

Violence Against Women and Its Immediate and Long-term Health Consequences

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Abstract

Violence against women is a major human rights violation, with 30% of women experiencing violence in their lifetime. While domestic violence has been repeatedly linked to negative health outcomes for the victim, little attention has been drawn to the outcomes of non-intimate partner violence. Therefore, the present literature review aims to explore the health consequences of non-intimate partner violence from immediate to long-term impact. Findings from research on intimate-partner violence have been added to extend and deepen the insight of the topic at hand. The results indicate that victims of non-intimate partner violence suffer from a significant reduction in health including psychopathologies, such as depression, anxiety, and PTSD. The victim's freeze response during the assault was associated consistently with PTSD severity post abuse. Intimate partner violence is linked to chronic illnesses and maladaptive health behaviours. The recovery process determines the long-lasting impact of experienced violence. These findings suggest that multiple factors are involved in the aftermath, which are ought to be considered in prevention as well as treatment interventions.

Keywords: Violence against women, non-intimate partner violence, intimate-partner violence, physical and/or sexual violence, freeze response, immediate health consequences, long-term health consequences

Violence against women and its immediate and long-term health consequences

Violence against women is a major human rights violation. Yet, women are victims of physical and sexual abuse worldwide. Currently, many women (and men) fight for their rights and freedom in the streets of Iran risking their own lives. Reports of sexual assault on women demonstrating against the Iranian regime have spread across the news. For example, the young woman Armita Abbasi, who is only 20 years old, has allegedly been brutally raped, repeatedly, after having been accused of leading anti-regime demonstrations. To this date, it is unknown where she is (CNN, November 2022). According to the World Health Organization (WHO, 2021), 30% of women worldwide have experienced *physical and/ or sexual violence* at least once in their lifetime from the age of 15 years onwards. More specifically, one third of all women have been subject to physical and/ or sexual violence from a former partner/ male intimate partner or from a non-intimate acquaintance/ stranger. Consequently, this also implies that one in three women will be a victim of abuse in the future. Taking a regional example, in the first national survey on wife abuse in the Netherlands (Römkens, 1997) 20,6% of all female participants reported to have experienced abuse from their partner. This had lasting effects: Two thirds of all abused women suffered from prolonged injuries with 20% having permanent physical injuries, such as scars and hearing difficulties resulting from severe physical abuse. 25 years later, no significant improvement could be reported. Still, the current lifetime prevalence for *intimate partner violence* in the Netherlands is 21% (WHO, 2021). Taking an example of a low-income country, such as Bolivia, the WHO reported that 42% of all women have been abused by their partner at least once in their lifetime. Violence against women is thus highly prevalent worldwide. Due to global crises, such as the covid pandemic, the prevalence of domestic violence increases. Reported cases of intimate partner violence have been rising rapidly

worldwide due to additional stressors of restrictions, covid measurements, and lockdowns (WHO, 2021).

Intimate partner violence (IPV) and *non-intimate partner violence* (NIPV) are the most common forms of violence against women. According to the WHO (2021), intimate partner violence is defined as violence by a spouse or an intimate partner (physical, sexual, or psychological) and is the most common form of abuse worldwide. Non-intimate partner violence is referred to as physical and/or sexual violence by a perpetrator, e.g., a relative, friend, acquaintance, or stranger, thus a non-intimate partner. The latter form of violence will be of main interest in this review. Given its little research attention it is important to shed more light onto this matter.

A physical fight, and violence in itself, is a threatening situation for women if the perpetrator is of clear physical advantage and dominating. She may aim to defend herself or to escape the situation, which is conceptualised as the fight-or-flight response. This elicits a stress response in her body leading to heightened autonomic nervous system activity preparing the human body to run away from the threat or to fight by mobilizing more physical powers, respectively (Hagenaars et al., 2014). If the chance to escape the threat situation or to win the fight with the perpetrator is (perceived to be) very little, the most likely response is *freezing*. Indeed, some studies suggest that humans tend to freeze in threatening situations in which the fight-or-flight response is maladaptive (Schmidt et al., 2007; Arduino & Goud, 1984; Korte et al., 2005). In animal studies freezing was characterized by immobility, a tense body posture (Hagenaars et al., 2014; Fanselow, 1984; Kalin & Shelton, 1989), reduced heart rate (Vianna & Carrive, 2005; Walker & Carrive, 2003) and reduced vocalization (Jelen et al., 2003; Takahashi & Rubin, 1993). It was also argued to function as a universal defence response and can be observed in response to conditioned and/ or unconditioned fear (Rosen, 2004). For animals, freezing can have an adaptive function in case of a predatory attack. For

