African Journal of Clinical Psychology
ISSN: 978-9966-936-05-9: 2022 Vol. 05, Issue 01
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School of Applied Human Sciences

Levels of Depression in Men and Women Survivors of Intimate Partner Violence at a Gender Violence Recovery Centre in Kenya

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Abstract

Intimate Partner Violence (IPV) is a worldwide human rights violation and a preventable public health concern. It affects males and females globally and has been linked to adverse health sequela, including depression, PTSD, and suicidal ideation. Literature shows that developing countries are the worst affected by IPV. This mixed-methods study aimed to identify levels of depression and associated demographic risk factors among male and female survivors of IPV seeking services at a Gender Violence and Recovery Centre (GVRC) in Nyeri County, Kenya. Study Questionnaires were distributed to 117 respondents, with an additional 30 reached through focus group discussions from May 2019-October 2019. Ten items derived from a shortened version of The Centre for Epidemiologic Studies Depression Scale (CES-D scale) were used to assess current depression amongst IPV survivors. The study found that more than half of the respondents (59%) reported severe depression, 34.2% indicated moderate depression, and 6.8% reported mild depression.

This study adds to the growing literature on IPV and mental well-being. Regarding demographic risk factors, there was a significant association between gender and level of depression, χ^2 (2, N=117) = 1.038, p= .023), occupation status, χ^2 (6, N=117) = 11.25, p= .03) and presence of a previous partner, χ^2 (2, N=117) = 2.72, p= 0.041). Screening for depression and allied risk factors among male and female IPV survivors would be considered a vital intervention component and management tailored toward treatment therapies that help the survivors identify and change negative thought patterns and allied behaviors.

Keywords: IPV, Depression, male and female survivors of IPV, mixed methods, Gender Violence and Recovery Centre.

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Introduction

Results of studies conducted worldwide indicate that IPV has been on the rise and is a worldwide concern (Australian Institute of Health and Welfare [AIHW], 2018; Kenya Demographic Health Survey (KDHS), 2014; Koziol-McLain, 2018; World Health Organization [WHO], 2017). WHO (2017) has defined IPV as any harmful act by an intimate partner that is psychologically, physically, or sexually harmful. It has been indicated that both men and women are victims of IPV globally (KDHS, 2014; Maingi, 2016; WHO, 2017). A survey by KDH indicates that overall, 39% of women who were ever married and 9% of men aged 15-49 years report having encountered spousal physical or sexual violence. Most established frameworks for recognizing occurrences of IPV have assessed women's victimization, largely ignoring men as survivors (Hess & Alona, 2018). Irrespective of the gender of the survivor, IPV has been indicated to lead to short-term and long-term effects (Hossain et al., 2021). Psychological breakdown emanating from Intimate Partner Violence (IPV) can result in severe consequences for the survivor's life (Hossain et al., 2021; Parcesepe et al., 2021).

Ondicho (2018) reports that IPV is not a new occurrence; what is new is the realization that it has a wide array of adverse effects for the survivors. Further, global studies have indicated that partner violence is a frightening problem and that brutalized survivors are more likely to suffer serious injuries or even death (Hess & Alona, 2018). Ondicho (2018) proceeds to mention that the public health sector has a considerable capacity to contribute to preventing the menace and significantly mitigating its health complications.

Besides physical injuries, IPV causes injurious psychological consequences and is a heavy burden to families and society (Pakhomova et al., 2021; Potter et al., 2021). Difficulties with depression and anxiety, in addition to other mental health issues, could go along with IPV, and this could cause a disturbance to other aspects of the survivor's life, for example, social and occupational engagements (*Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013; Karakurt et al., 2022; Potter et al., 2021). Results from documented empirical evidence from studies investigating the relationship between IPV and symptoms of depression show that both past and current IPV increase depressive symptoms (Guček & Selič, 2018; Sere et al., 2021). For example, the result of multi-centre cross-sectional research by Guček and Selič (2018) with 471 female and male IPV survivors in

Slovenia found that depression was interconnected with any encounter with IPV episodes in an adult's life. Further, Guček and Selič (2018) have proceeded to caution against the existence of undetected symptoms of depression in the survivors. Koziol-McLain et al. (2018) studied safety measures for female survivors who had an encounter with IPV in the previous six months from the general population in New Zealand. The result shows that out of the 412 participants (309/412, 75%), they evidenced symptoms of depression.

