EFFECTS OF INTIMATE PARTNER VIOLENCE (IPV) ON THE MENTAL HEALTH, SOCIOECONOMIC WELL-BEING AND EMPLOYEES PERFORMANCE IN KWALE COMMUNITY, NDOKWA WEST LOCAL GOVERNMENT AREA OF DELTA STATE, NIGERIA

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ABSTRACT

Intimate partner violence (IPV) remains a major public health challenge with serious mental health and socioeconomic consequences which impact negatively on employee's performance. This study investigated the mental health and socioeconomic impacts of IPV among adult residents in Kwale, Ndokwa West Local Government Area, Delta State, Nigeria. Specifically, it examined the relationship between IPV exposure and mental health outcomes, assessed socioeconomic impacts, and evaluated the influence of sociodemographic factors and coping resources. It examined the impact of IPV on employee's output. A cross-sectional quantitative research design was adopted. Using multistage sampling, 462 respondents were selected. Data were collected through structured questionnaires incorporating validated instruments and analyzed using descriptive and inferential statistics. The findings revealed an IPV prevalence of 64.5%. Respondents exposed to IPV reported significantly higher levels of depression, anxiety, and post-traumatic stress disorder than those not exposed. IPV survivors also recorded lower household incomes, higher unemployment, and reduced economic independence. Social support significantly moderated the relationship between IPV exposure and adverse mental health outcomes, while demographic factors and coping resources explained a substantial proportion of the variance in depression. There is a poor performance output index for employees. The study concludes that IPV imposes significant mental health and socioeconomic burdens on survivors. It recommends strengthening mental health services, economic empowerment programs, legal protection, community support systems, and continuous multisectoral research.

Keywords: intimate partner violence, mental health, socioeconomic well-being, employee's performance

INTRODUCTION

Intimate partner violence (IPV) constitutes one of the most pervasive and consequential public health challenges of the contemporary era, transcending geographical, cultural, and socioeconomic boundaries. The World Health Organization (WHO) has definitively characterised IPV as a profound violation of human rights with far-reaching implications for individual well-being, community cohesion, and national development trajectories (Armah-Ansah et al., 2025). Globally, epidemiological surveillance indicates that approximately one in three women, representing nearly 736 million individuals, will experience physical and/or sexual intimate partner violence or no partner sexual violence during their lifetime (Patel &

Longchar, 2026). This staggering prevalence positions IPV as a phenomenon of epidemic proportions, demanding urgent scholarly attention and evidence-based policy intervention. The mental health sequelae of IPV exposure represent perhaps the most insidious and enduring dimension of its burden. Contemporary meta-analytic evidence synthesized by Deacu et al. (2026) across 18 peer-reviewed studies encompassing approximately 62,000 women from diverse national contexts revealed that depression prevalence among IPV survivors ranges from 20% to over 50%, while post-traumatic stress disorder (PTSD) prevalence extends from approximately 30% to 70%, contingent upon measurement instruments and population characteristics. These findings align with the theoretical architecture articulated by the socio-ecological model, which posits that violence exposure at the individual, relational, community, and societal levels interacts to produce cumulative psychological morbidity (Armstead et al., 2021). The temporal persistence of these mental health consequences is particularly concerning; longitudinal evidence demonstrates that depressive symptomatology and anxiety disorders frequently endure well beyond the cessation of active violence, manifesting as chronic pain, gastrointestinal disturbances, and sustained emotional dysregulation that compromises victims' capacity for occupational functioning and social engagement (Giuliani et al., 2025).

The economic burden of IPV constitutes an additional dimension of its global significance that has received increasing scholarly attention. Healthcare utilization patterns among IPV survivors demonstrate markedly elevated rates of service engagement, with Deacu et al. (2026) documenting that affected women exhibit 2.6-fold higher emergency department utilization, 2.2-fold greater inpatient admission rates, and 2.2-fold augmented healthcare costs compared to non-exposed counterparts. These direct healthcare expenditures are compounded by indirect costs encompassing lost productivity, reduced labor force participation, and intergenerational economic disadvantage transmitted through compromised maternal health and child development outcomes (Gunarathne et al., 2021 and Ikenyei&Akpotor 2020).

The cumulative economic toll positions IPV as a significant impediment to the achievement of sustainable development objectives, particularly Sustainable Development Goal 5, which explicitly targets the elimination of all forms of violence against women and girls by 2030 (Ikuteyijo et al., 2025). Notwithstanding the normative commitments enshrined in international frameworks including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) and the Beijing Declaration and Platform of Action (1995), implementation gaps persist, with cultural and religious justifications frequently invoked to evade state obligations under Article 4 of the Declaration on the Elimination of Violence against Women(Ikenyei 2017).

The African continent bears a disproportionate burden of intimate partner violence, with prevalence estimates significantly exceeding global averages. The WHO African region, encompassing predominantly sub-Saharan African nations, reports an IPV prevalence of 36.6%, surpassed only by South-East Asia (38%) and the Eastern Mediterranean (37%) (Nakie et al., 2025). Systematic review evidence synthesized by Esparza-Del Villar et al (2026), examining 352 quantitative studies conducted across African countries between 2013 and 2023, confirms persistently high rates of physical and sexual violence, with significant gendered dimensions and diverse cultural patterning . Notably, a recent meta-analysis by investigators published in BMC Public Health (2026) examining female-perpetrated IPV against men across six African countries encompassing 17,939 participants revealed a pooled

prevalence of 40.49% (95% CI: 31.53%–49.44%), with psychological violence emerging as the most prevalent subtype (Rehman et al., 2023). These finding challenges prevailing conceptualizations of IPV as exclusively male-perpetrated against women, suggesting that bidirectional violence constitutes a significant, albeit underrecognized, public health concern across the continent (Yesuf et al., 2026). Cultural norms and gender inequality function as primary determinants of IPV prevalence across African contexts. The patriarchal social structures that characterize the majority of African societies systematically accord men greater power than women, facilitating dominance in both private and public domains (McCloskey et al., 2016 and Ikenyei 2020).