example, it may “play dead” and the flow of painkillers throughout the body reduces pain severity (Schmidt et al., 2007). Translated into the context of violence against women, women may not be able to act or react due to freezing. Consequently, the inability to demonstrate proactive behaviours, such as fighting the perpetrator or to escape the situation, might put them at even greater risk of being abused. Additionally, resulting from the inability to act accordingly, affected women might experience helplessness, which can have substantial negative effects on their mental well-being (Moor et al., 2013). For example, abused women are more likely to develop psychopathologies. Particularly the risk for developing PTSD (Hagenaars et al., 2008; Rizvi et al., 2008) and social phobia (Buss et al., 2004) increases significantly. However, most research on the freeze response is based on animal studies and thus, generalizability to humans is limited. Furthermore, only little research can be found on sex differences in response to an acute threatening situation. A study by Taylor et al. (2000) argues that females tend to “tend-and-befriend” as a response to stress instead of “fight-or-flight”. Followingly, women rather gather in groups and maintain their social networks. If threat is approaching or their offspring is perceived to be in danger, they tend to act in an aggressive manner towards their perpetrator. Hence, social bonds can function as a protective shield against abuse. Logically, women with rather weak social networks might be at a higher risk to become a victim of violence (Taylor et al., 2002; Mitchell, 1990; Wolf & Witke, 1975). Hence, the quality of a woman’s social bond can be a variable related to her susceptibility and response to acute abuse.

Women experiencing violence suffer from significant *health consequences*. Studies on intimate partner violence suggest that gynaecological, central nervous system, and stress-related problems increase by 50% - 70%. More specifically, abused women experienced more headaches, vaginal bleedings/ infections, and pelvic pain compared to non-abused women (Campbell et al., 2002). In addition, domestic violence is also linked to a higher probability of

developing a depressive disorder, an anxiety disorder, or symptoms of PTSD (Oram et al., 2017). According to a study on the effects of domestic and sexual violence against patients with a pre-existing severe mental illness, suicidality increased by more than 50% (Khalifeh et al., 2015). There appears to be no substantial difference in negative effects between intimate partner violence and non-intimate partner sexual violence (Oram et al., 2017). In other words, physical and/or sexual non-intimate partner violence can be as harmful as domestic violence. Both have a severe negative effect on the victim's life.

The current review aims to have a deepened understanding of the immediate and long-term health consequences of physical and/or sexual non-intimate partner violence. By integrating research findings from health consequences of intimate-partner violence, it is aimed to create a coherent picture of its immediate and long-term impact. Furthermore, most studies focus on long-term consequences of abuse, whereas the immediate response is just as important. By having a better understanding of the female stress response to abuse, intervention plans and self-defence programmes can be designed and enhanced to reduce the prevalence of violence against women worldwide. In addition, post-abuse support can be improved to reduce the risk for depression and other psychopathologies.

