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Connections between family violence and violence in the public sphere in Afghanistan

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Afghanistan has endured over four decades of violence in the public sphere, such as war and suicide attacks. To effectively provide psychosocial counseling using a psychodynamic approach in Afghanistan, it is crucial to recognize the potential connection between ongoing public violence and high rates of family violence. In 2019, we conducted a study to explore the relationship between public violence and family violence among Kabul residents, including those seeking counseling and those who were not. Our cross-sectional mixed methods survey recruited 299 participants from a psychosocial counseling service as well as community members who were not receiving the service. The findings revealed a significant positive correlation between experiences of public violence and family violence. Both clients and non-clients reported experiencing high levels of violence, which led to impairments in daily functioning and increased suicidality. Additionally, a thematic analysis of open-ended questions indicated changes in attitudes resulting from exposure to violence, including feelings of helplessness and hopelessness both in and out of the home. We conclude that applying a psychodynamic approach to psychosocial counseling in Afghanistan requires awareness of the positive correlation between public violence and family violence in a society that has been exposed to violence in the public sphere for over forty years. Mental health care needs to contribute towards breaking cycles of violence by empowering clients to take control of their lives and become agents of change within their families and communities.

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Introduction

Afghanistan has been exposed to violence in the public sphere for more than four decades. According to the United Nations' midyear record, there were 5,183 civilian casualties between January 1st and June 30th, 2021 (1,659 killed and 3,524 injured), which shows an increase of 47% compared with the first half of 2020. Women (14%) and children (32%), in particular, made up 46% of all civilian casualties (United Nations Assistance Mission in Afghanistan, 2021). Displacement and other stressful living conditions, physical injuries, disease, and psychosocial and mental health problems are frequent consequences of experiencing long-term violence in the public sphere (Miller & Rasmussen, 2010). In Afghanistan, levels of family violence are also high (Catani et al., 2009; Dadras et al., 2022; Gibbs et al., 2018; O'Leary et al., 2018; Panter-brick et al., 2009; Shinwari et al., 2022). Violence within the family includes verbal, physical and sexual abuse, limiting sustenance, education or work opportunities, forced marriage and honor killings. The United Nations' Afghanistan database on violence against women reported that 51% of ever-partnered women aged 15–49 years experienced physical and/or sexual intimate partner violence at least once in their lifetime and 46% experienced intimate partner violence within the last 12 months (The United Nations, 2017). In a cross-sectional survey on a community sample of 145 children and 104 parents across three Afghan cities, 71% of children experienced physical violence in the past year, most of which occurred at home (O'Leary et al., 2018). A recent nation-wide survey conducted across eight provinces of Afghanistan utilized The Life Event Checklist five (LEC5) to assess the prevalence of traumatic experiences among the population. The survey revealed that 37% of the respondents had either personally experienced or witnessed one to three traumatic events, while 49% reported experiencing or witnessing four or more traumatic events in their lifetimes. On average, those who had experienced or witnessed traumatic events had encountered approximately 4.16 such events. Given the context of exposure to multiple traumatic events, as well as pervasive poverty and social inequality, the survey found that nearly half of the Afghan population (47.12%) suffered from psychological distress (i.e., PTSD, major depression, generalized anxiety, suicidal thoughts and attempts). Furthermore, more than one third of the respondents (39.44%) reported substantial impairment in their mental health due to the effects of these traumatic experiences (Kovess-Masfety et al., 2021).

In addition to the mental health consequences, research suggests that violence in the public sphere has a cumulative effect on experiences of violence within families in Afghanistan (Gibbs et al., 2019; Jewkes et al., 2019; Mannell et al., 2021; O'Leary et al., 2018). Notably, individuals exposed to war, particularly women and children, are more likely to experience family violence (Haj-yahia et al., 2003; Jewkes et al., 2018; Rieder & Elbert, 2013). In a qualitative investigation focusing on the lived experiences of political conflict and domestic violence among 20 Afghan women living in safe houses in Kabul, Mannell and colleagues (2021) found that the women attributed their experience of domestic violence to political conflict and violence in the public sphere. Factors such as the loss of patriarchal support due to death of family members in war, the proliferation of the drug trade, and the prevailing poverty and instability played significant roles. This entangled relationship between violence in the public and domestic spheres has also been observed in other conflict-ridden regions. For instance, in a survey of 1185 Palestinian secondary school students, Haj-Yahia and colleagues (2003) found a positive correlation between family exposure to political stressors, such as imprisonment of family members, and inter-parental psychological and physical violence and physical and emotional child abuse. Furthermore, research by Rieder and Elbert (2013) demonstrated that exposure to war and genocide increased the risk of later violence against children in post-conflict regions of Rwanda. They argued that posttraumatic stress disorder (PTSD) symptoms, such as affect dysregulation and hyperarousal, play a critical role in lowering tolerance and triggering aggressive impulses among parents, predisposing them to inflict violence on their children. Further, traumatic exposure to war and violence in children could lead to behavioral disturbances, emotional problems, or attention deficits, which may provoke aggression in a parent. Evidence has also shown that mental health problems such as PTSD, depression, and anxiety are frequent consequences of violence in the public sphere and are risk factors for both family violence victimization and perpetration (Bolton et al., 2012; Catani et al., 2008, 2009; Mueller-bamouh et al., 2016; Panter-brick et al., 2009; Rieder & Elbert, 2013; Saile et al., 2014; Sullivan & Elbogen, 2015). Furthermore, it is suggested that male family members not being able to fulfill their culturally defined role as family providers can lead individuals to resort to violence as a means of regaining a sense of power and control in conflict and post-conflict settings (Mannell et al., 2021). Moreover, disrupted judicial systems in conflict-affected regions of Afghanistan can give men a sense of impunity to engage in family violence (Alemi et al., 2021).