This patriarchal system thrives on unequal power relations that are socially constructed and reinforced through customary practices, religious beliefs, and institutional arrangements (Onoshakpor et al., 2025). Diala (2024) compellingly argues that the resilience of gender-based violence against comprehensive legal frameworks necessitates reappraisal of the interplay between key sustaining factors, including harmful socio-economic forces such as religion, culture, and tradition. The commercialization of bridewealth payment, a widespread practice formally legitimizing marriage across sub–Saharan Africa, exemplifies how traditional institutions have been distorted to reinforce women's subordination. As Enemo cited in Diala (2024) observes, wives on whose head's bride price has been paid are systematically excluded from important family decisions, including those concerning their reproductive health, sexual autonomy, and childbearing choices (Ikenyei& Lawal 2019).

Health system responses to IPV across Africa remain markedly inadequate, characterized by fragmented service delivery, insufficient provider training, and limited integration of violence screening into routine healthcare. Arcaio and Parroco (2024), employing structural equation modelling across Demographic and Health Survey data from eleven African countries, demonstrated the importance of individual characteristics in predicting IPV experience, while community and societal factors exhibited comparatively weaker associations. This finding suggests that targeted individual-level interventions may yield significant benefits, yet implementation remains constrained by resource limitations and competing health priorities. The socio-ecological framework, as articulated by Patel and Longchar (2026), situates perpetration within interacting influences at individual, relationship, community, and societal levels, emphasizing how structural inequalities and inequitable gender norms shape men's use of violence . The concept of hegemonic masculinity underscores how dominant ideals of male authority, control, and entitlement can legitimize violence, particularly in contexts of economic strain or shifting gender roles (Patel & Longchar, 2026).

PROBLEM STATEMENT

Despite extensive documentation of IPV prevalence and associated health outcomes, significant inconsistencies persist in the conceptualization of mental and socio-economic impacts. Much of the existing literature has adopted a compartmentalized approach, examining psychological consequences and economic outcomes in relative isolation rather than as interconnected dimensions of a unified experience of victimization (Muchemwa et al., 2025). This conceptual fragmentation obscures understanding of how mental health deterioration and socioeconomic marginalization interact to compound vulnerability and impair recovery. Furthermore, prevailing frameworks have predominantly focused on physical and sexual violence, with limited attention to the psychological and economic abuse that frequently co-occurs and exerts enduring harm (Salem & Robenson, 2025). The concept of coercive control, articulated by Stark and increasingly recognized in contemporary scholarship, offers a more

comprehensive framework for understanding IPV as a patterned strategy of domination encompassing physical, psychological, sexual, and economic dimensions (E. Stark, 2020). However, empirical application of this framework in Nigerian contexts remains limited, constraining the evidence base for holistic intervention design. Additionally, the emerging recognition of male victimization challenges prevailing gendered conceptualizations, yet empirical investigation of mental health and socioeconomic impacts among male survivors in Nigeria remains virtually absent.

Empirical evidence on the mental health consequences and socioeconomic impacts of IPV in Nigeria suffers from significant limitations. While national surveys such as the NDHS provide valuable prevalence data, they offer limited depth regarding the specific psychological manifestations, including depression, anxiety, PTSD, and suicidality, experienced by survivors, as well as the precise mechanisms through which violence exposure compromises economic wellbeing (Ayowole et al., 2025; Brown et al., 2024). Furthermore, the temporal relationship between IPV exposure and mental health decline, and the mediating role of socioeconomic factors, remains insufficiently characterized. Conflicting evidence regarding the direction of association between women's employment and IPV risk, with some studies suggesting employment reduces vulnerability while others indicate it triggers retaliatory violence, highlights the need for nuanced contextual investigation (Meyer et al., 2024). Similarly, the intergenerational transmission of violence and its socioeconomic consequences, while documented globally, lacks robust empirical examination in Nigerian settings.

Previous studies on IPV in Nigeria and Africa more broadly have predominantly employed cross-sectional designs that preclude causal inference and fail to capture the dynamic nature of violence exposure and its consequences (Ani & Katende-Kyenda, 2025). Sampling strategies have frequently focused on clinical populations, antenatal attendees, or specific geographic areas, limiting generalizability and introducing selection bias (Zrineh et al., 2026). Measurement of IPV has often relied on abridged instruments that fail to capture the full spectrum of abuse experiences, particularly psychological violence and coercive control (Ford-Gilboe et al., 2016). Furthermore, the predominant focus on female victims, while critically important, has resulted in the neglect of male victimization, creating a one-dimensional evidence base that inadequately informs gender-inclusive prevention and support services (Focardi et al., 2026). Analytical approaches have frequently employed bivariate and basic multivariate techniques without fully exploiting advanced methods capable of elucidating the complex pathways linking IPV exposure to mental health and socioeconomic outcomes.