Methods

A literature research was conducted by searching the psycINFO database in September 2022 with the following keywords: "Violence against women" AND "health consequences" (n=157), "mental health" AND "non-intimate partner violence" NOT "domestic violence" (n=5), "physical health" AND "violence against women" NOT "domestic violence" (n=174), "rape" AND "health consequences" (n=227), "Violence against women" AND "health consequences" AND "domestic violence" AND "sexual violence" NOT "child abuse" (n=10), "freeze response" AND "humans" AND "stress response" (n=6). In order to filter out irrelevant studies, it was adjusted for correlating variables, such as child

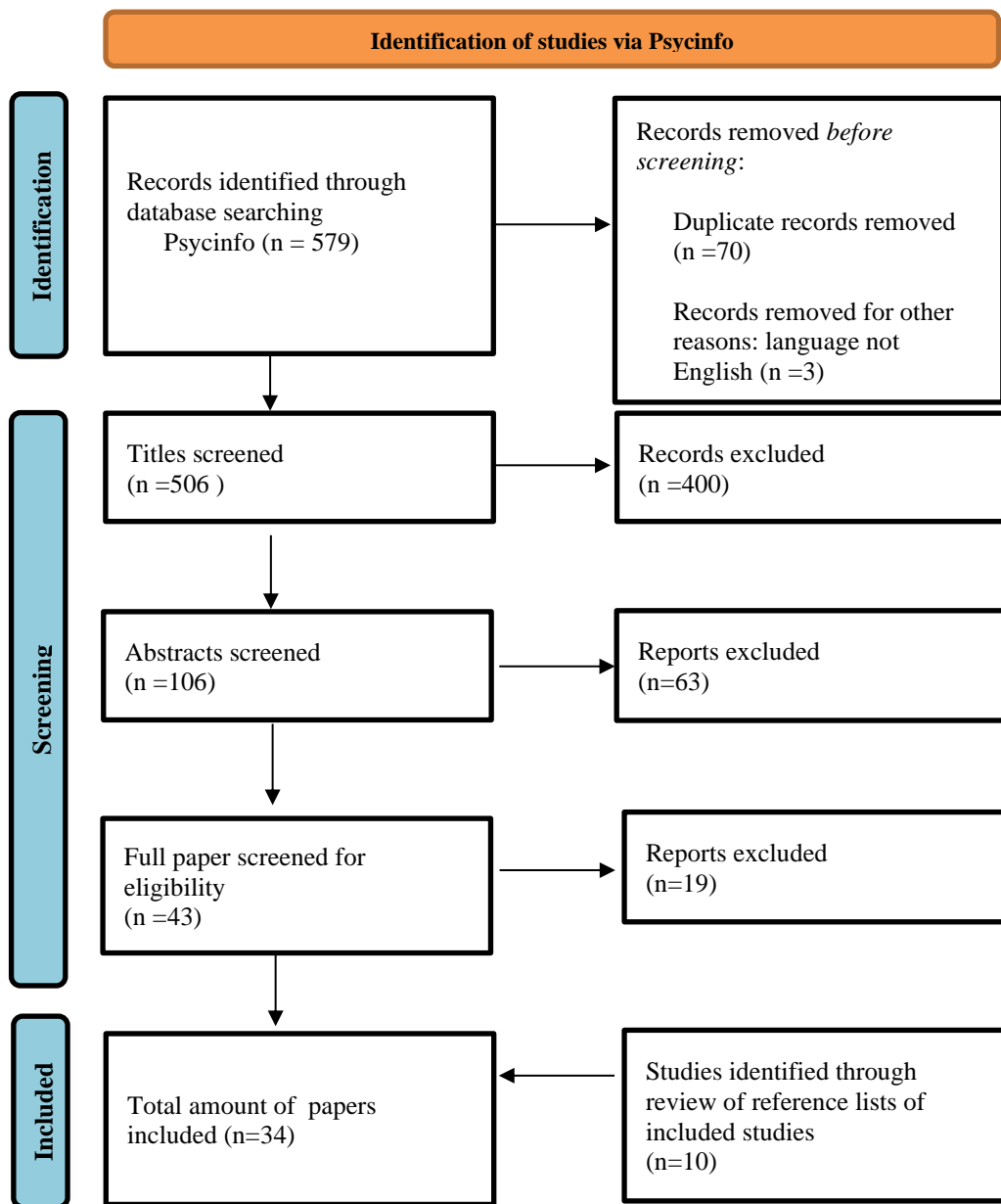
abuse. It is highly interrelated with violence against women but yet, not of interest in this literature review as its focus is on physical and/or sexual violence against adult women.

