et al. 2002). There is consistent evidence that younger children, born prematurely or with a low birth weight or a disability are more vulnerable to maltreatment, probably because their needs are higher (Gilbert et al. 2009; Krug et al. 2002). However, these associations become insignificant when factors related to their families and communities are taken into account (Krug et al. 2002). Parents who are in a low socioeconomic position, with limited education, who have mental health problems, abuse alcohol and illicit drug or were themselves poorly parented and exposed to childhood abuse are more likely than others to maltreat their children (Briere et al. 2009; Gilbert et al. 2009). Abuse of children is more prevalent in neighbourhoods characterised by high crime rates, low community cohesion, and poor informal social networks with low economic and social resources (Gilbert et al. 2009; Krug et al. 2002).

Childhood abuse is a transgression of the child's human rights, and causes death, serious life-threatening injuries, other physical health problems and long term adverse consequences for education and employment (Krug et al. 2002; Brown et al. 2009; Gilbert et al. 2009; Greenfield 2010). There is in addition, consistent evidence from retrospective and prospective studies that childhood abuse results in serious mental health problems among victims not only during childhood, but also into adulthood (Anda et al. 2006; Krug et al. 2002; Briere et al. 2009; Brown et al. 2009; Gilbert et al. 2009; Greenfield 2010; Nguyen et al. 2010). It is estimated that about 5.0 % of mental disorders are attributed to physical abuse after controlling for family characteristics, but this is more than doubled to 13.0 % following sexual abuse, to which girls are especially vulnerable (Fergusson et al. 2008).

Anxiety and depression are the 2 most common forms of mental disorder experienced by victims of childhood maltreatment (Briere et al. 2009). Symptoms meeting Diagnostic and Statistical Manual of Mental Disorders-IV criteria for major depression are observed in a very substantial proportion (about 30.0 %) of abused children before they reach the age of 30 (Gilbert et al. 2009). Odds of depression among adolescents and adults who were abused as minors are 30.0–140.0 % higher than in individuals who have not experienced abuse (Gilbert et al. 2009). Maltreated children, also suffer from long-lasting post-traumatic stress disorders (PTSD) (Briere et al. 2009; Gilbert et al. 2009; Greenfield 2010; Krug et al. 2002; Widom 1999). In a prospective investigation of abused children 17 years after their maltreatment, PTSD as assessed by Diagnostic and Statistical Manual of Mental Disorders-III criteria, was found among about 20.0 % of the victims, which was twice the proportion among non-abused controls (Widom 1999). Among the victims, PTSD was more common with more severe forms of maltreatment, ranging from 17.0 % among neglected children, to 23.0 % among those who had been sexually abused (Widom 1999).

Additionally, there is an elevated risk of suicidal behaviours associated with childhood maltreatment (Gilbert et al. 2009). Results from a population-based study in New Zealand revealed that while only 1.0–3.0 % of adolescents and young adults

who had not been abused in childhood made suicide attempts, 11.0–21.0 % of their childhood abused counterparts did (Fergusson et al. 2008). Likewise, in a recent study of 8–18 year-old-children and adolescents in rural China there were increased odds of 1.69 for suicidal ideation and of 2.69 for suicide attempts among victims of sexual abuse, compared with non-sexually-abused participants after adjusting for age, education level, school type, parents' education attainment, and the family's socioeconomic status (Lin et al. 2011). Survivors of childhood maltreatment have been shown to be more likely to engage in risk-taking behaviours including alcohol or substance abuse than individuals who have not been abused (Briere et al. 2009; Gilbert et al. 2009; Krug et al. 2002).

There is also evidence of an association between child abuse and later psychological difficulties in capacities for self-regard and forming trusting relationships. These including chronically low sense of personal entitlement, tendency to self-blame, pessimism and expectations of rejection (Briere et al. 2009). There can be lasting difficulties in emotional regulation and tolerating ambivalence, especially in intimate relationships. Victims of childhood abuse can have impaired capability in appraising risk and danger, including making judgements about the risks posed to them by others and self-awareness is often limited (Briere et al. 2009).