Further, Koziol-McLain proceeds to state that 1/12 of the respondents made self-reports of suicidal ideation ("I wished I was dead") "nearly every day" for the last two weeks. Taylor et al. (2021) conducted a study on 147 male IPV survivors via purposive sampling in the UK. This research by Taylor et al. (2021) publicized a questionnaire through social media (for example, Facebook and Twitter) and institutions that offer services to male IPV survivors in heterosexual unions. The results of this study by Taylor et al. (2021) reveal that all the study participants stated the impact of their painful experiences on feelings of worthlessness, suicidal ideation, and overall degenerated mental health. The suggestion is that while previous IPV may cast enduring effects, the impact is heavier for ongoing violence (Dahlen et al., 2018). All forms of IPV have been indicated to be moderately associated with current symptoms of depression among survivors (Sere et al., 2021; Yuan & Hesketh, 2021). Results from other research show that IPV and ensuing health issues could result in a decline in quality of life, loss of workability, debilitation, and premature death (Guček & Selič, 2018; Koziol-McLain et al., 2018).

Additional research posits that all types of IPV have a long-lasting health impact on survivors' social, occupational, and general well-being, reverberating all through the survivors' lives (Adams, 2021; Brown et al., 2020; Hess & Alona, 2018). This disturbance brings about a web of complications that make it challenging to proceed in recovery (Hess & Alona, 2018; Karakurt et al., 2022). Hess and Alona (2018) recently carried out research in the US with 164 IPV survivors of IPV with questionnaires administered at transitional housing programs, shelters, and other domestic violence programs. Findings from this research by Hess and Alona (2018) reveal that the majority of the respondents, 56%, reported having an encounter with multiple types of abuse from more than one partner. Further, the study argues that the varied IPV forms permeate survivors' lives, bringing about a complex set of needs. This situation makes it hard for the

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survivors to exit and move on with recovery and life. Hess and Alona (2018) discovered that 73% of participants reported experiencing helplessness and continuing to live with a violent partner longer than they desired. Further, the results of yet another research carried out by Gibbs et al. (2018) reveal that nearly half of the total participants, 45.3%, reported that IPV negatively impacted their mental health and general well-being.

It has been indicated that the survivors of IPV report that abusers interrupt their ability to attain set goals in life (Giesbrecht, 2020). Giesbrecht (2020) argues further that the abusers isolate the survivors socially, monitor or control their mobility, steal their money, damage their personal property, encourage, force, or pressure them to engage in a misdemeanour, and disrupt their work programs. Other researchers report that the abuse can be chronic, severe, and entrapping, especially in relationships with stalking, threats, and isolation (Ondicho, 2018; Taylor et al., 2021). Survivors of IPV report facing legal expenses to repair or recover damaged property, retain or regain custody of children, and pay fines over offences committed (Potter et al., 2021; Taylor et al., 2021). These disturbances could have colossal implications impacting the survivors' mental well-being and resulting in IPV-related homicides and suicides (Karakurt et al., 2022; Taylor et al., 2021). In the research by Karakurt et al. (2022) through meta-analysis, results show that in most of the studies analyzed, PTSD and depression were the primary outcomes. The findings of this study by Karakurt et al. (2022) indicate that depression might interfere with how survivors respond to normal day-to-day functioning and events and how they form relationships with others. Karakurt et al. (2022) mention that IPV survivors have been reported to be four times more likely to commit suicide.

Traumatic and psychological distress reactions have been cited as the core components explaining why IPV could cause depression in the survivor (Sparrow et al., 2017). Further, Selye (1956) and Wright et al. (2019) postulate that recurrent and extended exposure to stressful happenings, in the end, weakens the body's physical defences to illnesses. Studies carried out by Devries et al. (2013) and Dutton (1992) mention that trauma arising from IPV could lead to stress, fear, isolation, feelings of helplessness, and powerlessness which could lead to depression. Devries et al. (2013) and Sparrow et al. (2017) mention that survivors of physical IPV are more likely to meet the criteria for PTSD and depression, as well as isolate themselves due to shame

and failure to attend to their responsibilities at the workplace as a result of injuries and low self-esteem. This supposition has been echoed by Lazarus and Folkman (1984) and Gunawan (2017). They indicate that stress from daily main life events and disturbances might result in feelings of anxiety, depression, severe and chronic illness, and alterations in behavior and physiology.