The literature used for the review was chosen based on its currency with regard to violence against women prevalence estimates. In order to create a coherent overview, only articles about domestic violence, sexual and/or physical non-intimate partner abuse on adult women were chosen. Plus, only articles investigating the effect of threatening situations on humans' stress response were considered. Followingly, the inclusion criteria for choosing articles involved violence against women worldwide, sex differences in stress response to threat, sexual abuse, physical abuse, intimate partner abuse, domestic abuse, rape, freeze response, physical and sexual violence, mental health consequences of violence against women, physical health consequences of violence against women. The exclusion criteria were the following: Forced marriage, Female Genital Mutilation (FGM), trafficking, child abuse, abuse during pregnancy, adolescent female participants, online abuse, transgender/homophobic violence, racist-oriented violence, gender-based violence, violence against women with disabilities, psychological/ emotional violence, economic violence, and violence against sex workers.

Another quality assessment method was to check for peer reviewed articles. The papers were investigated thoroughly for possible research gaps, contradictory findings, or arguments. Systematic review articles on freeze responses and health outcomes were selected to get an overview as well as insight into the topic at hand. Followingly, 20 articles about the health consequences of violence against women were included, and four studies were reviewed about human freeze responses to a stressor. Ten studies were identified and screened for eligibility by reviewing reference lists of included studies. In total, the current literature review entails 34 studies. Figure one shows a detailed overview of the

aforementioned literature research process.

Figure 1: PRISMA 2020 flow diagram for new systematic review (Page et al., 2021)



Results

The current review aims to examine the immediate and long-term health consequences of non-intimate partner abuse on female victims. However, there is not much literature to be found that provides evidence-based results about the (immediate) impact of non-intimate partner sexual and/or physical violence (NIPV). Most information is based on documented observations or self-reports. Consequently, findings from studies on intimate partner violence (IPV) have been added to fill the respective research gaps. The type of violence will be indicated in the text, correspondingly. For further clarification purpose, immediate health consequences entail arising symptoms occurring immediately after the assault up to three months. From four months onwards, it is considered as long-term health consequences in this paper.

Immediate Health Consequences

Psychological

Immediately after the sexual assault, victims consistently reported feelings of shock, fear, anxiety, panic, and feeling vulnerable, as well as denial, confusion, and numbness (Jina & Thomas, 2012; Goodman et al., 1993). Plus, feelings of extreme helplessness and the perceived inability to control the scope of the assault have been consistently reported by survivors of sexual NIPV (Moor et al., 2013; Goodman et al., 1993). More specifically, due to the natural “freeze” response right before and during the sexual assault, also referred to as “rape-induced paralysis” (Schmidt et al., 2007), women tend to blame themselves and feel guilty for not having “defended” themselves. Moor et al. (2013) argue that the peritraumatic dehumanisation, e.g., the feeling of being objectified and humiliated during the assault, predicts the degree of freezing. Freezing during the assault is associated with guilt and self-blame post abuse. Likewise, in a study by Boven et al. (2014), guilt was found to be a

significant mediator between tonic immobility during the assault and the degree of PTSD severity in the aftermath. Thus, freezing (or tonic immobility) has been consistently linked to self-blame and to the severity of PTSD symptoms.

Afterwards, symptoms were found to peak after 3 weeks, remain high for up to one to two months, and usually begin to decline after two months (Campbell, 2001). The victim's mental well-being at the end of the third month post-abuse was argued to be a valid indicator of their long-term adjustment (Burgess & Holmstrom, 1979; Roth & Lebowitz, 1988). Some affected women, however, do not show signs of mental health issues immediately after the abuse (assumed to repress their feelings, appear calm; Jina & Thomas, 2012) or their symptoms disappear temporarily and return later (Forman, 1980). Hence, the scope of the aftermath is highly individual and cannot be generalized.