Violence in the public sphere not only impacts families directly exposed to it, but can also be transmitted to future generations in the form of intergenerational trauma (Shinwari et al., 2022). Research indicates that parental trauma symptoms resulting from childhood abuse and neglect are closely linked to the development of trauma symptoms in children and can influence their future likelihood of experiencing or perpetrating violence (Lünnemann et al., 2019). For instance, in the context of Afghanistan, mothers who endured poverty and parental domestic violence during their own childhood, and currently face food insecurity and intimate partner violence, are more likely to use corporal punishment against their own children (Ndungu et al., 2021). Moreover, the exposure of Afghan children to family violence, as well as their witnessing of such violence, has been associated with increased peer violence victimization and perpetration (Corboz et al., 2018). Panter-Brick and colleagues (2009) conducted a large school-based survey in several cities across Afghanistan in 2006 and found that multiple traumas resulting from violence in both the domestic and public spheres, along with mental health disruptions experienced by caregivers, are two robust predictors of poor mental health outcomes among Afghan adolescents. Therefore, providing family support and access to psychosocial support in the midst of persistent conflict can be instrumental in reducing the risk of negative psychological outcomes in children and breaking the cycle of intergenerational trauma.

Research indicates that mental health and psychosocial interventions have positive effects on adults experiencing psychological distress in conflict-affected areas and on women exposed to sexual and other forms of gender-based violence in armed-conflict areas (Rahman et al., 2016; Tol et al., 2013). A comprehensive Cochrane review of 36 studies (33 RCTs) involving 3523 participants from low- and middle-income countries, including regions like sub-Saharan Africa, the Middle East and North Africa, and Asia, found that evidence-based psychological treatments can improve mental health conditions and socioeconomic productivity for individuals constantly exposed to high levels of stress (Purgato et al., 2018). Due to the challenges of limited access, resources, poverty, and mental health stigma, mental health service utilization remains low (Viviane Kovess-Masfety et al., 2021; Trani et al., 2016). Consequently, some intervention studies have targeted Afghan families, especially mothers and

children, to break the cycle of mental health problems and violence aggregation within families and society. Various initiatives, such as internet-based interventions, digital technologies, community-level programs, and involving primary health workers in raising mental health awareness and access, aim to bridge the gap between high mental health needs and constrained resources in Afghanistan. For instance, an international project in Badakshan province of Afghanistan utilized simple e-Health technologies like SMS and smartphone applications through community healthcare workers to successfully raise awareness among young adults about mental health problems, reduce stigma, enhance access to care for remote communities, and improve quality of health services (Khoja et al., 2016). In addition, community-level interventions for survivors of complex trauma showed promising results; a psychosocial group counseling program in Kabul for Afghan female survivors of violence in both the domestic and public spheres concluded that teaching new social skills and providing psychoeducation and support networks can be essential in assisting Afghan women facing violence (Manneschmidt & Griese, 2009). These interventions offer hope in addressing mental health challenges and violence-related issues in Afghanistan, with particular focus on vulnerable populations.

In 2004, an innovative mental health initiative began in Afghanistan to address the lack of structured treatment for psychological problems (Missmahl, 2018; Missmahl & Brugmann, 2019). Between 2008 and 2016, Value-Based Counseling (VBC) was integrated into the Afghan public health care system. VBC is a short-term psychodynamic intervention with a salutogenic approach that aims to enhance clients' sense of coherence and self-efficacy through non-directive but carefully structured conversations, without pathologizing clinical symptoms related to underlying intrapsychic or interpersonal conflicts, traumatic experiences, a disruptive social environment, or difficult life transitions such as migration or loss of livelihoods. The intervention is based on C.G. Jung's psychodynamic approach and considers clinical symptoms as a carrier for a potential developmental energy that needs to be recognized and fostered. This requires an identification of the connection between the symptoms and emotions associated with the psychosocial stressors and underlying psychodynamics.

The International Psychosocial Organization (IPSO) provides counseling services using an intra-cultural approach with Afghan counselors sharing cultural backgrounds and native languages with their Afghan clients. To address gender barriers, women counsel women, and men counsel men. Considering the challenges in conflict areas, IPSO established an online counseling platform for remote sessions. Two studies, the first investigating the efficacy of VBC in the context of ongoing stress and trauma in Afghanistan (Ayoughi et al., 2012), and the second investigating the efficacy of VBC provided to migrants, in particular refugees, in a western country, found significant reductions in symptoms of depression, anxiety, PTSD, perceived stress, somatic complaints, daily functioning impairment, and mental health service utilization, along with improved resilience and perspective taking (Orang et al., 2022, 2023).

Connections between violence in the public sphere and domestic violence emerged as a recurring theme in counseling sessions in Afghanistan, particularly concerning the rise in violence during the period leading up to the Taliban's return to power. It became important to contextualize and, if possible, to validate these observations as part of IPSO's quality management and needs assessments for counseling services. The present study aimed to investigate the relationship between continuous and ongoing exposure to violence in the public sphere and family violence in Afghanistan. Specifically, it explored perceived violence among Kabul residents, war, political conflict, and family violence co-occurrence among clients of a psychosocial counseling service and non-clients, and the impact of violence and coping mechanisms to inform the further development of IPSO services.