It is difficult to elucidate the effects of any individual form of child maltreatment on victims' mental health, as it is more common to experience multiple rather than single forms of childhood abuse (Gilbert et al. 2009). However, current evidence supports the association between the more elevated risks of mental health-related problems and more severe forms as well as with multiple forms of maltreatment (Andrews et al. 2004; Fergusson et al. 2008). The most severe mental health symptoms and degree of disability have been associated with exposure to 4 or more types of child maltreatment, compared with exposure to fewer forms of child abuse (Finkelhor et al. 2007).

Sexual abuse is especially damaging to mental health. Girls who have experienced genital contact or sexual penetration, perpetrated by a family member or known caregiver (especially if it occurs repeatedly and over sustained periods) are at highly elevated risk of mental health problems including depression, anxiety, substance abuse and co-morbid occurrence of these conditions in adolescence and adulthood (Astbury and Cabral de Mello 2000; Finkelhor et al. 1990). Seriousness and chronicity of exposure to childhood sexual abuse and severity of mental health problems have a dose response relationship (Krug et al. 2002).

Female Genital Mutilation

Female genital mutilation (FGM) is defined by the World Health Organization as *all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons* (World Health Organization 2012).

There are 4 types of FGM: excision of the prepuce and part or all of the clitoris; removal of the clitoris and part or all of the labia minora, infibulation which is the excision of the female genitalia and the use of stitches or other techniques to close the wound leaving only a narrow opening for the flow of urine or menstrual blood and other harmful procedures for non-medical purposes, like pricking, piercing, incising, or placing herbs or caustic agents into the vagina (World Health Organization 2012). It is carried out at a range of ages from a few days after birth, at 8–10 years, prior to marriage or after the birth of a first child, depending on setting and local cultural beliefs and practices (Ball and Ball 2008; Ogunsiji et al. 2007; Utz-Billing and Kentenich 2008). Approximately 140 million girls and women alive today have experienced some form of this procedure and at least 2 million are at risk or are subjected to it each year; children are the most vulnerable (World Health Organization 2012). The practice is most common in the countries of sub-Saharan Africa, some in the Middle East including Egypt, Oman, Sudan and Yemen and in Indonesia and Malaysia (Ogunsiji et al. 2007; Utz-Billing and Kentenich 2008). Female genital mutilation is a public health concern, violating the human rights of girls and women and threatening their lives (World Health Organization 2012).

There are immediate, short and long-term adverse physical consequences of FGM including physical and mental health consequences. Physical consequences are bleeding, anaemia, severe pain, acute and chronic genito-urinary infections. Septicaemia and gangrene even death (Ogunsiji et al. 2007; Utz-Billing and Kentenich 2008). In 1994, Toubia (1994) reported clinical observations of chronic symptoms of the common mental disorders of depression and anxiety, in particular associated with gynaecological dysfunction. Young women, who want to conform to parental and societal expectations by complying with FGM, but who are thereby exposed to fear, pain, complicated recovery and possible long-term health problems experience psychological conflict. Their trust in family members may be seriously jeopardised (Baron and Denmark 2006). Lightfood-Klein and Shaw (1990) interviewed women and health care providers in Sudan, and found that anxiety was associated with obstructed menstrual flow and both anticipation of and actual experience of painful intercourse. Some women reported intensely traumatic memories of their first experience of sexual intercourse after marriage. Chalmers and Hashi (2000) interviewed 432 Somali women who had previously experienced genital cutting and were now living in Canada. Participants recalled intense fear, severe pain, and being seriously ill. In countries where genital cutting is not commonly practised or is illegal, women who have had FGM fear that the quality of obstetric care provided by health professionals may be compromised by their lack of experience (Lightfood-Klein and Shaw 1990; Vangen et al. 2004). Pelvic examinations may be experienced as humiliating or offensive especially if conducted by male practitioners.