Physical

Any form of physical and/or sexual violence can bring the risk of injuries, e.g., by means of physical force or by use of weapons. Rape, specifically, has been linked to a higher risk for injuries (Abraham et al., 2014; Culbertson & Delhe, 2001). In a study by Beebe (1991), 39% of abused women reported a nongenital physical injury, e.g., scrapes on the head, face, or (on) other body parts. 54% of those sought medical treatment for their injuries. Additionally, physical or sexual NIPV can lead to a mild to moderate traumatic brain injury (TBI), which is associated with (temporary) changes in cognition, affect, motivation, and behaviour. Severe TBI can include multiple traumas, major fractures, or major lacerations which might require the survivor to hospitalize for further treatment (Geist, 1988; Cybulska, 2013).

The majority of women sustain minor (outer-)genital injuries, such as open wounds and lacerations, bites, burns, or anorectal injuries/ tears (Cybulska, 2013; Goodman et al.,

1993). Major injuries can include deep open wounds, heavy pelvic bleeding, rectal bleeding, and deep genito-rectal lacerations that may require suturing and/or surgery (Cybulska, 2013).

Long-Term Health Consequences

Psychological

The most common mental disorder diagnosed for IPV and NIPV survivors is post-traumatic stress disorder (PTSD). Affected women might experience flashbacks or nightmares of the traumatic event, dissociative symptoms, and impaired functioning in their daily lives (Temple et al., 2007). One of the explanatory factors has been argued to be the freeze reaction during the sexual assault itself. Moor et al. (2013) stated that freezing during the assault is linked to prolonged self-blame. Thus, freezing during a distressing event has been linked to psychopathology and to PTSD in particular (Hagenaars et al., 2008). Some studies found that rape victims (in specific) form the largest group of diagnosed PTSD victims (Campbell & Wasco, 2005; Jina & Thomas, 2012; Campbell, 2001; McFarlane et al., 2009), whereas others argue that IPV victims are mostly affected by PTSD. Followingly, their likelihood of developing PTSD symptomatology increases by seven times (Oram et al., 2017; Trevillion et al., 2012).

Furthermore, sexual and/or physical abuse has been linked to depression and anxiety (WHO, 2013). Particularly, domestic violence increases the risk for depression, even in women with no previous history of depressive symptoms (Oram et al., 2017; Holmes et al., 1996). In more detail, a three time increase in developing a depressive disorder has been reported, as well as a four time increase in the likelihood of an anxiety disorder when experiencing IPV (Oram et al., 2017; Golding et al., 1988). Likewise, NIPV (e.g., rape) has been consistently linked to depression as well (Kilpatrick et al., 1981; Goodman et al., 1993; Campbell, 2002; Jina & Thomas, 2012; Abraham et al., 2014; WHO, 2013). Violence against

women is also strongly associated with suicide attempts (Devries et al., 2011), which particularly holds for IPV. Accordingly, 22-50% of affected women report suicidal ideation (Ellis, Atkeson, & Calhoun, 1981; Koss, 1988). Non-partner sexual violence was generally not linked to female suicidality (Devries et al., 2011).

Further long-term mental health consequences can include the development of an eating disorder, as well as substance abuse (Oram et al., 2017). Domestic violence is positively correlated with maladaptive eating patterns, such as fasting, bingeing, purging, and abusing diet pills (Jina & Thomas, 2012; Löbmann et al., 2003). Particularly women who experienced sexual IPV suffer from a lower self-esteem and a more distorted body image (Campbell, 1989). Findings from other studies suggest that this also holds for NIPV victims (Jina & Thomas, 2012). Besides, substance abuse and other risky health behaviours have been reported across studies. For example, smoking cigarettes, heavy drinking, and illicit drug use is linked to IPV, as well as to NIPV (Jina & Thomas, 2012; Faravelli et al., 2004; Oram et al., 2017; Goodman et al., 2013).