Yuan and Hesketh (2021) report that survivors of IPV are at an elevated risk of bearing the twofold load of IPV and poverty, leading to added stress and other mental disorders (Yuan & Hesketh, 2021; Machisa & Shamu, 2022; WHO, 2014). Further, Machisa and Shamu (2022) mention that long-term exposure to stress and worrying from uncertainties and worries of living in unpredictable situations negatively impact mental health. This notion has been echoed in the results of a study carried out by Sere et al. (2021) via a systematic review of empirical studies with 159 female IPV survivors in South Africa found that IPV and the absence of resources plus basic needs for example, food, bring about similar effects and limit coping techniques. Additionally, the authors of the study by Sere et al. (2021) argue that both IPV and constrained resources elicit stress, powerlessness, and social isolation, which could evoke depression and PTSD, plus other emotional disorders. Gelles (1974) mentions that difficult economic situations could result in frustration, anger, and low self-esteem, leading to tension, which could manifest as violence. The results of research carried out by Pakhomova et al. (2021) reveal that overall possible depression stood at a relatively high baseline (42.8%), with female respondents reporting more severe symptoms of depression than male respondents (48.4 % vs. 34.7%), which is in line with varied global findings.

Further, Yuan and Hesketh (2021) state that survivors with more children indicate elevated symptoms of mental-health disturbance. Additional factors known to be associated with depression among survivors of IPV are poor social support (Mansa, 2020; Yuan & Hesketh, 2021), lower educational attainment (Pereira et al., 2020), unemployment (Ackerson, 2018; Clemons, 2021), living in overcrowded environments, and communities that have high incidents of IPV (Machisa & Shamu, 2022; Pakhomova, 2021). All the factors mentioned above may increase life stressors which could result into an increase in vulnerability to depression (Machisa & Shamu, 2022).

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Methodology

Because both females and males are battered by an intimate partner, globally, a great variety of institutions have been put up in Kenya to handle survivor needs. This study was conducted at a Gender Violence Recovery Centre (GVRC) in Nyeri Provincial General Hospital (Nyeri, PGH), Kenya. The GVRC is located within Nyeri- PGH and is one of the centers that offer support to survivors of IPV seeking assistance in the county. The Nyeri County Referral Hospital was purposively selected for this study as it has a well-organized GVRC with information on the variables under study. A mixed-methods design (Creswell, J. W., & Creswell, J. D., 2017) with both qualitative and quantitative approaches was used to investigate the variables under study. One hundred seventeen respondents completed the questionnaire, and 30 participated in one of the six focus group discussions. To qualify for this study, the survivor of IPV must have met the stated inclusion criteria: having been in a heterosexual intimate relationship of at least twelve months, a respondent's submission of at least one act of IPV from her/his partner within the past twelve months, respondents aged ≥18years, looking for services from the Recovery Centre and be dedicated to taking part in the research project via written consent. The participants were recruited into the study continually from May 2019- to October 2019 as they sought services at the GVRC until the required 147 participants were reached. Two research assistants trained by the leading researcher on data collection and securing participants' confidentiality assisted in data collection.

The data collection instrument was a study questionnaire that was constituted by the researcher comprising the participants' demographics and questions derived from the brief 10-item tool of The Centre for Epidemiologic Studies Depression Scale {CES-D} scale), a measure designed by the National Institute of Health used to collect data on probable symptoms of depression. Each question on the assessment tool asked the study respondents how they could have felt or behaved in the past seven days prior to the study using a 4-point Likert scale response. The researcher used a cut-off score of ≥10 to classify symptoms of depression. For this tool, possible scores range from 0-to 30, with higher scores indicating severe levels of depression.

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Data analysis of the quantitative and qualitative data collected was guided by the stated research objective, research tools, and available literature on similar studies. The stated study objectives were tested, and the Statistical Package for Social Sciences (SPSS) version 25.0 was used in the statistical analysis. The data gathered from the focus groups were transcribed and coded, and analysis was done thematically, guided by the stated research objective in line with other studies on similar topics (Clemons, 2021). Descriptive statistics (considering the frequencies and percentages) were calculated on the mean scores of reported depressive symptoms. Additionally, occurrence rates were determined based on the total percentage of respondents reporting each symptom, both women and men.

Results

Sixty-nine women (59%) and forty-eight male (41%) respondents participated in the study. The mean age of the respondents was 35.1 (±0.9) years. The majority of the respondents were married (64.1%). Many had primary education (59%), and more than half (55.6%) were unemployed. Almost all the participants (96.6%) indicated a religious affiliation. Many participants (44.4%) had been in their current unions for 0-5 years. More than half of the respondents (55.6%) had one to two children with their current partners.