In Senegal, 47 women from Dakar (half of whom had experienced FGM), completed semi-structured interviews about the events of circumcision and their reactions to it and structured psychiatric diagnostic interviews (Behrendt and

Moritz 2005). FGM had taken place between the ages of 5 and 14 years and, when interviewed, participants were aged 15–40 years. The events of circumcision were recalled as 'appalling and traumatic' by most and intrusive re-experiencing in the form of thoughts and images was almost universal. Overall, 80.0 % met current criteria for depression and anxiety and 30.4 % for posttraumatic stress disorders. In the non-circumcised group, only one person had symptoms of mood disorder and none had PTSD (Behrendt and Moritz 2005). Elnasha and Abdelhady (2007) surveyed 264 newly married women, 75.8 % of whom had been circumcised, in Benha, Egypt. Overall, 40 (20.0 %) of the circumcised group had been married by the age of 20, while none of the non-circumcised group had married in adolescence. The circumcised group had higher rates of somatisation, general anxiety and phobias than the non-circumcised group. In a descriptive review (Utz-Billing and Kentenich 2008) concluded that psychosomatic disorders such as sleeping difficulties, nightmares, excess eating or loss of appetite, weight loss or gain and concentration difficulties were common consequences of FGM.

Psychosexual functioning including sexual desire and sexual pleasure may also be adversely affected (Lewnes 2005). Women who have been infibulated may have difficulty having sexual intercourse, as a result of a narrowed introitus (Johansen 2002). Odoi et al. (1997), compared 76 women who had undergone FGM, with 119 who had not. All were attending hospital clinics in northern Ghana. They found that FGM was associated with a threefold increase in postcoital bleeding and a twelvefold increase in anorgasmia.

In settings where FGM is the norm, women who refuse to undergo the procedure may also experience adverse psychological consequences (Baron and Denmark 2006), including social exclusion, being regarded as unmarriageable and as having brought shame or dishonour to the family (Baron and Denmark 2006).

Trafficking for Sexual Exploitation

The United Nations defines human trafficking as *the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation [can]… include, prostitution or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs* (United Nations 2000).

Despite the methodological difficulties in establishing the magnitude of human tracking (Gajic-Veljanoski and Stewart 2007), it is estimated that about 0.6–0.8 million people, mostly girls and women, are trafficked trans-nationally each year for the primary purpose of sexual exploitation (United States of America: Department of State 2006). However, this figure only represents a small proportion of the

potential total as millions of people are trafficked within their own countries (United States of America: Department of State 2006).

Victims of trafficking for sexual exploitation commonly experience multiple deceptions by traffickers (Gajic-Veljanoski and Stewart 2007; Zimmerman et al. 2008). Promises of employment and improved incomes are common and take advantage of women's potentially limited understanding of jobs they have not heard of, for example as 'nannies' or 'exotic dancers' (Gajic-Veljanoski and Stewart 2007; Zimmerman et al. 2008). Risk factors for becoming victims of tracking are poverty, unemployment and lack of awareness, which are increased among those who have received little education, are young or are in disadvantaged personal circumstances like being a single mother (Gajic-Veljanoski and Stewart 2007).

In a study conducted among 47 women trafficked for sexual purposes in Nepal, almost a third had experienced food instability, physical or sexual abuse or rape during their childhood and almost 1 in 5 had been homeless (Cwikel et al. 2004). Zimmerman et al. (2008) conducted a survey of 192 women who had accessed post-trafficking services in 7 European countries. They found an even higher prevalence: 59.0 % had experienced pre-trafficking exposure to abuse (Zimmerman et al. 2008). In some settings, prostitution is regarded by family members as an acceptable solution to poverty, and that there is status in sending a daughter or wife to a high-income country even if it is to be exploited (Aghatise 2004).

In addition to the risks imposed by sex work, multiple forms of violence are experienced during the trafficking period (Schloenhardt and Klug 2011). Psychological abuse in the forms of threats either against the woman or her family; extreme social isolation; severe physical violence including hitting, kicking, torturing and using weapons; and sexual violence are prominent among this population, being reported by more than 90.0 % (Cwikel et al. 2004; Hossain 2010; Zimmerman et al. 2008).

Working intensively for long hours most days of the week, including during menstruation, is common. About 70.0 % of the 47 trafficked sex workers who participated in Cwikel et al. study (2004) reported being forced to work every day and having to service at least 10 clients per day. Unsafe sex practices were widespread. While condoms are used during vaginal intercourse by most of the participants in Cwikel's study, a much smaller proportion (about 50.0 %) reported using this protection for oral sex (Cwikel et al. 2004). Clients' preferences in this situation are paramount (Schloenhardt and Klug 2011). Most of the women have poor living conditions and language difficulties and fear deportation if they approach local authorities for assistance (Gajic-Veljanoski and Stewart 2007; Schloenhardt and Klug 2011).