Overall sexual dissatisfaction has been reported thoroughly as well, for both IPV and NIPV victims. Manifestations of this dissatisfaction range from reduced sexual pleasure (Feldman-Summers et al., 1979), generalized sexual dissatisfaction (Orlando & Koss, 1983) to impaired sexual functioning and low satisfaction in an intimate relationship after a sexual trauma. A systematic review of the impact of sexual trauma on the victim's sexuality (Denis et al., 2020) argued that a sexual disorder can be understood as a somatoform manifestation of sexual assault (PTSD). On the other hand, IPV has been associated with overall risky sexual behaviour. More specifically, women suffering from (domestic) sexual violence are more likely to have multiple sex partners and tend to engage in less safety sex behaviours, e.g., no condom use and irregular gynaecological check-ups. It is argued to be a result of their sustained psychological distress and suffering (Jewkes et al., 2010).

Besides, abused women tend to socially withdraw from their family and friends. This lack of social bonds and support can negatively affect their mental health status (Taylor et al., 2002). A study examining the effects of (assault-related) PTSD on women's use of social cues found that affected women respond differently in social interactions. In particular, it was argued that due to their hypervigilance to threat they show a lack of social trust and reciprocity (Cisler et al., 2015). Another study argued that women's egalitarian attitudes and their view of gender roles are negatively affected due to prolonged experiences of IPV. Consequently, they show poorer decision-making regarding health promoting choices, such as getting help or leaving their abusive spouse (Rodriguez, 2018).

Physical

The physical long-term consequences of violence against women depend, among other factors, on the type of violence and its severity. However, there is emerging research on the physical impact of sexual NIPV showing its association with prolonged and chronic physical health problems (Campbell & Wasco, 2005; Golding, 1994; Koss et al., 1991). Yet, there is still more evidence-based findings on sustained injuries of IPV. In a national survey of IPV in the Netherlands by Römken (1997), $\frac{2}{3}$ of all abused women suffered from sustained injuries, of which $\frac{1}{3}$ suffered from permanent injuries, such as scars, hearing difficulties, etc.

Also, gastrointestinal symptoms are very common among abused women. Particularly symptoms of nausea, vomiting, abdominal pain, and digestive problems have been reported across studies (Golding, 1994; Campbell et al., 2002; Jina & Thomas, 2012). NIPV has been linked to gastrointestinal irritability as well, e.g., rape victims experienced stomach pain and reduced appetite (Goodman et al., 2013). Another common health consequence of IPV are chronic conditions, such as chronic pelvic pain, chronic back pain, migraines, chronic pain

syndromes, alcoholic liver disease, and fibromyalgia (Campbell et al., 2002; Cunningham et al., 1988; Drossman et al., 1990; Golding et al., 1988; Koss & Heslet, 1992).

Violence against women also has a negative impact on a woman's reproductive health. The most commonly reported gynaecological complaints involve genital injuries or irritations, vaginal bleeding or infection, premenstrual syndrome (PMS), urinary tract infections, as well as painful intercourse and menstruation (Jina & Thomas, 2012; Campbell et al., 2002). Sexual violence can also lead to an unwanted pregnancy, which can have immense negative consequences on the woman's physical (and mental) health. According to a study of the WHO (2013), the risk of miscarriage increases by 16%, and that of a preterm birth by 41%. Besides, in some countries women might be forced to either keep the child or to undergo a risky abortion, which can have fatal health consequences, mentally and physically (Jina & Thomas, 2012; WHO, 2013). Moreover, the risk for sexually transmitted infections (STI) increases significantly for both, victims of IPV and NIPV. The most common STI are gonorrhoea, chlamydia, and trichomonas vaginalis (Cybulska, 2013). Logically, the risk of being infected with HIV (human immunodeficiency virus) or hepatitis B increases as well, which can be fatal if not treated on time (Jina & Thomas, 2012; Cybulska, 2013).

Lastly, abused women (IPV) are more likely to be diagnosed with a cardiovascular disease (CVD) (McFarlane et al., 2010; Black & Breiding, 2008). In their study, McFarlane et al. (2010) found a positive association between IPV, depression and PTSD, and CVD which was associated with overall worsened health status. Additionally, another study found that IPV victims are more likely to be diagnosed with cancer, in particular cervical cancer (Cesario et al., 2013). Followingly, contributing factors are extreme psychological distress, chronic distress, depression, bad health behaviours (such as smoking and alcohol abuse), and risky sexual behaviours, which have been linked to IPV repeatedly.

