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Review Article

Dissolving the Precipitating Events in the Cycle Connecting Intimate Partner Violence and Violence against Children Through a Holistic Approach

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Abstract

Intimate partner violence (IPV) has been described as a form of gender-based violence, which has become a global public health issue. In Nigeria, like most African countries, the victim usually the wife is seen as the property of the husband who has the right of use and misuse of his authority over his property. Consequently, such violence with its ripple effects on the family go unreported. Intimate partner violence is interwoven with the other forms of violence experienced by people, especially violence against children, within the confines of relationships, family settings, and communities. Violence against children (VAC) refers to all forms of violence conducted against persons under 18 years of age. The younger children are subjected to child maltreatment which entails emotional, physical, and sexual abuse, and neglect experienced in the company of parents or other guardian or authority figure. Girls and boys are at similar risk of sexual abuse as they grow into adolescence. The article is aimed at reviewing the cycle of events connecting IPV and VAC affecting the family unit, and to proffer solutions to the complex menace through a holistic approach.

Keywords: *Intimate Partner Violence; Violence against Children; Holistic Care*

Introduction

Intimate partner violence (IPV) is defined as a pattern of behavior within a relationship used to attain or sustain authority, control, or power by a person who serves as an intimate partner to another individual [1]. Intimate partner violence refers to emotionally abusive behaviours displayed by a current or previous intimate partner, spouse, or dating partner. It is also known as 'domestic abuse' or 'domestic violence'. It has been described as a form of gender-based violence, and it can intersect with other forms of violence experienced within the confines of relationships, family settings, and communities. These forms include domestic, interpersonal, or sexual violence [2]. Intimate partner violence comprises physical, psychological, or sexual harm that an individual is exposed to, from a current or previous partner [3]. Intimate partner violence has been described as a global public health issue of human rights concern [4]. It poses a key obstacle to the attainment of the universal sustainable development goals of the United Nations, which aim to promote gender equality and empower the female gender [5]. Often, IPV is executed by a male partner of a female person, which could be linked to emotional attachment with the perpetrator, or economic dependence on the offender. IPV has no barrier in terms of a cultural, economic, social, or religious group [6]. It can be in the form of physical aggression (beating, hitting, kicking, and slapping), psychological abuse (humiliation, intimidation, and persistent belittling), forced sexual activity, different controlling behaviours (isolation from family and friends, close monitoring of movements and restricting access to others) [6].

The US National Institutes of Mental Health Committee on Family Violence also proposed a broad description of IPV. They defined it as-acts that are physically and emotionally harmful or that carry the potential to cause physical harm … [and] may also include sexual coercion or assaults, physical intimidation, threats to kill or harm restraint of normal activities or freedom, and denial of access to resources [7]. Technology is increasingly facilitating abuse, through the utilization of social media and various other online platforms. Examples of technology-facilitated means are stalker ware on personal gargets; and the use of smart meters, cameras, and locks through manipulation [8,9]. In addition, other forms of IPV including stalking, and cyber abuse are in existence [10-12].

This article utilized a wide range of resources on Intimate partner violence and Violence against children, with the aim to show the interconnections between the two issues of global health relevance, and proferring solutions through a holistic approach to the precipitating events within the IPV/VAC complex cycle.

Burden of IPV

Global epidemiology

Looking through the literature, the impact of IPV is enormous in all ramifications and globally it is said to be the commonest type of violence against women. The alarming statistics figures across the globe and the socio-economic burden also call for a review of the situation. It is said that one in four to one in five women will experience some form of violence in their lifetime [2]. Worldwide, the prevalence of IPV is estimated to be between 10% and 75% [13]. Globally, IPV can be described as a pandemic due to the widespread nature of the menace. IPV has been denoted as the most popular form of violence worldwide, contributing largely to mental health disorders [14]. A wide variation exists across countries regarding the prevalence of IPV perpetrated by the male partners of affected women. The prevalence rates range from 75% in Bangladesh, 52% in Bolivia, 45% in Zambia, to 16% in the Dominican Republic [15]. A multi-country study by the World Health Organization (WHO) found between 15% and 71% of adult females to have experienced IPV in the form of sexual and physical abuse by an intimate partner. In Europe, reports show a lifetime prevalence of IPV ranging between 10% to 36% [16]. In Asia, reports show a prevalence of IPV at 34.4% in Afghanistan, 57% in India, and 87% in Jordan [17]. In Africa, IPV prevalence found is 28% in Madagascar, 74% in Ethiopia, 41.1% in Angola, and 34% in Ghana [18,19].

Reports vary across the United States where nearly one-third of women experience physical violence meted out by an intimate partner within their lifetime [20]. IPV could be psychological, emotional, economic, or sexual in nature. The recent coronavirus pandemic was associated with increased cases of IPV and reported cases were more severe in nature [21]. The severity of IPV varies as it affects people's lives negatively in both short-term and long-term forms. Intimate partner violence results in intimate partners killing about three women daily [22]. About 1in 4 females, and 1 in 9 males in the United States experience physical violence, stalking, or rape by an intimate partner during their life [3]. Nearly 50% of women and 44% of men are affected by IPV [23]. Almost two-thirds (61%) of bisexual women [24-26], and more than half (54%) of trans/non-binary persons reported experiences of IPV [27,28]. In all, the majority of people first experience IPV prior to 25 years of age [23].