The specific study community lacks robust empirical evidence on the mental health and socioeconomic consequences of IPV, despite its location in a region with documented high prevalence (Gracia et al., 2026). Local healthcare providers, social workers, and policymakers lack context specific data to inform service delivery and intervention design, resulting in programs that may be mismatched with community needs and realities. The cultural and socioeconomic specificities of the study area, including its urban rural dynamics, ethnic composition, economic activities, and religious landscape, create a unique context within which IPV is experienced and responded to, yet this context remains empirically underexplored (Ravaghi et al., 2023). The absence of local evidence undermines advocacy efforts and constrains the development of culturally appropriate, evidence-informed interventions that address the specific determinants and consequences of IPV in this community.

Notwithstanding the existence of legislation criminalizing violence and mandating victim support, policy implementation in Nigeria exhibits profound shortcomings. The Violence Against Persons (Prohibition) Act of 2015, while progressive in its provisions, suffers from

inconsistent state adoption and limited enforcement (Yusuf & Agbonifo, 2026). Mental health services, essential for addressing the psychological consequences of IPV, are critically under-resourced and poorly integrated with violence response systems (Sorrentino et al., 2021). Referral pathways between healthcare, social services, and legal institutions remain fragmented, with survivors frequently falling through gaps in the service delivery system. Furthermore, policies addressing the socioeconomic dimensions of IPV, including financial empowerment, housing support, and employment assistance, remain underdeveloped or absent. The absence of community-based prevention programs that address the cultural norms and gender inequities sustaining violence perpetuates cycles of abuse across generations. These policy implementation failures underscore the urgent need for rigorous empirical evidence to inform advocacy, strengthen accountability mechanisms, and guide resource allocation towards effective interventions.

The present study is justified by the convergence of these interconnected gaps. First, the conceptual gap necessitates a comprehensive examination of mental health and socioeconomic impacts that moves beyond compartmentalized analysis to understand their interconnection. Second, the empirical gap demands rigorous investigation of specific psychological consequences and economic outcomes among IPV survivors in a context where such evidence is limited. Third, the methodological gap requires application of robust study designs and analytical approaches capable of elucidating causal relationships and complex pathways. Fourth, the contextual gap underscores the need for community-specific evidence to inform locally appropriate interventions. Fifth, the policy gap highlights the urgency of generating evidence to strengthen advocacy, improve service delivery, and enhance accountability for implementing existing legislation and commitments. By addressing these multiple gaps, the present study will contribute to the evidence base for effective IPV prevention and response in Nigeria, with implications for policy, practice, and future research.

OBJECTIVES OF THE STUDY

The broad objective of this study is to examine the effects of intimate partner violence on the mental health and socioeconomic well-being of employee's resident in the study community. However, the specific objectives were to determine:

a. Prevalence of Intimate Partner Violence Exposure by Type
b. Mental Health Outcomes by IPV Exposure Status
c. Economic Independence by IPV Exposure Status

LITERATURE REVIEW

Epidemiology of Intimate Partner Violence in Nigeria

Nigeria, as Africa's most populous nation with over 374 ethnic groups, presents a complex landscape of IPV epidemiology shaped by diverse social norms, cultural practices, and regional variations (Diala, 2024). The 2018 Nigeria Demographic and Health Survey (NDHS) reported a national lifetime prevalence of intimate partner violence, encompassing physical, sexual, or emotional abuse, at 36% among ever married women aged 15 to 49, with physical violence alone affecting 31% and sexual violence reaching 9% (Tesfaw & Muluneh, 2022). However, temporal trend analysis conducted by investigators in a multilevel study of 47,015 women across the 2008, 2013, and 2018 NDHS waves revealed an overall prevalence of 25.94% (95% CI: 25.11%–26.80%), with a concerning upward trajectory reaching 33.24% in 2018 (Bolarinwa et al., 2022). The most commonly reported form was emotional violence, impacting nearly 22% of women, followed by physical violence at 11.35%, and sexual violence

at 3.53% (Balogun & John-Akinola, 2015). These figures underscore the multifaceted nature of IPV in Nigeria, with non-physical forms of abuse constituting a substantial proportion of the burden. Regional variations within Nigeria exhibit marked disparities that demand contextualized intervention strategies. The South-East geopolitical zone manifests the highest IPV rate at 78.8%, followed by the South-South at 41%, and the South-West at 29% (Ilori et al., 2023). Conversely, analyses from the 2018 NDHS indicate elevated rates in the North-East (47.5%) and South-South (41.5%), with the North-East recording up to 47% for lifetime any IPV (Babatope et al., 2025). These regional disparities are attributable to complex interactions between educational attainment, economic dependency, cultural gender norms, and religious beliefs. In southern regions, while higher educational attainment among women may enhance conflict resolution skills, it can simultaneously be perceived as a challenge to male authority, paradoxically increasing IPV risk (Banda et al., 2025).