All of these aforementioned findings reveal interesting patterns that will further be discussed in the following discussion section. Plus, implications of these results as well as prospective research on the topic at hand will be discussed.

Discussion

The primary purpose of this review was to deepen the understanding of immediate and long-term health consequences of physical and/ or sexual non-intimate partner violence. While domestic violence has been repeatedly linked to negative health outcomes for the victim, little attention has been drawn to the outcomes of NIPV. Results of the current literature review suggest that NIPV indeed has a significant negative effect on the victim. More specifically, abuse has been argued to be the highest risk factor for developing PTSD, depression, and anxiety. Furthermore, physical injuries are likely to occur from a mild to severe degree. In addition to findings of NIPV, IPV is correlated with numerous negative health consequences, too. Based on the latest research findings, it has been linked to a significantly worse health outcomes compared to NIPV (Cultbertson & Dehle, 2001). This may be due to the nature of domestic violence. More specifically, affected women are constantly exposed to potential violence leading to sustained psychological distress, as well as a heightened risk for (severe) physical injuries (Temple, 2007). Common health consequences include chronic illnesses, reproductive health issues, gastrointestinal issues, psychopathologies and more.

Embodied process

In this review, immediate and long-term health consequences are differentiated by means of a specific time duration. Hence, the immediate impact of abuse involves symptoms occurring immediately after the incidence up to three months. From the fourth month onward, it was classified as a long-term health consequence. This operationalisation allows for a clear overview and a better understanding of the topic. However, the transition and process of the aftermath is rather fluent and non-linear. Thus, it is not fully applicable to the real-world setting. Several factors influence the scope of the recovery process post abuse, which in turn, also determines the impact and severity of arising symptoms in the long run. Namely, the victim's social support system, intrapersonal characteristics (resilience, personality traits, coping skills), their demographic context, as well as cultural norms and values play a significant role (Campbell, 2002; Cesario et al., 2013). In fact, many rape victims encounter stigma and rape-myths hindering them from seeking or receiving help. Therefore, they tend to socially withdraw. In line with research findings, social support is a strong predictor for long-term recovery and well-being (Cesario et al., 2013). Logically speaking, low social support negatively correlates with the victim's health status, physically and psychologically. Therefore, the transition from immediate shock and guilt to the onset of PTSD (or another mental disorder) could be partly explained by the aforementioned variables.

Besides, health consequences were subdivided into physical and psychological effects. As discussed above, it serves for a better overview of the reviewed topic. However, those two domains are highly interrelated and thus, cannot be fully differentiated in reality. The victim's physical health status strongly impacts their mental well-being and vice versa – the so-called “mind-body connection” (Levine et al., 2021). In fact, there is increasing evidence that an individual's psychological health is causally linked to biological alterations and health behaviours, which can cause cardiovascular diseases (Levine et al., 2021; Cesario et al.,

2013) or cervical cancer (McFarlane et al., 2009). Such biological alterations in hormone levels are caused by activation of the hypothalamic-pituitary-adrenal axis (HPA), which is triggered by psychological distress. As follows, the HPA-axis releases the stress hormones adrenaline and cortisol preparing the body to fight-or-flight, whereas in most rape scenarios the victim tends to freeze. It is argued that when the human body is trapped in a freeze response, the stress hormones flow continuously (i.e., the HPA-axis is still activated) with potentially fatal consequences on the physical health due to the body's collapse. Common symptoms are dissociative features and digestive symptoms, as mentioned above in this literature review (Burke, 2020; Van der Kolk, 2014). The manifestation of trauma in the human body, as in the human body being locked in a trauma response, is one of the main factors for the onset of chronic illnesses and other medical symptoms. It appears as if the human brain cannot adapt to the new psychological state. It cannot comprehend that the trauma has passed and is caught in a vicious circle of stress.