Method

Procedure. In 2019, the convenience sampling method was used for the collection of data in Kabul due to limited resources and working conditions in a conflict setting. Study participants were recruited from three settings: clients seeking help from the counselling center in Kabul, clients seeking help on the online counseling platform before they received counseling, and non-clients who were Kabul residents approached by a team of counselors in their neighborhoods. These counselors were known within the community and had built trust and rapport with community members. After providing informed consent, participants completed a 10-item structured-interview survey about their experiences of war and conflict, family violence victimization and/or perpetration, and a 6-item questionnaire based on the Mini International Neuropsychiatric Interview (MINI) suicidality module. Following the interview, the counselor completed the Global Assessment of Functioning (GAF) Scale, in order to evaluate each participant's psychological, social and occupational functioning.

Inclusion criteria. Clients visiting the counselling center in Kabul for face-to-face counseling and clients receiving counseling on the online counseling platform were invited to take part in the study with the exception of clients with an active psychosis. Non-clients were invited to take part if they had been Kabul residents for at least one year and were aged 18 years or above. The survey was carried out before the clients received counseling.

Measures. Due to the low level of literacy among clients and the need to respect religious and cultural sensitivity of clients, it was necessary to develop a new survey instrument. A questionnaire was designed based on 15 years of work experience with mental health and psychosocial support (MHPSS) services provided in Afghanistan. The instrument evaluated two domains: 1) experiencing and/or witnessing violence in the public sphere; and 2) experiences of family violence through victimization or perpetration. The assessment consisted of ten items, six of which assessed the intensity and occurrence of violence in the public and domestic sphere and its impact on family relationships on a 5-point Likert scale. The remaining four items included qualitative open-ended questions, asking about the experience of participants living in a context of violence (See Supplementary Appendix 1).

In addition, the Global Assessment of Functioning (GAF) scale was used to measure the effect which participants' symptoms had on their day-to-day psychological, social, and occupational functioning on a scale of 0 to 100. A low score indicated low functioning. Moreover, the Suicidal Scale of the Mini-International Neuropsychiatric Interview (MINI) was implemented to screen for suicidal ideations, behavior and self-harm. Finally, sociodemographic data such as gender, age, ethnicity, education and income level was collected.

Data analysis. Two hundred ninety-nine Afghan locals participated in the cross-sectional survey, with 99 participants recruited from face-to-face services, 99 participants from the online counseling service, and 101 non-client Kabul residents. We accumulated online and face-to-face clients in one subgroup, named 'clients', in order to compare them specifically with 'non-clients'. Descriptive data are presented as frequencies (%), mean

scores, and standard deviations. Potential group differences in regard to sociodemographic characteristics and survey measures were analyzed with IBM SPSS Statistics 24 using parametric and non-parametric statistical tests. The Chi-square, Mann–Whitney U and Kruskal–Wallis tests were the three nonparametric tests used to detect possible differences between the study groups in terms of sociodemographic variables, violence experiences, psychological, social, and occupational functioning (GAF), and suicidality. The nonparametric correlation coefficient test, Spearman's Rho, was used to investigate the interrelationships between accumulated violence experiences, GAF scores, and suicidality. Independent T-test was used to investigate age, as a continuous variable, across the study groups. Level of significance was determined at p values 0.001, 0.01, 0.05 (2-tailed).

Results

Quantitative results. Socio-demographics and accumulated experiences of violence in the public and domestic sphere in the total sample and across the two subgroups of clients and non-clients are summarized in Tables 1 and 3. Accumulated violence was calculated based on questions 5 (violence in the public sphere), 7, 8, and 9 (family violence), with a total sample mean and standard deviation of 5.36 (3.64), and a range of 0 to 16 ($n = 264$).

Sociodemographic profiles of clients and non-clients. Sociodemographic variables, including age, gender, and marital status, and ethnicity, location of living, education level, and income level in the total sample and across the two subgroups of clients and non-clients are summarized in Table 1. Due to the low frequency of responses for some categories, marital status was recoded into three categories of "single", "married", and "widowed/divorced". Similarly, ethnicities were recoded into four groups of "Hazara", "Pashtun", "Tajik", and "others (such as Uzbik, Qazel, Bash etc)".

Investigating age across the two subgroups of clients and non-clients, using an independent T-test, we found that clients were significantly older ($M = 31.60$, $SD = 12.08$) than non-clients ($M = 25.43$, $SD = 8.89$) on average, $t\ (296) = 4.510$, $p < 0.001$.

We conducted several pairs of Chi-Square Tests to examine whether there are statistically significant sociodemographic differences between the two subgroups of clients and non-clients. We did not find significant differences between the two subgroups in regard with gender, ethnicity and education level. However, we found significant differences between clients and non-clients in regard with marital status ($X^2\ (n = 297) = -0.157$, $p = 0.007$), location of living ($X^2\ (n = 297) = 0.161$, $p = 0.006$), and income level ($X^2\ (n = 299) = 0.130$, $p = 0.024$). The detailed results of Chi-Square Tests on sociodemographic variables across the two subgroups of clients and non-clients are reported in Table 1.