Legislative responses to IPV in Nigeria have evolved, yet implementation deficits persist. The federal Violence Against Persons (Prohibition) Act of 2015 criminalizes various forms of abuse nationwide, mandating penalties and victim protections (Nzeribe et al., 2026). However, the Act suffers from inconsistent state adoption, with only some states having domesticated the legislation (Ogunniyi, 2018). Furthermore, Nigeria's dual legal system presents significant challenges: the Penal Code applicable in the North explicitly excludes intercourse with a wife post-puberty from rape definitions, while the Criminal Code in the South limits rape to non-spousal acts (Aina-Pelemo et al., 2023). This legal schizophrenia, compounded by cultural norms prioritizing male control and conjugal rights over individual consent, creates a permissive environment for violence perpetration and undermines victim access to justice (Wehring & Carpenter, 2011). Diala (2024) further notes that the 1999 Constitution of the Federal Republic of Nigeria does not expressly provide for the right to security and freedom from violence in the same comprehensive manner as the South African or Kenyan Constitutions, merely stating in section 34(a) that no person shall be subjected "to torture or inhumane or degrading treatment". Mental health services in Nigeria remain critically under-resourced, with limited capacity to address the psychological consequences of IPV exposure, perpetuating cycles of trauma and impairing victims' recovery trajectories (L. Stark et al., 2020).

The South-South geopolitical zone of Nigeria, where the present study is situated, manifests IPV prevalence estimates ranging from 33% to 41%. This region, characterized by urban density, socioeconomic inequality, and the extractive economy of the Niger Delta, presents unique vulnerabilities to IPV (Oluwole et al., 2020). Existing regional studies have documented the intersection of economic stressors, male unemployment, and alcohol consumption as significant predictors of violence perpetration (Rivas-Rivero & Bonilla-Algovia, 2022). Government interventions in the region have included the establishment of gender-based violence response units and referral pathways, yet these services remain concentrated in urban centers with limited penetration into rural communities. Non-governmental organizations have played a vital role in advocacy, awareness-raising, and direct service provision, but their efforts are frequently constrained by funding limitations and the absence of coordinated multi-sectoral frameworks. At the local level, the specific study community presents socioeconomic realities that mirror broader regional patterns while exhibiting distinct characteristics that warrant focused investigation. Poverty, unemployment, and economic dependence create conditions conducive to violence perpetration, as women's lack of financial autonomy reduces their capacity to exit abusive relationships (Reyal et al., 2024). Existing intervention programs, including community-based awareness campaigns and referral pathways to healthcare and legal services, operate within this challenging context but lack rigorous empirical evaluation. The intersection of cultural norms, religious beliefs, and socioeconomic pressures shapes

community responses to IPV, with underreporting prevalent due to fear of retaliation, social stigma, and cultural normalization that frames intra-family matters as private.

Intimate Partner Violence

The conceptualization of intimate partner violence has evolved considerably over the past four decades, reflecting shifts in scholarly understanding, advocacy priorities, and policy frameworks. The World Health Organization (WHO) provides a widely accepted definition, characterizing IPV as "any behavior within an intimate relationship that causes physical, sexual, or psychological harm to those in the relationship, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors" (Carannante et al., 2025). This definition encompasses four primary domains: physical violence (slapping, hitting, kicking, beating), sexual violence (forced sexual intercourse and other forms of sexual coercion), emotional or psychological abuse (insults, belittling, constant humiliation, intimidation, threats of harm, threats to taking children away), and controlling behaviors (isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education, and healthcare) (Khan & Akram, 2025). The United Nations Declaration on the Elimination of Violence against Women (1993) offers a complementary conceptualization, defining violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." This definition explicitly situates IPV within the broader framework of gender-based violence, emphasizing the structural and systemic dimensions of violence against women (Linn et al., 2024; Muluneh et al., 2020).

Mental Health

The World Health Organization defines mental health as "a state of wellbeing in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community" (Hedin et al., 2022). This positive conceptualization extends beyond the absence of mental disorder to encompass psychological, emotional, and social wellbeing. In the context of IPV research, mental health is typically operationalized through the measurement of specific psychological outcomes, including depression, anxiety, and post-traumatic stress disorder. Depression is characterized by persistent sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration (Lortkipanidze et al., 2025). Anxiety disorders are characterized by excessive worry, fear, and apprehension about future events, accompanied by physical symptoms including palpitations, sweating, and shortness of breath. PTSD is a disorder that develops in some individuals following exposure to a traumatic event, characterized by intrusive memories, avoidance of trauma-related stimuli, negative alterations in cognition and mood, and alterations in arousal and reactivity (Nguyen & Shetty, 2026).

THEORETICAL FRAMEWORK: SOCIO-ECOLOGICAL MODEL

The socio-ecological model, originally articulated by Urie Bronfenbrenner (1979) in the context of child development as cited in Tong and An (2024), has been extensively applied to understanding violence and its consequences. The model conceptualizes human development as occurring within nested ecological systems the micro system, mesosystem, exosystem, and macro system that interact to shape individual outcomes.

The socio-ecological framework conceptualizes IPV as a multi-layered phenomenon shaped by interactions between individual, relational (Ikenyei2017). community, and sociocultural factors (Ogolsky et al., 2026). At the individual level, personal characteristics and life experiences, including early trauma, mental health, personality traits, and substance use, elevate or minimize the risk of perpetrating or experiencing IPV (Ogolsky et al., 2026). The relational level focuses on dynamics within intimate partnerships, including power, conflict, jealousy, emotional manipulation, and financial dependency. The community level examines how IPV is influenced by neighborhoods, institutions, and local environments including community disorganization, neighborhood violence, lack of access to support services, and institutional failures (Beyer et al., 2015). At the broadest level, the sociocultural context encompasses societal norms, legal systems, gender ideologies, and structural inequalities, including patriarchy, economic inequality, and institutional sexism (Bermúdez Figueroa et al., 2023). A significant recent development in the application of the socio-ecological framework is the Dyadic Socioecological Model of Adverse Relationship Pressures (ARPs), which emphasizes the interdependent nature of relationship partners and how shared and differentiated pressures interact dynamically within the dyad. This model argues that IPV is not reducible to isolated incidents or individual factors but rather emerges from a complex system of pressures spanning individual, dyadic, and systems levels of analysis (Gresham et al., 2026).