There are serious health consequences for women of being trafficked for sexual exploitation. Nearly two third of the 204 trafficked girls and women, who received care in 7 European post-trafficking sites in 2004–2005 in Hossain et al.'s study (2010), reported serious injuries. Unintended pregnancies, abortions and sexually transmitted diseases, including HIV/AIDS, were common (Beyrer 2001; Gajic-Veljanoski and Stewart 2007; Schloenhardt and Klug 2011). The problems were

worsened further by having limited access to health care (Busza et al. 2004; Gajic-Veljanoski and Stewart 2007).

The mental health burden of sexual exploitation is profound. Anxiety, depression and post-traumatic stress disorders (PTSD) are among the most common mental disorders reported in research about trafficking victims (Cwikel et al. 2004; Gajic-Veljanoski and Stewart 2007; Hossain et al. 2010; Schloenhardt and Klug 2011; Zimmerman et al. 2008). In Hossain et al.'s study, 80.0 % of the participants were experiencing at least one of the common mental disorders of depression, anxiety and post-traumatic stress disorder and more than half had all 3 disorders (Hossain et al. 2010). Tsutsumi et al. (2008) investigated the prevalence and determinants of symptoms of depression, anxiety and posttraumatic stress disorder (PTSD) in female victim survivors of trafficking aged 15–44 in Kathmandu, Nepal, rates of depressive and PTSD symptoms were high in women forced into sex work. All had clinically significant depressive symptoms, 97.7 % anxiety symptoms and 29.5 % symptoms indicating PTSD.

Co-occurring alcohol and substance misuse among trafficked women are common (Ostrovschi et al. 2011). It is common for women in these circumstances to contemplate suicide as a means of escape. In Cwikel et al.'s study (2004), 47.0 % had suicidal ideas and 20.0 % had committed acts of self-harm at least once. Overall, female victims of trafficking have been shown to have more severe mental health problems than victims of other crimes (Clawson et al. 2003; Gajic-Veljanoski and Stewart 2007).

There are lasting adverse consequences for mental health, which do not improve spontaneously once the trafficking victim has returned to her country of origin. Using diagnostic psychiatric interviews, Ostrovschi et al. found that nearly 90.0 % of the 120 trafficked and sexually exploited Moldavian women, who had returned to Moldova, were psychologically distressed 1–5 days after arrival and more than half had a diagnosable mental disorder 2–12 months after return (Ostrovschi et al. 2011). The most common mental disorders were co-morbid PTSD and mood disorders (Ostrovschi et al. 2011).

Forced Marriage

Marriage without "full and free consent" or where duress involving physical, financial, or emotional violence, kidnapping, and threats to harm or kill are used to enact the marriage or to seek consent is regarded as a forced marriage (Chantler 2012). Forced marriage, therefore, is considered a form of gender- based violence (Chantler 2012; World Health Organization 2002).

In some South Asian and Middle Eastern countries forced marriage is common, often involving marriage among relatives and arranged marriages where the bride and the groom only meet each other after the wedding ceremony (Chaleby 1988). In some countries arrangements for marriage are made at or before the birth of the baby girls (Ouattara et al. 1998). It is estimated that in Niger up to a third of girls are

married, usually without choice by the age of 15 years (United Nations Children's Fund 2012). Even where some form of consent is given by a young woman to an arranged marriage, it is not usual in most high-income settings for a person under the age of 18 to be regarded as sufficiently mature to give informed consent to a contractual commitment (Chantler 2012).

Child brides are deprived of educational opportunities (Ouattara et al. 1998). After marriage, girls, who often move to their husband's parents' household in this circumstance, occupy a very low social position, have a huge domestic workload and can experience criticism and hostility from their in-laws (Ouattara et al. 1998). Pregnancy during adolescence in these settings is risky because physical growth is not yet complete and maternal anaemia and malnutrition are common. Adolescent mothers are also at risk of stillbirth and injuries of the genital tract, including genitourinary and/or anorectal fistulae. These lead to urinary and faecal incontinence which, when untreated, can lead to social ostracization and marginalisation (Fisher et al. 2011). A study among 120 Nigerian women with genitourinary fistulae whose age ranged from 10 to 36 found that a large proportion were experiencing social exclusion and many were 'mentally depressed' (Kabir et al. 2003).