Violence experiences across socio-demographic variables in the total sample. Using several pairs of Chi-square tests (X^2), we further investigated reported violence experiences (war- and conflict-related violence and family violence) across the socio-demographic variables. Detailed results are reported in Table 2.

Gender. We did not find a significant difference between women and men in the accumulated violence in the total sample [X^2(df= 22, $n = 264$) = 24.17, $p = 0.338$]. The results were the same across the two types of violence.

Marital status. We did not find a significant difference between the three categories of marital status in the accumulated violence

Table 1 Sociodemographic characteristics in the total sample and the two subgroups of clients and non-clients.

Baseline demographics	Total sample	*Subgroups*			
		Clients	Non-clients	Test value	*p* Value
Age; M (SD)	29.55 (11.48)	31.60 (12.08)	25.43 (8.89)	$t\ (296) = 4.510$	*0.001*
Range	*18–60*	*18–60*	*18–60*		
Gender; n (%)	299	200 (66.9)	99 (33.1)		
Female	160	102 (51)	58 (58.5)	$X^2 = 0.072$	0.217
Male	139	98 (49)	41 (41.4)		
Marital Status; n (%)	297	198 (66.6)	99 (33.3)	$X^2 = -0.157$	0.007**
Single	130	77	53		
Married	156	111	45		
Divorced/Widowed	11	10	1		
Ethnicity; n (%)	298	199 (66.7)	99 (33.2)	$X^2 = -0.007$	0.908
Hazara	67	45	22		
Pashtun	67	42	25		
Tajik	141	98	43		
Others	23	14	9		
Location; n (%)	297	198 (66.6)	99 (33.3)	$X^2 = 0.161$	0.006**
City center	171	119	52		
Suburb	52	40	12		
Close to the city	44	27	17		
Rural areas	30	12	18		
Education; n (%)	299	200 (66.9)	99 (33.1)	$X^2 = 0.083$	0.150
Illiterate	66	52	14		
Elementary/middle school	86	56	30		
Diploma	43	22	21		
University degree	104	70	34		
Income level; n (%)	299	200 (66.9)	99 (33.1)	$X^2 = 0.130$	0.024*
Low income	116	87	29		
Middle income	168	104	64		
High income	15	9	6		

M (SD) Mean (Standard Deviation). *n* (%) Number (percentage).
*$p < 0.05$, **$p < 0.01$. All reported *p* values are two-tailed.

Table 2 Sociodemographic characteristics across the general violence score and the two subcategories of violence in the public sphere and family violence.

Baseline Demographics	Violence experiences								
	General violence score			Violence in the public sphere			Family violence		
	Test Value	*p* Value	n	Test Value	*p* Value	*n*	Test Value	*p* Value	*n*
Gender	$X^2 = 24.17$	0.338	264	$X^2 = 9.65$	0.086	299	$X^2 = 16.11$	0.186	267
Marital status	$X^2 = 59.18$	0.063	264	$X^2 = 4.69$	0.911	297	$X^2 = 68.13$	0.001	267
Ethnicity	$X^2 = 75.19$	0.205	263	$X^2 = 9.622$	0.843	298	$X^2 = 43.09$	0.194	266
Location	$X^2 = 71.41$	0.303	262	$X^2 = 19.36$	0.198	297	$X^2 = 40.87$	0.265	265
Education	$X^2 = 84.14$	0.065	264	$X^2 = 13.04$	0.599	299	$X^2 = 76.57$	0.001	267
Income level	$X^2 = 72.89$	0.004	264	$X^2 = 13.68$	0.188	299	$X^2 = 43.36$	0.009**	267

**$p < 0.01$. All reported *p* values are two-tailed.

Table 3 Violence experiences, divided by types of violence across the total sample and the two subgroups of clients and non-clients.

Violence experiences M (SD)	Total sample	Subgroups				
		Clients	Non-clients	Test value	*p* -Value	*n*
General violence score (Accumulated violence experiences?)	264	9.97 (4.59)	10.88 (5.02)	$U = 6156.5$, $z = -1.37$	0.171	*192,72*
Two types of violence						
Violence in the public sphere (Q5 only?)	296	1.04 (1.12)	0.833 (1.09)	$U = 8344.5$, $z = -2.22$	0.026*	196,100
Family violence (Q7,8,9 sum)	267	4.12 (3.20)	5.16 (3.21)	$U = 5825.0$, $z = -2.24$	0.025*	194,73
Two aspects of family violence						
Violence victimization (Q7)	299	1.51 (1.44)	0.94 (1.29)	$U = 7629$, $z = -3.54$	0.01	198,101
Violence perpetration (Q8)	298	2.04 (1.29)	1.85 (1.39)	$U = 9126$, $z = -1.21$	0.225	197,101

M (SD) Mean (Standard Deviation). *$p < 0.05$. All reported *p* values are two-tailed.

$[X^2(\mathrm{df} = 44,\ n = 264) = 59.18,\ p = 0.063]$ in the total sample. However, the result showed significant difference between the categories in family violence $[X^2(\mathrm{df} = 24,) = 68.13,\ p < 0.000]$. Such comparison was not significant in war- and conflict-related violence experiences.

Ethnicity. There was no significant difference in accumulated violence experiences between the four ethnic groups in the total sample $[X^2(\mathrm{df} = 66,\ n = 263) = 75.19,\ p = 0.205]$. The results were the same across the two types of violence.