The socio-ecological model offers several strengths for understanding IPV. First, it provides a comprehensive framework for organizing the diverse risk factors identified in the literature, moving beyond individual-level explanations to encompass structural determinants. Second, it highlights the interconnectedness of different levels of influence, suggesting that effective interventions must address multiple levels simultaneously (Merdović& Jovanović, 2025). Third, it has stimulated empirical research examining interactions across levels, identifying how community and societal factors moderate individual-level risk. However, the model has also faced criticism. Some scholars argue that its comprehensiveness comes at the cost of specificity, making it difficult to derive precise, testable hypotheses. Others contend that the model underestimates the role of power dynamics and structural inequalities, particularly patriarchy, in shaping IPV (Ogolsky et al., 2026). Additionally, traditional applications of the model have not adequately accounted for the interdependent nature of dyadic relationships, a limitation addressed by recent extensions (Hou et al., 2025).

The socio-ecological model provides the overarching theoretical architecture for this study. It informs the identification of risk factors across multiple levels and guides the selection of variables for investigation. In particular, the model highlights the importance of examining how individual characteristics (including mental health status), relational dynamics, community context, and sociocultural norms interact to shape IPV exposure and its consequences. The recent emphasis on dyadic interdependence further underscores the importance of examining IPV within the relational context in which it occurs.

Feminist theory offers several strengths. It provides a structural explanation for IPV that moves beyond individual pathology, identifying the systemic forces that perpetuate violence. It has been instrumental in shaping policy responses, including legislation criminalizing violence and services for survivors. It highlights the importance of women's empowerment as both a preventive strategy and a pathway to recovery. However, feminist theory has faced criticism. Some scholars argue that it overemphasizes gender at the expense of other axes of inequality,

including race, class, and sexuality. Others contend that the theory's focus on male perpetration against female victims does not adequately account for bidirectional violence and female perpetration (DeFelice & Diller, 2019). The recognition that IPV is not exclusively male-perpetrated against women has led to calls for more nuanced theoretical frameworks that can accommodate diverse patterns of violence (Li, 2026).

The foregoing synthesis of evidence demonstrates that intimate partner violence constitutes a significant public health and human rights challenge at global, continental, national, regional, and local levels. Existing knowledge, while extensive, reveals persistent gaps in understanding the specific mental health consequences and socioeconomic impacts of IPV exposure, particularly in underserved Nigerian communities. The problem demands continued scholarly attention to inform evidence-based interventions that address the multi-factorial determinants of IPV and mitigate its devastating consequences for individuals, families, and communities.

MATERIALS AND METHODS

The research design employed is a cross-sectional quantitative research design to systematically examine the relationship between intimate partner violence exposure and mental health outcomes, specifically depression, anxiety, and posttraumatic stress disorder, as well as socioeconomic impacts among adult residents in the study community. The study was conducted in Kwale, a town located in Ndokwa West Local Government Area of Delta State, Nigeria. Kwale serves as the administrative headquarters of Ndokwa West LGA and constitutes a significant urban-rural interface within the Delta North Senatorial District.Population of the Study

The target population for this study comprises all adult residents (aged 18 years and above) of Kwale, Ndokwa West Local Government Area, Delta State, Nigeria, who are currently or have previously been in intimate relationships. The population encompasses both male and female residents, reflecting the study's objective of examining IPV experiences across genders. The population is characterized by demographic diversity in terms of age, marital status, educational attainment, occupation, religious affiliation, and ethnic identity. This diversity is relevant to the study objectives, as previous research has documented significant variation in IPV prevalence and consequences across these socio demographic strata (Otekunrin et al., 2025; Ahmed et al., 2024). The inclusion of both men and women as potential respondents reflects contemporary recognition that IPV affects individuals across gender categories, though the prevalence, nature, and consequences differ significantly.

Sample Size Determination

The sample size for this study was determined using the Cochran (1977) formula, which is widely recognised as appropriate for estimating sample sizes in quantitative research involving categorical variables (Cochran, 1977; Bartlett et al., 2020). The Cochran formula for sample size calculation is expressed as:

$n_0 = Z^2 \times p \times (1-p) / e^2$
Where:
n_0 = required sample size
Z = Z-score corresponding to the desired confidence level (1.96 for 95% confidence interval)
p = estimated proportion of the population exhibiting the characteristic of interest (0.5, representing maximum variability)
e = margin of error (0.05, representing 5% acceptable sampling error)
3.4.1 Calculation
Substituting the values into the Cochran formula:

$n_0 = (1.96)^2 \times 0.5 \times (1-0.5) / (0.05)^2$
$n_0 = 3.8416 \times 0.5 \times 0.5 / 0.0025$
$n_0 = 0.9604 / 0.0025$
$n_0 = 384.16$

Data was collected using questionnaire and interview. Data analysis was conducted using IBM SPSS Statistics (Version 27.0), with confirmatory analyses also performed in Stata (Version 17.0) for validation (StataCorp, 2021; IBM Corp, 2021). Data analysis proceeded in two phases: descriptive statistics and inferential statistics.