The psychological impact of forced marriage has not been investigated comprehensively, but young women in this circumstance experience multiple risks to mental health (Chantler 2012). Sexual intercourse in forced marriage is against the will of the woman, and is, therefore, a form of sexual gender-based violence (Ouattara et al. 1998). In Calcutta, India, for some victims of very early marriage (before age 15), sexual intercourse happened prior to menarche, recalled as horrifying even years afterwards (Ouattara et al. 1998; Sen 1997). Although half of these young women informed their partners of their unwillingness to have intercourse and told them that it was painful, for most, forced sexual intercourse continued.

Some girls attempt to escape from the forced marriage (Ouattara et al. 1998). If these women are found, they face risks of severe violence from their families (Ouattara et al. 1998).

Intimate Partner Violence

Intimate partner violence (IPV), which is defined as *behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours* (Krug et al. 2002) IPV is a serious public health problem, worldwide (World Health Organization/London School of Hygiene and Tropical Medicine 2010).

There is increasing evidence about the scope and extent of IPV. In a WHO Multi-Country study on IPV against women there were wide inter-country variations in lifetime prevalence of physical violence from current or ex-husbands or boyfriends: 13.0 % in Japan to 61.0 % in Peru, with most countries in the range 23.0–49.0 % (Garcia-Moreno et al. 2006). Co-occurrence of violence was widespread: 94.0 % of women experiencing physical violence also experienced verbal

insults and humiliations and 36.0 % forced sex. More recent studies using comparable methods from resource-constrained countries have found even higher prevalence (Abeya et al. 2011; Zakar et al. 2012). Nearly 76.0 % of the total 373 married women aged 16–49 in Lahore and Sialkot in Pakistan, who participated in Zakar et al.'s study, reported being psychologically abused by their partner across their lifetime (Zakar et al. 2012).

Intimate Partner Violence is multifactorially determined including by cultural and social factors (Abeya et al. 2011; Dixon and Graham-Kevan 2011). Risk is higher among the poorest women, who have low educational attainments, live in rural rather than in urban areas, have been married by "abduction" (Abeya et al. 2011) as an adolescent, are in a polygamous marriage, or have witnessed IPV between their parents. IPV is most common in settings in which women are devalued and discriminated against and in those where strong gendered-role restrictions prevail (Abeya et al. 2011; Afifi 2009; Akmatov et al. 2008; Dixon and Graham-Kevan 2011; Oshiro et al. 2011; Raj et al. 2010; Santhya 2011; Speizer 2010; Speizer and Pearson 2011).

Not only are the victims' human rights transgressed, but their physical and mental health are seriously affected by IPV. Women experiencing IPV are more likely to have unintended pregnancies, to report poorer physical and reproductive health and to have elevated rates of sleeping and eating disorders and sexually transmitted diseases, including being HIV-positive (Jejeebhoy et al. 2010; Stephenson et al. 2006; Vizcarra et al. 2004; World Health Organization/London School of Hygiene and Tropical Medicine 2010; Zakar et al. 2012).

Mental health problems such as post-traumatic stress disorders (PTSD), depression, anxiety, suicidal behaviours and other emotional distress are more commonly experienced by female victims of IPV than their non-victim counterparts (Devries et al. 2011; Jejeebhoy et al. 2010; Ludermir et al. 2008; Vizcarra et al. 2004; World Health Organization/London School of Hygiene and Tropical Medicine 2010). A study conducted among 2,128 Brazilian women in the age range of 15–49 years found that the rates of symptoms of common mental disorders, as measured by the Self Reporting Questionnaire (SRQ-20), were more than twice as high among those exposed to IPV (physical, or psychological, or sexual abuse), than among those who had not been (Ludermir et al. 2008). For those who experienced all 3 forms of IPV, the risk was tripled: 62.9 % as opposed to 19.6 % (Ludermir et al. 2008). Pico-Alfonso et al. (2006) compared the mental health of 130 women recruited from a women's shelter with 50 recruited from community-based clubs and living in non-violent relationships. When the effects of lifetime victimisation were controlled, women who had experienced psychological abuse, with or without physical violence had a higher incidence and severity of depressive and anxiety symptoms, PTSD, and thoughts of suicide than women in the comparison group. Sexual violence in association with any other form of violence was associated with more severe depressive symptoms and suicidal behaviours. PTSD was rarely observed as the only psychological morbidity and most commonly co-occurred with depression and state anxiety (Pico-Alfonso et al. 2006). Increased risks of memory loss, sleeping difficulties and suicidal behaviours were also recorded in the WHO Multi-Country