The participants were requested to indicate their general feeling emanating from stress related to their experience with the abuse from their intimate partners. From the study results, as shown in Table 1, the powerful feelings associated with the abuse mentioned by the participants were: feeling depressed (low mood), loss of interest in all tasks, inability to move on, and being bothered by things that initially were not a bother to them, and insomnia. The least mentioned feelings the study respondents experienced were hope and happiness.

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Table 1: Symptoms of Depression

	Rarely (Less than one day)	Sometimes (1 - 2 days)	Occasionally (3 - 4 days)	Mostly (5 - 7 days)	Mean	Std dev
I was bothered by things that usually do not bother me	0.85%	17.09%	36.75%	45.30%	2.26	0.77
I had trouble keeping my mind on what I was doing	1.71%	16.24%	50.43%	31.62%	2.12	0.73
I felt depressed/ (I felt low mood, I lost interest in all activities)*	1.71%	10.26%	40.17%	47.86%	2.34	0.73
I felt that everything I did was an effort/I felt tired)*	5.13%	19.66%	47.86%	27.35%	1.97	0.82
I felt hopeful about the future/I felt optimistic about the future)	23.08%	23.93%	33.33%	19.66%	1.5	1.06
I felt fearful/I felt afraid*	1.71%	20.51%	43.59%	34.19%	2.1	0.78
My sleep was restless/I could not sleep*	5.98%	12.82%	35.04%	46.15%	2.21	0.89
I was happy	20.51%	48.72%	28.21%	2.56%	1.13	0.76
I felt lonely	7.69%	15.38%	26.50%	50.43%	2.2	0.97
I could not get “going” / I could not move on*	4.27%	15.38%	29.91%	50.43%	2.26	0.87

During the focus group discussions, participants stated that the psychological consequences of violent encounters were much graver and more enduring than physical injuries. On their side, male survivors of IPV reported that they are silently battered by their spouses in their homes and do not make it public due to fear of stigma and ridicule. These acts also happen to women survivors of IPV, especially the elderly. Male survivors, too, reported fear of judgment. It arose from all IPV survivors, irrespective of gender; an encounter with partner violence diminishes one's self-worth, dignity, and security. Female survivors reported experiencing feelings of distress and suicidal ideation. Respondents bearing physical wounds reported mild to severe

body injuries, including black eyes and loss of dentures. Other respondents, particularly females, had to bear the burden of enduring sexually transmitted infections and HIV.

The researcher examined the scores on depressive symptoms that stretched from 0 to 30. The scores were then clustered as follows: from 0-10 (mild depression), 11-20 (moderate depression), and 21-30 (severe depression).

Table 2: Levels of depression

	Frequency	Per cent
Mild depression	8	6.8%
Moderate depression	40	34.2%
Severe depression	69	59%
Total	117	100%

Association between Demographic Characteristics and Symptoms of Depression

A Chi-square test was conducted to establish the association between demographic characteristics and symptoms of depression. The results, as displayed in Table 3 below, indicate that most of the respondents who reported severe levels of depression were females, 26 (65%). Also, most of the respondents who reported severe levels of depression were married 42 (60.9%). Further, most of the respondents who indicated severe levels of depression had a primary level of education, 47 (68.1%). Additionally, most of the respondents who indicated severe levels of depression were Protestants 34 (49.3%). The other category of respondents who reported severe levels of depression were those who were unemployed 44 (63.8%).

Additionally, most of the respondents who reported severe levels of depression were those who had stayed with their current partners for less than five years 31 (44.9%). Finally, the results indicated that most of the respondents who exhibited severe levels of depression had 1-2 children with their current partner. Further, the results indicate that most of the respondents who reported severe depression had ended their previous relationships through separation. The outcomes

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further showed that respondents with a previous partner exhibited higher levels of depression compared to those that did not have previous partners.

There was a significant association between gender and symptoms of depression χ^2 (2, N=117) = 1.038, (p= .023) and occupation/employment status χ^2 (6, N=117) = 11.25, p= .03. There was also a significant relationship between the presence of a previous partner and depression symptoms (χ^2 (2, N=117) = 2.72, p= 0.041. No statistically significant association was found between marital status, education level, religion, length of stay with a partner, children with a current partner, children from a previous relationship, break-up reasons and the symptoms of depression.