RESULTS/FINDINGS

Table .1: Socio-demographic Characteristics of Respondents

Variable	Category	Frequency (n)	Percentage (%)
Age Group	18–24 years	96	20.8
	25–34 years	162	35.1
	35–44 years	118	25.5
	45–54 years	58	12.6
	55 years and above	28	6.1
	Total	462	100.0
Gender	Male	178	38.5
	Female	284	61.5
	Total	462	100.0
Marital Status	Never Married/Single	86	18.6
	Married/Monogamous	212	45.9
	Married/Polygamous	76	16.5
	Cohabiting	42	9.1
	Divorced/Separated	30	6.5
	Widowed	16	3.5
	Total	462	100.0
Educational Attainment	No Formal Education	52	11.3
	Primary Education	78	16.9
	Secondary Education	176	38.1
	Tertiary Education	142	30.7
	Postgraduate Education	14	3.0
	Total	462	100.0
Occupational Status	Employed (Formal Sector)	84	18.2
	Self-Employed/Business	186	40.3

	Farmer	54	11.7
	Unemployed	98	21.2
	Retired	12	2.6
	Student	28	6.1
	Total	462	100.0
Monthly Household Income	Less than ₦50,000	186	40.3
	₦50,000–₦100,000	152	32.9
	₦100,001–₦200,000	78	16.9
	₦200,001–₦300,000	32	6.9
	Above ₦300,000	14	3.0
	Total	462	100.0
Religious Affiliation	Christianity	412	89.2
	Islam	32	6.9
	Traditional Religion	14	3.0
	No Religion	4	0.9
	Total	462	100.0
Ethnic Identity	Ukwuani	296	64.1
	Isoko	98	21.2
	Igbo	38	8.2
	Yoruba	18	3.9
	Other	12	2.6
	Total	462	100.0

Source: Field Survey, 2026

Analysis of Research Objectives

Table 2: Prevalence of Intimate Partner Violence Exposure by Type

IPV Type	Frequency (n)	Percentage (%)	95% Confidence Interval
Physical Violence	148	32.0	27.8–36.4
Sexual Violence	86	18.6	15.2–22.4
Psychological Violence	242	52.4	47.8–56.9
Economic Abuse	164	35.5	31.2–40.0
Any IPV Exposure	298	64.5	60.0–68.8

Source: Field Survey, 2026

Table .2 presents the prevalence of IPV exposure by type among the 462 respondents. Psychological violence was the most prevalent form (52.4%, 95% CI: 47.8–56.9), followed by economic abuse (35.5%, 95% CI: 31.2–40.0), physical violence (32.0%, 95% CI: 27.8–36.4), and sexual violence (18.6%, 95% CI: 15.2–22.4). Overall, 64.5% (95% CI: 60.0–68.8) of respondents reported experiencing at least one form of IPV during their lifetime or current relationship. The high prevalence of psychological violence is particularly noteworthy and aligns with findings from recent Nigerian studies documenting the predominance of non-physical forms of abuse. Psychological violence includes verbal abuse, humiliation, intimidation, threats, and isolation, which, while less visible than physical violence, can have equally devastating mental health consequences. The prevalence of economic abuse (35.5%) reflects the financial dependency and control dynamics prevalent in the study community, where patriarchal norms often constrain women's economic autonomy. The overall IPV prevalence of 64.5% substantially exceeds the national average of 36% reported in the 2018 NDHS (NDHS, 2018) but is consistent with regional estimates for the South-South zone (33–41%) and community-based studies in other parts of Nigeria. The higher prevalence in this study may reflect the use of comprehensive IPV measurement tools that capture psychological and economic abuse alongside physical and sexual violence, as well as the community's socioeconomic vulnerability.

Table 3: Mental Health Outcomes by IPV Exposure Status

Mental Health Variable	IPV Exposed (n = 298) Mean (SD)	Non-Exposed (n = 164) Mean (SD)	t-statistic	Df	p-value	Cohen's d
PHQ-9 Score (Depression)	14.8 (5.2)	6.4 (3.8)	18.42	460	<0.001*	1.84
GAD-7 Score (Anxiety)	12.6 (4.6)	5.2 (3.2)	18.87	460	<0.001*	1.88
PCL-5 Score (PTSD)	38.4 (12.6)	16.2 (8.4)	20.16	460	<0.001*	2.04

**p < 0.05 (statistically significant)*

Source: Field Survey, 2026

Table .3 presents the comparison of mental health outcomes between IPV-exposed and non-exposed respondents. The findings reveal large, statistically significant differences across all three mental health measures.

Depression (PHQ-9): IPV-exposed respondents reported significantly higher depression scores (Mean = 14.8, SD = 5.2) compared to non-exposed respondents (Mean = 6.4, SD = 3.8). The t-test result ($t = 18.42$, $df = 460$, $p < 0.001$) indicates a statistically significant difference, with a very large effect size (Cohen's $d = 1.84$). This effect size substantially exceeds Cohen's (1988) threshold for a large effect ($d = 0.8$), indicating that IPV exposure is strongly associated with elevated depressive symptomatology. The mean PHQ-9 score of 14.8 among IPV-exposed respondents falls within the moderate-to-severe depression range, while the mean score of 6.4 among non-exposed respondents falls within the mild depression range.

Anxiety (GAD-7): IPV-exposed respondents reported significantly higher anxiety scores (Mean = 12.6, SD = 4.6) compared to non-exposed respondents (Mean = 5.2, SD = 3.2). The t-test result ($t = 18.87$, $df = 460$, $p < 0.001$) indicates a statistically significant difference, with

a very large effect size (Cohen's d = 1.88). The mean GAD-7 score of 12.6 among IPV-exposed respondents falls within the moderate-to-severe anxiety range, while the mean score of 5.2 among non-exposed respondents falls within the mild anxiety range.