Study on Domestic Violence Against Women (Ellsberg et al. 2008). Victims of IPV were at nearly 3 times higher risk of having suicidal thoughts and almost 4 times at higher risk of committing suicidal acts than their non-abused counterparts (Ellsberg et al. 2008). The risk of suicidal behaviours was elevated by exposure to IPV, even after controlling for the potential confounding factors of age, educational attainment, marital status, history of childhood abuse, witnessing IPV between their own parents, non-partner violence, alcohol abuse and family support (Devries et al. 2011).

A study conducted among 2,876 women sampled randomly from a health plan in the USA found increased proportions of women with severe depressive symptoms from the group who were not abused (6.3%) to the groups who experienced physical IPV only (13.7 %), sexual IPV only (21.5 %) and both physical and sexual abuse (25.5 %) (Bonomi et al. 2007). Compared with victims of physical IPV alone, victims of sexual abuse and of combined physical and sexual IPV abuse had elevated risks of severe depressive symptoms even after controlling for age, socioeconomic status and history of childhood abuse (Bonomi et al. 2007). More deleterious effects of the addition of sexual abuse on women's depression scores and the incidence of suicidal attempts was also observed in Pico-Alfonso et al.'s study (2006). In a recent review, Beydoun et al. (2012) examined 37 studies conducted in both low and high income settings. The review concluded that there is a two to three-fold increased risk of major depression among women reporting exposure to IPV compared to those who have not had this exposure.

IPV during pregnancy increases the risk of common perinatal mental disorders among mothers (Fisher et al. 2010, 2012; Groves et al. 2012; Jejeebhoy et al. 2010; Karmaliani et al. 2009; Rico et al. 2011; World Health Organization/London School of Hygiene and Tropical Medicine 2010), and is also associated with higher rates of low birth weight and child mortality among their offspring (Jejeebhoy et al. 2010; Rico et al. 2011; World Health Organization/London School of Hygiene and Tropical Medicine 2010). In a study conducted in Viet Nam, the prevalence of common perinatal mental disorders was found to be doubled among victims of IPV, compared to their non-victim counterparts, 49.2 % as opposed to 25.4 % (Fisher et al. 2010). With a sample of 1,500 pregnant women in Durban, South Africa, Groves et al. (2012) also found an increased risk of emotional distress among those who were exposed to physical, psychological, or sexual abuse, compared to those who were not. Exposure to IPV increases the likelihood that women will have high-risk health behaviours including smoking, alcohol consumption and substance abuse (Jejeebhoy et al. 2010; Vizcarra et al. 2004).

Women who live in poverty are more likely to experience IPV. A study conducted among 19,000 women in the USA found a two-fold increased risk of experiencing IPV among women with an income of less than USD 25,000, compared to those with higher incomes (Vest et al. 2002). This increased risk was also observed in prospective studies of the relationship between poverty and experience of IPV. Victims of IPV, with low income, were more likely to be re-abused after 2 years, than their peers who had higher incomes (Bybee and Sullivan 2002). IPV survivors, in addition, were less likely than other non-victims of the same

socioeconomic status to have stable employment (Browne et al. 1999), due to problems like a partner's harassment at a work place and injuries due to physical abuse (Goodman et al. 2009). Unstable mental health and mental health-related disorders also prevented women from obtaining and retaining stable employment (Goodman et al. 2009).

Exposure to IPV coupled with poverty contributes to powerlessness, social isolation and marginalisation among women (Goodman et al. 2009). Many survivors have little support from families, or social networks. Social protection services are often perceived as difficult by women who were exposed to IPV because these services are difficult to access (Goodman and Epstein 2008; Laughton 2007). Uptake of mental health services among IPV-victims is often low, especially among members of ethnic minorities who might not speak the dominant language (Rodriguez et al. 2009).