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Table 3: Association between Demographic characteristics and levels of depression

			Mild depression	**Moderate depression**	**Severe depression**	**Chi-square**	**P-value**
Gender	Male	48	4(50.0%)	14(35%)	30(43.5%)	χ^2=1.038	0.023
	Female	69	4(50.0%)	26(65%)	39(56.5%)		
Marital Status	Married	75	7(87.5%)	26(65%)	42(60.9%)	χ^2=6.650	0.575
	Single	11	0(0%)	4(10%)	7(10.1%)		
	Cohabiting	24	0(0%)	7 (17.5%)	17(24.6%)		
	Separated	6	1(12.5%)	3(7.5%)	2(2.9%)		
	Widowed	1	0(0%)	0(0%)	1(1.4%)		
Education level	No formal Education	3	0(0%)	2(5%)	1(1.4%)	χ^2=12.995	0.112
	Primary school	69	6(75%)	16(40%)	47(68.1%)		
	Secondary school	26	1(12.5%)	13(32.5%)	12(17.4%)		
	Middle-level school	15	0(0%)	7(17.5%)	8(11.6%)		
	University	4	1(12.5%)	2(5.0%)	1(1.4%)		
Religion	Catholic	26	1(12.5%)	9(22.5%)	16(23.2%)	χ^2=12.995	0.937
	Protestant	57	5(62.5%)	18(45.0%)	34(49.3%)		
	Muslim	30	2(25.0%)	12(30%)	16(23.2%)		
	Atheist	4	0(0%)	1(2.5%)	3(4.3%)		
Occupation	Formal	20	1(12.5%)	7(17.5%)	12(17.4%)	χ^2=11.25	0.037
	Self-employed	30	4(50%)	14(35%)	12(17.4%)		
	Unemployed	65	3(37.5%)	18(45%)	44(63.8%)		
	Others	2	0(0%)	1(2.5%)	1(1.4%)		
Length stayed with a partner	0-5 years	52	0(0%)	21(52.5%)	31(44.9%)	χ^2=0.146	0.158
	6-10 years	30	4 (50%)	8 (20%)	18 (26.1%)		
	11-15 years	12	0 (0%)	5 (12.5%)	7 (10.1%)		
	16-20 years	16	3 (37.5%)	3 (7.5%)	10 (14.5%)		

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			Mild depression	Moderate depression	Severe depression	Chi-square	P-value
	Over 20 years	6	26	3 (7.5%)	2 (2.9%)		
Children with Current Partner	None	28	2 (25.0%)	10 (25%)	16 (23.2%)	χ^2=8.753	0.188
	1- 2	65	3 (37.5%)	24 (60%)	38 (55.1%)		
	3- 4	22	2 (25.0%)	5 (12.5%)	15 (21.7%)		
	5 -7	2	1 (12.5%)	1 (2.5%)	0 (0%)		
Children from the previous relationship	None	56	3 (35.5%)	20 (50%)	33 (47.8%)	χ^2=1.698	0.791
	1- 2	50	4 (50%)	18 (45%)	28 (40.6%)		
	3- 4	11	1(12.5%)	2 (5%)	8 (11.6%)		
Presence of a previous partner	Yes	63	5 (62.5%)	21 (52.5%)	37 (53.6%)	χ^2=2.276	0.041
	No	54	3 (37.5%)	19 (47.5%)	32 (46.4%)		
Break up reasons	Separation	54	4 (50%)	19 (47.5%)	31(45.6%)	χ^2=1.043	0.984
	Death of partner	8	1 (12.5%)	2 (5%)	5 (7.4%)		
	Other reasons	2	0 (0%)	1 (2.5%)	1 (1.5%)		

Discussion

Researchers have regularly agreed that current and ongoing IPV adversely impacts survivors' mental well-being (Clemons, 2021; Machisa & Shamu, 2022; Potter et al., 2021; Yuan & Hesketh, 2021). This concept has been declared by the results of studies conducted worldwide and established a correlation between IPV and mental-related health difficulties, for example, depression (KDHS, 2014; Fawole et al., 2019; Potter et al., 2021). The current study's findings show that the symptoms of depression that the respondents highly mentioned included: feeling depressed (low mood, losing interest in all activities), inability to move on, being bothered by

things that did not usually bother the respondent, and lack of sleep. Conversely, the symptoms of depression that the study participants least mentioned were: feeling happy and hopeful.