Location. We found no significant difference in accumulated violence experiences between the four areas of living $[X^2(\mathrm{df} = 66, n = 262) = 71.41, p = 0.303]$. The results were the same across the two types of violence.

Education. There was not a significant difference in accumulated violence experiences between the four levels of education in the total sample $[X^2(\mathrm{df} = 66, n = 264) = 84.14, \mathrm{p} = 0.065]$. However, the results showed significant difference between the education levels in family violence $[X^2(\mathrm{df} = 36, n = 267) = 76.57, p < 0.000]$, but not in war- and conflict-related violence experiences.

Income level. Accumulated violence experiences were also significantly different between the income categories $[X^2(\mathrm{df} = 44, n = 264) = 72.89, p = 0.004]$. In terms of types of violence, there was significant difference between the levels of income in family violence $[X^2(\mathrm{df} = 24,\ n = 267) = 43.36,\ p = 0.009]$, but not in violence in the public sphere.

Violence experiences across the two subgroups of clients and non-clients. Conducting Spearman's Rho correlation test, we found a significant positive association between family violence experiences (Qs 7, 8, and 9), and war-and conflict-related violence experiences (Q5) in the total group ($r_s = 0.22$, $p < 0.00$).

Given that the sample included both clients who were seeking counseling services, either in-person or online, and community members who were not receiving counseling, a nonparametric approach using the Mann-Whitney U test was used to compare whether there is a difference between the two groups in the different experiences of violence. As expected, counseling clients reported more negative impact of the current security situation on family life and interactions compared to community members who were not seeking counseling (Mann–Whitney $U = 8068$, $z = -2.82$, $p = 0.005$). Clients also reported having witnessed or been a victim of violence in the public sphere (Q5) more than non-clients (Mann-Whitney $U = 8344.5$, $z = -2.22$, $p = 0.026$). On the other hand, non-clients reported family violence experiences (Qs 7, 8, 9) more than clients (Mann-Whitney $U = 5825.0$, $z = -2.24$, $p = 0.025$). Finally, counseling clients reported experiencing significantly more domestic violence as a victim (Q7), in their family, compared to non-clients (Mann-Whitney $U = 7629$, $z = -3.54$, $p < 0.000$). Table 3 shows violence experiences and its two subcategories in the total sample and two groups of clients and non-clients.

Finally, descriptive analyses of periods during which violence incidents were experienced show that most of the participants were affected by war and conflict and family violence 'since years ago' (Q1a: 158 (52.8%), Q3a: 159 (53.2%), Q5a: 91 (30.4%), Q7a: 107 (35.8%), Q8a: 148 (49.5%), Q9a: 77 (25.8%)).

Global assessment of functioning. The overall average GAF score was 69.17 (SD = 16.87). Counseling clients overall had an average

Table 4 Global Assessment of Functioning and suicidality across the total sample and the two subgroups of clients and non-clients.

	Total sample	Subgroups				
		Clients	Non-clients	Test value	*p* Value	*n*
GAF scale; M (SD)						
	69.17 (16.87)	68.27 (16.88)	70.94 (16.92)	U = 8558, z = −1.91	0.056	299
MINI scale; M (SD)						
Lifetime suicide attempt	1.18 (0.402)	1.18 (0.410)	1.18 (0.388)	U = 99000, z = 0.00	1.0	200,99
Recent suicide plan	1.14 (0.358)	1.13 (352)	1.16 (0.370)	U = 9595, z = −0.706	0.48	200,99
Self-harm	1.28 (0.465)	1.28 (0.472)	1.28 (0.453)	U = 9900, z = 0.00	1.0	200,99
Suicidal thoughts	1.28 (0.459)	1.28 (0.459)	1.30 (0.462)	U = 9637, z = −0.474	0.636	200,99

M (SD) Mean (Standard Deviation). All reported *p* values are two-tailed. *GAF scale* Global Assessment of Functioning scale, *MINI scale* the International Neuropsychiatric Interview (MINI) suicidality module.

GAF score of 68.27 (SD = 16.88) with no significant differences between clients, both in-person and online, and non-client community participants (See Table 4). The accumulated experience of violence (family and war- and conflict-related violence) was not significantly associated with psychological, social, and occupational functioning (GAF) in the total group (r (Spearman's rho) = −0.109, $p = 0.077$). In addition, conducting a pair of correlation coefficients, we found a significant relationship between GAF score and violence experiences (family/ war- and conflict-related violence) in the community group ($r_s = -0.23$, $p < 0.05$), but not within the face-to-face clients ($r_s = 0.04$, $p = 0.73$) or within the online clients ($r_s = -1.1$, $p = 0.37$).