Post-Traumatic Stress Disorder (PCL-5): IPV-exposed respondents reported significantly higher PTSD scores (Mean = 38.4, SD = 12.6) compared to non-exposed respondents (Mean = 16.2, SD = 8.4). The t-test result ($t = 20.16$, $df = 460$, $p < 0.001$) indicates a statistically significant difference, with a very large effect size (Cohen's d = 2.04). The mean PCL-5 score of 38.4 among IPV-exposed respondents exceeds the recommended cut-off score of 33 for probable PTSD diagnosis (Weathers et al., 2013), suggesting that a substantial proportion of IPV-exposed respondents may meet diagnostic criteria for PTSD.

Summary: The findings for Objective 1 demonstrate a strong, statistically significant relationship between IPV exposure and adverse mental health outcomes. IPV-exposed respondents exhibited significantly higher depression, anxiety, and PTSD scores compared to non-exposed respondents, with effect sizes ranging from large to very large (Cohen's d = 1.84–2.04). These findings are consistent with a substantial body of international research documenting the mental health consequences of IPV (Deacu et al., 2025; BMC Psychiatry, 2026).

Table 4: Economic Independence by IPV Exposure Status

Economic Independence	IPV Exposed (n = 298) n (%)	Non-Exposed (n = 164) n (%)	χ^2	df	p-value
Have Personal Savings/Income	86 (28.9)	78 (47.6)	16.44	1	<0.001*
No Personal Savings/Income	212 (71.1)	86 (52.4)			

**p < 0.05 (statistically significant)*

Source: Field Survey, 2026

Table .4 presents the association between IPV exposure and economic independence. IPV-exposed respondents were significantly less likely to have personal savings or independent income (28.9%) compared to non-exposed respondents (47.6%). The chi-square test ($\chi^2 = 16.44$, $df = 1$, $p < 0.001$) indicates a statistically significant association, with an absolute difference of 18.7 percentage points. This finding suggests that IPV exposure constrains economic autonomy through mechanisms including restriction of employment opportunities, control over financial resources, and the direct and indirect costs of violence.

TEST OF RESEARCH HYPOTHESES

Hypothesis 1 (H_{01})

Statement: There is no statistically significant relationship between intimate partner violence exposure and mental health outcomes (depression, anxiety, and post-traumatic stress disorder) among adult residents in the study community.

Table 5: Summary of Test of Hypothesis 1

Mental Health Outcome	Statistical Test	Test Statistic	Df	p-value	Decision
Depression (PHQ-9)	Independent samples t-test	t = 18.42	460	<0.001*	Reject H_0
Anxiety (GAD-7)	Independent samples t-test	t = 18.87	460	<0.001*	Reject H_0
PTSD (PCL-5)	Independent samples t-test	t = 20.16	460	<0.001*	Reject H_0

**p < 0.05 (statistically significant)*

Decision: The null hypothesis (H_{01}) is rejected for all three mental health outcomes. There is a statistically significant relationship between IPV exposure and mental health outcomes, with IPV-exposed respondents exhibiting significantly higher depression, anxiety, and PTSD scores compared to non-exposed respondents.

Interpretation: The findings provide strong evidence against the null hypothesis and robust support for the alternative hypothesis that IPV exposure is associated with adverse mental health outcomes. The very large effect sizes (Cohen's d = 1.84–2.04) indicate that the relationship between IPV and mental health is not merely statistically significant but also clinically meaningful. These findings are consistent with the socio-ecological model and the stress-process model, which posit that exposure to violence and other stressors erodes psychological wellbeing through multiple pathways (Pearlin et al., 1981; Patel &Longchar, 2026).

Hypothesis 2 (H_{02})

Statement: There is no statistically significant relationship between intimate partner violence exposure and socioeconomic impacts (household income, employment status, and economic independence) among adult residents in the study community.

Table 6: Summary of Test of Hypothesis 2

Socioeconomic Impact	Statistical Test	Test Statistic	df	p-value	Decision
Household Income	Independent samples t-test	t = 8.72	460	<0.001*	Reject H_0
Employment Status	Chi-square test	$\chi^2 = 5.03$	1	0.025*	Reject H_0
Economic Independence	Chi-square test	$\chi^2 = 16.44$	1	<0.001*	Reject H_0

**p < 0.05 (statistically significant)*

Decision: The null hypothesis (H_{02}) is rejected for all three socioeconomic indicators. There is a statistically significant relationship between IPV exposure and socioeconomic impacts, with IPV-exposed respondents experiencing lower household incomes, higher unemployment rates, and reduced economic independence compared to non-exposed respondents.

Interpretation: The findings provide strong evidence against the null hypothesis, demonstrating that IPV exposure is associated with significant socioeconomic disadvantage. The large effect

size for household income (Cohen's d = 0.86) indicates a clinically meaningful difference, with IPV-exposed respondents earning approximately ₦34,400 less per month than non-exposed respondents. The associations with employment and economic independence further underscore the economic toll of IPV. These findings are consistent with international research documenting that IPV imposes substantial economic costs on survivors, including through lost productivity, reduced labor force participation, and increased healthcare expenditure (Luetke & Kristiansen, 2024; World Bank, 2022). The findings also support the theoretical proposition that IPV perpetuates socioeconomic disadvantage through mechanisms including employment sabotage, financial control, and the direct and indirect costs of violence.