Sexual Violence Against Girls and Women During Armed Conflicts

During and in the aftermath of armed conflict, it has been common for armed groups to loot, pillage and rape with impunity, treating women as the "spoil of war" (United Nations 2008). Although not a recent phenomenon, mass rape of girls and women was witnessed and documented following recent wars in Bosnia, Rwanda, Democratic Republic of Congo and Sierra Leone. In response to these recent wars, the UN Security Council unanimously adopted, in 2008, Resolution 1820, which recognizes sexual violence as a weapon of war and calls for its cessation. Sexual violence in wars is profoundly damaging to women, not only because of the direct physical and psychological consequences of rape, but also because of the consequences of stigmatization of survivors. In many settings survivors are regarded as unmarriageable, or are accused of adultery and rejected by their husbands. Women who conceive are accused of damaging family honour and are frequently ostracized.

The mental health consequences of war-related sexual violence were examined in 573 women living in displaced person's camps as a result of war in Northern Uganda. Overall, 28.6 % had experienced at least one form of sexual violence. Being younger than 44 and Catholic (thought to be taken as an indicator by perpetrators that the victim was less likely to be HIV positive) increased risk of violence. Gynaecological morbidities were common among victim-survivors and 69.4 % had significant psychological distress (Kinyanda et al. 2010).

Neighbourhood Violence and Women

Neighbourhood violence, which involves witnessing, hearing about or being directly exposed to community violence involving serious injury or death or hearing gunshots, observing fights, knife attacks and shootings. It increases the likelihood of experiencing common mental disorders among women even when the effects of intimate partner violence and neighbourhood poverty are controlled for (Clark et al. 2008). Gracia and Herrero (2007) investigated attitudes towards reporting gender-based violence among a nationally representative sample of 14,994 people in Spain or Spanish people in the USA. They found that people in neighbourhoods with high social disorder had less favourable attitudes to reporting violence against women. They conclude that where disadvantage and social disorder are concentrated in neighbourhoods there is less trust or willingness to assist others, including women in perilous personal predicaments.

Conclusion

Women are disproportionally exposed to violence over the lifetime. Structural determinants of this exposure of women are those related to inequalities in the distribution of power, income, goods, and services within a country. Gender-based violence is an indicator of the lower social position occupied by women worldwide. The roles and rights of women have undergone major change in some parts of the world, but women's rights to equality of participation; reproductive choice; freedom from discrimination and, most importantly, personal safety are not recognized universally. Gender-based violence is more prevalent in settings in which disparities in the rights and opportunities of women and men are most marked. Many women's day-to-day lives are characterised from the beginning by interpersonal violence. These include female feticide, female genital mutilation, forced marriage, adolescent marriage, polygamy and honour killing. As illustrated in this chapter gender-based violence is one of the predominant contributors to psychological morbidity in women.

Multiple levels of determination contribute to the existence, perpetuation and effects of violence against women. Macro level or social contextual variables interact with the characteristics of individuals and groups and these interrelationships require multilevel analyses and action for the reduction of violence against women. Isolated approaches to the reduction of violence are unlikely to be effective.

Psychological problems in the long term are not however inevitable. As outlined in the section Intimate Partner Violence, interventions and support for individuals are possible in a variety of settings and there is growing evidence that these can be effective in permitting women to recover. Strategies need to be developed by health care providers, educators and others concerned with reducing the incidence and

impact of violence on women, to reduce women's social isolation, enhance social support networks and increase access to opportunities for experiencing competence, autonomy and success in all domains of life. More research is also needed on the qualities of courage, resilience and capacity for recovery from violence that are apparent among many women.

Any comprehensive plan to improve women's mental health will involve action to:

- improve policies and legislation,
- provide direct interventions through population based strategies to ensure that adequate, affordable and accessible health care and community support services are available,
- give support to the development of grassroots activities, and
- use media based strategies to influence awareness of issues in the general public and the decision makers.

Every effort must be made to improve the status of women, to remedy the human rights abuse deriving from gender based violence and to increase women's control over the determinants of their health.

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