The results of the current study indicate that 59% of the respondents were severely depressed, 34.2% moderately depressed, and 6.8% reported mild symptoms of depression. This finding is in tandem with the result of a multi-centre cross-sectional study conducted by Guček and Selič (2018) and Ibala et al. (2021) with both women and men in Slovenia and Africa (Uganda, Malawi, and Nigeria), which found that depression was realized to be associated to any exposure to IPV in adult life. The findings of the study by Pakhomova et al. (2021) with female and male participants in South Africa affirm this finding. O'Conner (2020) and Taylor et al. (2021) with male IPV survivors further support this finding, with the participants reporting a decline in mental health, general worthlessness, and suicidal ideation. The current study results show that the adverse effects of traumatic IPV-associated experiences on a survivor's mental health might be long-lasting, as reported during the focus group discussions. This finding corroborates the results of a recent study conducted by Hossain et al. (2021), who found that those female survivors who reported an experience of past year IPV might be at an elevated risk of anxiety, depression, and PTSD.

On demographic risk factors, findings in the current study showed that symptoms of depression were dominant among female IPV survivors. This finding was in line with the expectation of this study and the results of a study carried out by Pakhomova et al. (2021) with survivors of IPV, which indicate that high scores in symptoms of mental illness were twice as high in women survivors as in men. A study by Pakhomova et al. (2021) indicates that men’s use of aggression against women is more detrimental than women’s aggression against men affirming the reported high scores in depressive symptoms. As regards marital status, married participants reported high scores of violent acts. This finding is amazingly contrary to what is expected. However, the result tallies with a study by Mansa (2020). A possible explanation for the finding in the present study could be that in Kenya, just like in many African settings, the man is regarded as the head of the house, with the woman surrendering her obedience, amongst other rights, to her husband. This practice customarily gives her husband the right to batter her whenever he feels she has not sufficiently fulfilled her obligations. However, cohabiting couples also experience IPV, as indicated in this study. This finding could be due to the weak bonding between the partners and

probably low respect and recognition. Participants with lower education and no employment reported higher scores of depressive symptoms. This finding is echoed in the results of studies carried out by Ackerson et al. (2018), Clemons (2021), Mansa (2020), and Pereira et al. (2020), which mention low education, and low economic status, amongst others, as risk factors for IPV and associated mental health issues as survivors experience feelings of low esteem helplessness and loss of workability. Another explanation could be that cognitive resources acquired through schooling help the survivor choose adaptive coping mechanisms that instil resilience and ultimate stress mitigation.

Further, employment has been indicated as a factor that may reduce survivors' dependence on their partners, increase their power within households and unions, and as a result, lead to decreased vulnerability to partner abuse (Oloyede, 2020; Mansa, 2020; Pereira et al., 2020). As far as religion is concerned, almost all the survivors (96.5%) indicated that they belonged to religious affiliation. However, this did not prevent them from the demands of the experienced violence from their partners. This finding is in tandem with the results of the study by Oloyede (2020) cited throughout this study. The results further indicate that participants who had stayed with their partners for less than five years exhibited more depressive symptoms than those who had children with their current partners. This finding has been echoed in the result of a study by Sere et al. (2021), which indicates that partners experience increased functions and responsibilities and the associated stress during union launching years. Studies affirm the finding on children by Oloyede (2020) and (Yuan & Hesketh, 2021). Survivors with more children indicate elevated symptoms of mental-health disturbance due to the financial stress of raising children and disagreements about how children should be raised, resulting in increased stress. Further, the study showed that IPV survivors who had a previous partner exhibited more depressive symptoms than their counterparts with no previous partners. Survivors whose previous unions had ended in separation recorded higher levels of depression.

Conclusion

Worldwide, IPV has been indicated as a public health crisis. Survivors of IPV have persistently experienced and endured diverse acts of IPV, impacting their mental health negatively. Understanding the consequences of IPV and their impact on IPV survivors is noteworthy,

especially in developing effective policies and programs. The results of this study show that most of the study participants reported experiencing symptoms of depression following their painful experiences with acts of IPV. This analysis, therefore, underscores the importance of assessing survivors of IPV for symptoms of depression and the associated risk factors for developing the symptoms to improve survivors' health and protect against long-term health complications.

Findings from the current study add to the lingering debate around IPV and mental health globally. An intervention to decrease the negative influence of IPV and ensued psychological trauma would be most recommended. Consequently, assessing survivors for mental health issues is crucial to designing and implementing appropriate intervention programs at the institutions offering support services.

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