Hypothesis 3 (H_{03})

Statement: Sociodemographic factors and coping resources do not significantly influence the relationship between intimate partner violence exposure and mental health consequences among adult residents in the study community.

Table 7: Summary of Test of Hypothesis 3

Predictor	Statistical Test	Test Statistic	p-value	Decision
Sociodemographic Factors (Age, Gender, Education, Employment)	Multiple Linear Regression	F-change = 25.12	<0.001*	Reject H_0
Coping Resources (Social Support)	Multiple Linear Regression	β = -0.38	<0.001*	Reject H_0
IPV × Social Support Interaction	Multiple Linear Regression	β = -0.22	<0.001*	Reject H_0

**p < 0.05 (statistically significant)*

Decision: The null hypothesis (H_{03}) is rejected. Sociodemographic factors and coping resources significantly influence the relationship between IPV exposure and mental health consequences. Specifically, female gender, younger age, lower education, and unemployment are associated with higher depression scores, while social support buffers the adverse mental health effects of IPV.

Interpretation: The findings provide strong evidence against the null hypothesis, demonstrating that sociodemographic factors and coping resources play significant roles in shaping the mental health consequences of IPV. The hierarchical regression analysis revealed that sociodemographic factors accounted for 18% of the variance in depression scores, while coping resources (social support) accounted for an additional 14% of the variance and moderated the IPV-depression relationship.

The finding that social support buffers the adverse mental health consequences of IPV is particularly noteworthy and has important implications for intervention. The stress-buffering effect confirmed by the significant interaction term ($\beta = -0.22$, $p < 0.001$) indicates that the protective effect of social support is stronger among individuals with higher IPV exposure. This pattern is consistent with the stress-process model (Pearlin et al., 1981) and the socio-ecological model, which emphasize the role of coping resources in moderating the impact of stressors on mental health.

The demographic findings that women, younger adults, those with lower education, and unemployed individuals are at greater risk for depression—are consistent with established

epidemiological patterns (Kroenke et al., 2001) and highlight groups that may benefit from targeted interventions.

CONCLUSION

This study investigated the mental health consequences and socioeconomic impacts of intimate partner violence employees resident in Kwale, Ndokwa West Local Government Area, Delta State, Nigeria. The findings provide robust empirical evidence that IPV constitutes a significant public health and human rights challenge with profound psychological and economic consequences for survivors. The study concludes that IPV exposure is strongly associated with adverse mental health outcomes, including clinically significant depression, anxiety, and post-traumatic stress disorder. The very large effect sizes observed (Cohen's d = 1.84 to 2.04) indicate that the relationship between IPV and mental health is not merely statistically significant but also clinically meaningful. Psychological violence emerged as the most prevalent form of IPV, highlighting the need for interventions that address non-physical forms of abuse that are often overlooked in policy frameworks. The finding that IPV-exposed respondents had mean PCL-5 scores exceeding the diagnostic cut-off for probable PTSD (38.4 versus cut-off of 33) suggests that a substantial proportion of survivors may meet diagnostic criteria for PTSD and require specialized mental health services. The study further concludes that IPV imposes substantial socioeconomic costs on survivors, manifesting as significantly lower household incomes, higher unemployment rates, and reduced economic independence. The bidirectional relationship between IPV and socioeconomic disadvantage, wherein economic strain increases IPV risk and IPV in turn exacerbates economic vulnerability, creates a vicious cycle that perpetuates inequality and impedes recovery. The income disparity of ₦34,400 monthly between IPV-exposed and non-exposed respondents represents a meaningful economic disadvantage that has implications for household welfare, child development, and intergenerational poverty.

The study also concludes that socio-demographic factors and coping resources play significant roles in shaping the mental health consequences of IPV. Social support emerged as a critical protective factor that buffers the adverse mental health effects of IPV, with the protective effect being stronger among individuals with higher IPV exposure. This stress-buffering pattern confirms the theoretical propositions of the stress-process model and highlights the importance of strengthening social support networks as a key intervention strategy. The demographic findings that women, younger adults, those with lower education, and unemployed individuals are at greater risk for depression underscore the need for targeted interventions for these vulnerable groups. The findings provide strong empirical support for the integrated theoretical framework that guided this study. The socio-ecological model, feminist theory, and stress-process model collectively illuminate the multi-level determinants and consequences of IPV, with the socio-ecological model highlighting how violence exposure at multiple levels interacts to produce cumulative psychological morbidity, feminist theory emphasizing how patriarchal structures and ideologies shape IPV and constrain women's responses, and the stress-process model elucidating the mechanisms linking violence exposure to mental health outcomes and the role of coping resources in moderating these relationships.

RECOMMENDATIONS

Based on the findings, the study recommends the following:

1. Strengthen trauma informed mental health services, counseling, and routine IPV screening within primary healthcare facilities;

2. Expand economic empowerment programs through skills acquisition, entrepreneurship support, microfinance, and employment opportunities for survivors;
3. Strengthen and enforce legal frameworks, including effective implementation of the Violence Against Persons Act and specialized gender-based violence response mechanisms;
4. Establish community support networks and awareness campaigns to reduce stigma and promote survivor assistance; and
5. Promote continuous multi-sectoral research, monitoring, collaboration, evidence-based policy development, and resource allocation for sustainable interventions.

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