Suicidality. Suicidality was assessed using the Mini International Neuropsychiatric Interview (MINI) suicidality module. The average score of all 299 participants on the MINI scale was 1.51 (SD = 1.84). There was significant correlation between suicidality and total violence experiences ($n = 266$, $r_s = 0.25$, $p < 0.000$), family violence ($n = 267$, $r_s = 0.23$, $p < 0.000$), and war-and conflict-related violence ($n = 294$, $r_s = 0.22$, $p < 0.000$). Furthermore, there was a significant negative relationship between suicidality and global functioning ($n = 299$, $r_s = -0.32$, $p < 0.000$). The security situation having a negative impact on family life (Q3) is associated with lifetime suicide attempt [$X^2(8, n = 299) = 16.37$, $p < 0.05$]; recent suicide plan [X^2 $(8, n = 299) = 18.28$, $p < 0.05$]; self-harm [X^2 $(8, n = 299) = 26.68$, $p < 0.01$]; and suicidal thoughts [X^2 $(10, n = 299) = 20.04$, $p < 0.05$]. Also, being a victim (self or family member) of family violence is associated with suicidal thoughts [X^2 $(8, n = 299) = 18.52$, $p < 0.05$]. We did not find significant differences between clients and non-clients in lifetime suicide attempt, recent suicide plan, self-harm and suicidal thoughts (See Table 4).

Qualitative content analysis

Psychological reactions to the security situation in Afghanistan. 240 participants provided answers to the four open-end questions (questions 2, 4, 6 and 10: See Supplementary Appendix 1) and thematic categories were identified followed by recording the frequencies of each category. Worries ($n = 90$), anger ($n = 74$), fear ($n = 73$), hopelessness ($n = 47$), negative thoughts ($n = 35$), negative feelings ($n = 31$), and social withdrawal ($n = 28$) emerged as the most frequent perceived changes in attitudes, feelings, and behavior (See Fig. 1). Participants reported expression of anger mostly to family members, such as children, wife, husband, parents, etc. Social withdrawal category means that participants tried to avoid going out, or not allowing their family members going outside of home. In some cases, this resulted in school dropout, limitation of leisure activities, and social isolation. Categories 'worries', 'fear', and 'negative thoughts' mostly centered on fear of going out of the home, and becoming exposed to suicide attacks, explosions, and other types of violence in the public sphere. Most of the reported perceived changes led participants to feelings of helplessness and hopelessness in and outside of home.

Negative impacts on family life. Participants reported that the current security situation in Afghanistan negatively impacted family conflicts ($n = 60$), and led to aggressive behavior ($n = 36$), domestic violence ($n = 25$), worries ($n = 25$), social withdrawal ($n = 23$), child abuse ($n = 15$), unemployment ($n = 15$), immigration ($n = 12$), and economic stress ($n = 12$) (See Fig. 2). We can argue that consequences of ongoing war and conflict, such as migration of a family member, or intention to migrate from Afghanistan, social withdrawal, unemployment, and economic stress all may change family dynamics and increase family tension, which in turn, can lead to family violence.

Types of violence incidents. Reports of family violence incidents ($n = 20$) are as common as different types of violence in the public sphere, including community physical violence ($n = 21$), explosion ($n = 19$), suicide attacks ($n = 17$), robbery ($n = 13$), kidnapping (n = 12), war experiences ($n = 11$), violence against women ($n = 9$), family members dying in combat ($n = 9$), and gunfire ($n = 5$). Other types of reported incidents of violence in the public sphere ($n = 42$) included mine explosion, murder, mass murder, imprisonment, sexual abuse etc. (see Fig. S1, Supplementary Information).

Coping behaviors. The most frequent coping behaviors towards family violence was 'leaving the place/home' ($n = 76$) in which the family violence incident occurred. This could have meant just leaving the room or leaving the home. In cases in which it meant leaving the home, the behavior may have been in conflict with the high amount of fear and worries reported about going out of the home. Other most frequent coping behaviors were keeping silence ($n = 44$), aggressive behavior ($n = 38$), talking with others, such as friends, relatives, neighbors ($n = 34$), crying ($n = 30$), patience ($n = 22$), ignoring ($n = 14$), and religious practices ($n = 8$). There were only few healthy coping behaviors reported by some participants: Anger management ($n = 5$), counseling ($n = 5$), looking for a solution ($n = 7$), respectful relationship ($n = 12$), and self-care ($n = 3$) (see Fig. S2, Supplementary Information).

Discussion and conclusion

Discussion. The current study aimed to investigate the impact of perceived violence on individuals and their families, as well as the connection between violence in the public and domestic