Implications of findings

Considering the drastic health consequences victims of violence suffer from, there is no doubt that prevention as well as appropriate treatment have to take place. To cite the World Health Organisation (2018): "Violence against women is a global public health problem of pandemic proportions, affecting hundreds of millions of women and requiring urgent action". The fact that the majority of IPV victims develop chronic conditions, suffer from depression, or even attempt suicide, should alarm everyone to act accordingly. Protection from violence should not be a privilege, but a given right. Yet, millions of women suffer from abuse, most of them silently. Prevention interventions should include awareness-raising campaigns to reduce the stigma around rape and to promote help-seeking behaviours in affected women. Also, health care institutions as well as health care professionals should

receive training to provide immediate help and to act accordingly. Screening and assessment for (domestic) abuse should be standard in every treatment by a health care professional if violence is suspected, e.g., obvious injuries and/or abuse-related injuries.

On an individual level, women's sense of agency should be addressed to promote a fight-or-flight response in the context of a threatening situation. In line with the discussed research findings, the majority of women tend to freeze when the chance to either escape or to fight is perceived to be very little/ impossible. This usually accounts for situations in which rape occurs. Freezing, however, is associated with guilt and self-blame and is the strongest predictor for PTSD severity (Hagenaars et al., 2016). By addressing their stress response to acute threat, by teaching them to defend themselves (thus, to fight-or-flight), the symptomatology would decrease post abuse (Moor et al., 2011; Moor et al., 2013). It is aimed to give affected women a feeling of control and power over the situation instead of feeling helpless and vulnerable. In addition, encouraging women in their autonomy and in their egalitarian values promotes decision-making for better health choices (Rodriguez, 2017). In other words, encouragement and empowerment are key elements to promote progressive and proactive behaviours towards a higher quality of (female) life. However, it can be challenging to implement this form of rethinking in orthodox and conservative countries. Lastly, survivors of IPV and NIPV should receive trauma therapy to cope with the emotional distress. By addressing the experienced trauma, their mental health will stabilize. Plus, due to the aforesaid mind-body connection their physical health will improve as well resulting in an increased quality of life (Burke et al., 2020; Levine et al., 2021). Cognitive-Behavioral Therapy (CBT) as well as EMDR (Eye Movement Desensitization and Reprocessing) are cost effective and efficient forms of therapy. CBT addresses the victim's repertoire of coping skills and behaviours, whereas EMDR aims to reduce the emotional load of certain distressing memories (Burke, 2020; Edmond et al., 2004).

Limitations

There are also limitations to this literature review. Firstly, the operationalisation and measurement of violence against women differs significantly between studies. Hence, comparing data from various studies and finding meaningful differences is difficult up to impossible given the lack of coherence. Yet, findings are still valid as all studies support the fact that (any kind of) violence negatively affects the victim's health. Only the severity differs. Secondly, many articles used in this review were identified by reviewing the reference lists of other studies. This increases the risk of cross-referencing and a unilateral perspective on the matter at hand. By integrating findings from various fields of social psychology, neuropsychology, and clinical psychology, it was aimed for a multi-sided approach and to adjust for cross-referencing. Thirdly, the victim's ethnicity and socio-economic status (SES) was not accounted for. Studies suggest that certain population groups, such as African American women, are at higher risk for abuse, as well as individuals with a low SES (Campbell et al., 2002). Lastly, it is important to note that there is a high number of unreported cases of violence against women. According to the WHO, 20-60% of abused women never reported their abuse to the police or any other public health care centrum (WHO, 2021; Römken, 1997). Thus, the prevalence of IPV and NIPV is, most likely, higher than estimated.

Future Research

Given the current prevalence of conflict settings, e.g., the revolution in Iran or the war in Ukraine, the prevalence of rape increases as well, logically. Future research should gather more insight into the immediate and long-term impact of NIPV to offer better help to victims. In addition, standardized measurements as well as a universal definition of the different forms of violence against women should be applied. This makes research outcomes more

comparable and clearer. This, in turn, is also beneficial for designing future intervention programmes. Lastly, it increases the validity of research findings. Considering the high number of unreported cases of violence against women, it implies that prevalence interventions are not sufficiently fruitful yet.

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