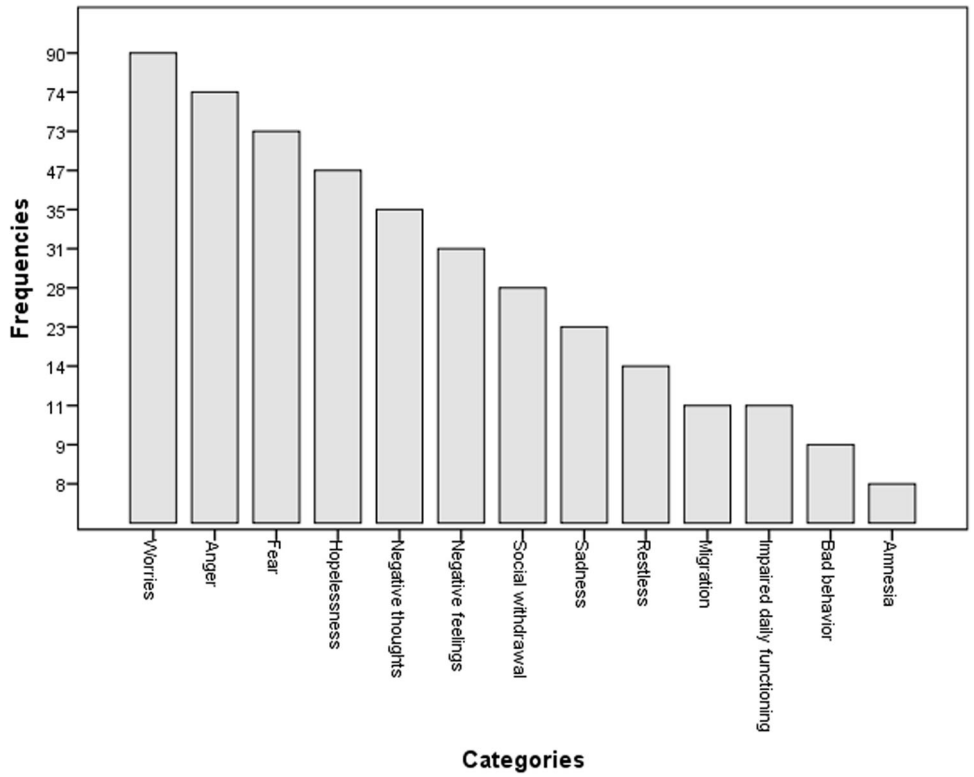

Fig. 1 Psychological reactions to the security situation in Afghanistan. Perceived changes in attitude, feelings and behavior in response to the security situation in Afghanistan.

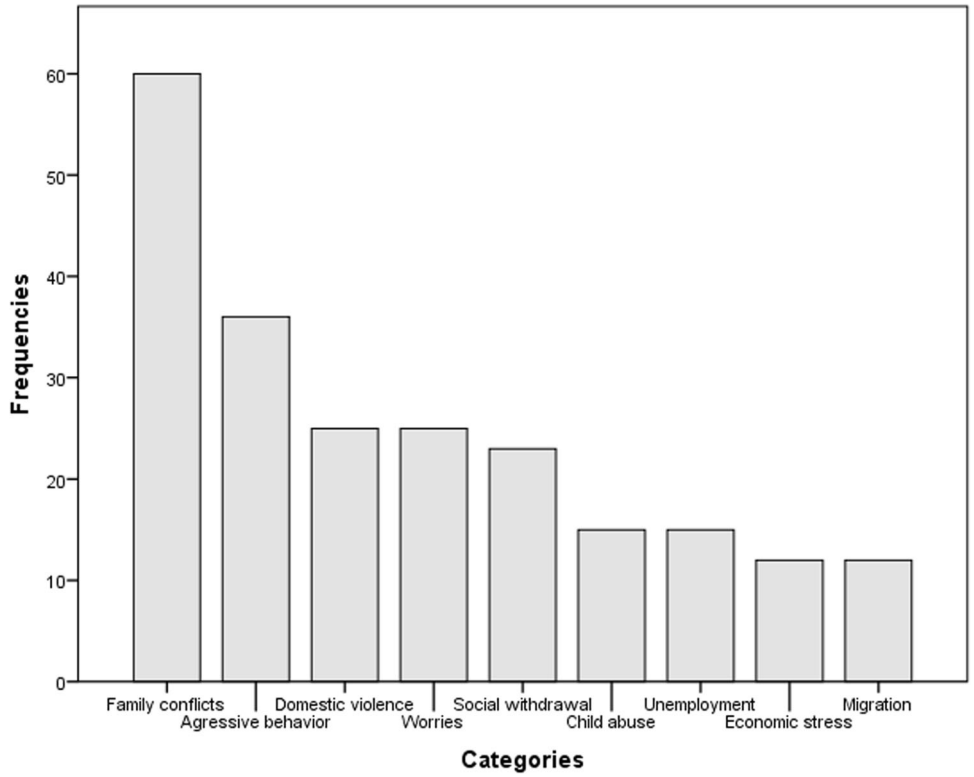

Fig. 2 Negative impacts on family life. Negative impacts of violence in the public sphere in Afghanistan on family life.

spheres among Kabul residents seeking help and those who were not. Results revealed a significant positive association between experiences of violence in the public sphere and family violence among Afghans (Gibbs et al., 2019; Jewkes et al., 2019; Mannell et al., 2021; O'Leary et al., 2018). Participants reported experiencing various forms of violence over an extended period, indicating the continuous and chronic nature of violence in Afghanistan. One possible explanation for the relationship between violence in the public and the domestic spheres is that long-term exposure to public violence leads individuals to feel insecure, lose control, and trust in the future. This loss of control may result in a compensatory effort to gain control within the family, often leading to increased violence. Trauma responses, such as affect dysregulation and hyperarousal, may also contribute to triggering aggressive impulses among family members, predisposing them to inflict violence on each other (Rieder & Elbert, 2013). Moreover, disrupted judicial systems in conflict-affected regions might foster a sense of impunity for men to engage in family violence (Alemi et al., 2021). This interaction between exposure to war, conflict, mental health issues, and family violence can create a vicious cycle that might perpetuate intergenerational cycles of conflict in both the public and domestic sphere (Gibbs et al., 2019; Jewkes et al., 2019; V Kovess-Masfety et al., 2021; Mannell et al., 2021; O'Leary et al., 2018; Widom & Wilson, 2015).

Furthermore, the study found that compared to non-clients, those seeking counseling, either face-to-face or online, reported significantly greater negative impact of the current security situation on their family life and interactions. They also perceived themselves as victims of violence in the public sphere and reported higher experiences of domestic violence victimization. The higher levels of perceived violence among clients may explain their motivation to seek professional help. Seeking help from psychosocial counseling services can be considered a healthy coping strategy for individuals living in the context of ongoing violence in the public sphere. Previous research has shown that psychosocial interventions in humanitarian regions can alleviate mental health problems, such as PTSD, depression, and anxiety (Purgato et al., 2018). The significant role of psychosocial counseling as a healthy coping behavior is further emphasized when considering responses to the qualitative survey questions, where many participants reported negative strategies such as aggression, crying, social withdrawal and keeping silence to deal with violence.

The importance of accessible psychosocial interventions becomes evident as non-clients reported experiencing more family violence overall, including witnessing domestic violence, perpetuating it, and being victimized, compared to clients seeking counseling. Both groups displayed high global functioning impairment (GAF) scores (averaging 69 out of 100) and frequent suicidality, indicating a significant need for support among Kabul residents. Research suggests that internet-based interventions, digital technologies, community-level programs, and involving primary health workers can help address the high mental health problems and needs with limited resources in Afghanistan (Khoja et al., 2016). Online support is particularly beneficial for both men and women, as men tend to have lower tendencies for help-seeking behavior, even in cases of suicidal ideation and self-harm (Han et al., 2018; Mackenzie et al., 2006), and women may face challenges leaving their homes.

The survey's socio-demographic profile aligns with existing literature, indicating that factors such as marital status, low education, and lower-income predict higher levels of family violence (Bahmani et al., 2018; Catani et al., 2009; Özcan et al., 2016; The United Nations, 2017). However, this does not hold true for experiences of violence in the public sphere, suggesting that specific vulnerable groups defined by socio-demographic backgrounds require special attention. Among Kabul residents surveyed in the current study, both quantitative and qualitative data revealed numerous lifetime suicide attempts, recent suicide plans, self-harm, suicidal thoughts, family conflicts, child abuse and a wide range of negative emotions (worries, anger, aggression, fear, hopelessness, negative thoughts, sadness, and social withdrawal) as a response to exposure to ongoing violence in the public sphere. The most common reaction to family violence was leaving the place where it occurred, which, in some cases, exposed individuals to violence in the public sphere, creating a vicious cycle that exacerbates anxiety and feelings of helplessness and hopelessness among survivors. The study highlights that the number of help-seeking clients is only a fraction of those who require assistance, supporting the notion of a mental health and psychosocial support service gap (Viviane Kovess-Masfety et al., 2021; Trani et al., 2016).

This study replicates previous findings, once again demonstrating the positive associations between violence in the public and domestic spheres within the context of ongoing war and violence. However, it is important to acknowledge some limitations. Being a correlational study, it cannot establish a cause-effect relationship, necessitating future research to identify possible mediating variables influencing this relationship. Additionally, the 10-item questionnaire used in the study was not standardized and may not comprehensively cover all aspects of violence perpetration and victimization within families and society. Furthermore, the convenience sampling method reflects resource constraints, calling for future studies to employ a randomized design with standardized questionnaires.

Conclusion

This study among Kabul residents revealed a positive correlation between violence in the public sphere and family violence. Individuals exposed to ongoing public violence were found to be at risk of experiencing family violence as perpetrators, as targets, or both. Considering this correlation, a psychodynamic approach to psychosocial counseling in a society exposed to public violence is crucial. It is essential not to pathologize clinical symptoms related to intrapsychic or interpersonal conflicts, traumatic experiences, disruptive social environments, or difficult life transitions. Instead, mental health care should focus on empowering clients to break cycles of violence, encouraging them to take charge of their lives and become agents of change in their families and communities.

Addressing the identified service gap can be achieved by providing well-designed online and face-to-face psychosocial counseling services and short-term trauma interventions, such as IPSO services. These interventions can complement existing support systems by offering evidence-based therapeutic tools and the approach make it suitable for scaling up to address significant unmet needs. The salutogenetic approach, with the focus on health rather than disease, eliminates the need to adapt or introduce mental health diagnoses in local healthcare settings. The brevity of the intervention is advantageous in resource-poor settings, and its basic structure can be integrated into a digital guided-self-help application, reducing the dependency on counselors (Missmahl, 2018; Missmahl & Brugmann, 2019; Orang et al., 2022). The mobile technology utilized in IPSO services is tailored to Afghan clients' language and cultural needs, ensuring accessibility and usability. Moreover, IPSO services employ and train community members as peer counselors, providing ongoing

supervision, which empowers and builds resilience, enhancing community engagement.

Data availability

The datasets generated during and/or analysed during the current study are not publicly available due to privacy restrictions and security issues but are available from the corresponding author on reasonable request.

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Author contributions

MO and FC contributed to this work equally through analyses and interpretation of the data, drafting the manuscript, and revising it critically. AH did substantial contributions to the implementation of the study and the data acquisition. RMK, JS, and KJ contributed to this work equally through the development of the concept and the study design. IM did substantial contributions to the conception and design of the work and interpretation of the data.

Competing interests

The authors declare no competing interests.

Ethical approval

All procedures performed in the study involving human participants were in accordance with the ethical standards of the institutional committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by HUMAN ETHICS Committee of University of British Columbia (Date: November 21, 2019, NO. H19-02544).

Informed consent

Informed consent was obtained from all the participants.

Additional information

Supplementary information The online version contains supplementary material available at https://doi.org/10.1057/s41599-023-02013-1.

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