In sub-Saharan Africa, the lifetime prevalence of IPV has been reported to be 20–71% in marriage or current partnerships [29]. The wide variation has been attributed to varying methodologies, IPV screening tools, and socio-demographic differences in the study population. All forms of IPV can be devastating to a woman's health, including increased long-term risk of chronic pain, physical disability, drug and alcohol abuse, and depression [30]. IPV is also said to increase the risk of unintended pregnancy, sexually transmitted infections, and adverse pregnancy outcomes [31]. The prevalence of gynaecological problems among victims of spousal abuse was 3 times higher than for women with no spousal abuse. There are also serious psychological impacts of IPV [32]. A national survey on IPV showed that 72.2% of victims were persistently fearful, 62.3% were concerned for their safety, 62.6% experienced at least one post-traumatic stress disorder (PTSD) symptom, 41.6% were injured as a result of the violence, and 28.0% missed at least one day of work or school [32]. Depression, post-traumatic stress disorder (PTSD), and anxiety are common among the victims in addition to suicidal behavior [32]. Sleep and eating disorders, social dysfunction, and an increased likelihood of substance abuse are also seen in them [32]. Severe cases could lead to fatal outcomes [12]. In Nigeria, it appears that similarity is observed with other African countries. Studies in Nigeria show a

prevalence of IPV ranging from 25% to 73% [33-39]. Based on data obtained from the NDHS, the National Population Commission (NPC) of Nigeria and the ICF International reported that 16% of women have experienced IPV of physical or sexual forms, which is considered lower than what was obtained from studies from other African countries which stood at 37% on the average [6].

Economic burden

A huge economic effect arises as a consequence of IPV. Greater than 250,000 hospital visits occur annually with an estimated cost of $8.3 billion dollars for direct medical care services, in addition to the loss of productivity from household chores and paid work [40,41]. There are the indirect costs that are associated with lost workplace and household productivity, and the long-term impact on human pain and suffering. In addition to medical costs and productivity losses, Great Britain estimate included costs from the criminal justice system, social services, housing, civil legal, and emotional costs borne by the individual victim. It has been estimated that approximately one-quarter of a million hospital visits occur as a result of IPV annually. There are also additional medical costs associated with ongoing treatment of alcoholism, attempted suicide, mental health symptoms, pregnancy, and paediatric-related problems associated with concomitant child abuse and witnessing abuse [42]. Intangible costs include women's decreased quality of life, undiagnosed depression, and lowered self-esteem. Destruction of the family unit often results in loss of financial stability or lack of economic resources for independent living, leading to increased populations of homeless women and children [30,32].

Facilitators of IPV

The most widely used model for understanding violence is the ecological model, which proposes that violence results from an interplay of factors operating at four levels: individual, relationship, community and societal [43]. At the individual level i.e. factors that predispose to either perpetration or victimization are numerous and they include socio-demographic variables. Age was found to be inversely related to both perpetration and victimization of IPV. Capaldi., *et al*. concluded that older age was associated with decreased IPV [45]. This was also seen in other studies where the adolescent relationship was associated with a higher incidence of IPV [13]. In a systematic review of IPV risk factors, education appeared to be a more significant predictor than employment status but then income was found to be a relatively strong predictor of IPV for each of the three main ethnic groups (Euro-American, African-American, and Hispanic) [45]. However, both low levels of education and low income have been shown to increase both perpetration and victimization of IPV [46]. For instance, college completion was observed to be protective against IPV. Other important risk factors are; witnessing or experiencing violence as a child, harmful use of alcohol and drugs, personality disorders/poor mental health, acceptance of violence (e.g. feeling it is acceptable for a man to beat his partner), and a past history of abusing partners. These factors by different authors have been shown to increase the perpetration and victimization of violence [46]. Childhood physical abuse and sexual abuse are known predictors of IPV victimization. It was discovered that the frequency of drinking alcohol was not related to mutual IPV for 14 employed adults, but for the unemployed relative to full-time workers, more alcoholic drinks significantly increased the risk of violence. Cohabiting couples were more likely to engage in IPV than were the married. Where male-dominance exists, conflict is experienced almost twice as likely as couples with an equalitarian relationship [45].

Risk factors for IPV

Understanding the circumstances surrounding the risk factors for IPV requires a thorough consideration of the characteristics of the perpetrator, beliefs and life experiences of the perpetrator and victim, the nature of the relationship between the partners, and the context of household and community where violence occurs [15]. Studies focusing on individual and household characteristics showed mixed results concerning the relationship between IPV and education, while higher economic status is protective against IPV [15]. A meta-analytic study from China revealed that lower educational status, lower socio-economic status, and longer relationship duration were related to a greater degree of IPV [47]. Decision-making autonomy, which is either male- or female- dominated was associated with higher reports of IPV, however, joint decision-making was noted to be protective against IPV [15]. Despite IPV affecting people across ethnicity/race, gender, and socioeconomic background, minority group women have been noted to experience IPV at disproportionately high levels [3]. Conflict settings have been associated with higher IPV rates when compared to non-conflict-affected areas [48,49]. Further risk factors for IPV include:

a. People with disabilities [50,51].
b. Dwellers of rural areas [52].
c. Young age and Adolescents [53,54].
d. Belonging to a sexual minority group such as Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) communities [24-28,55].
e. Pregnant women [56].
f. People living with HIV [44,57,59-61].
g. Persons who use substances [62].
h. Racial/Ethnically minoritized communities [23].
i. Unemployment and Socio-economic deprivation [3].
j. Adverse childhood experiences [3].

Impact of IPV on children

The experience of IPV has various negative effects on health outcomes, which can be long-lasting in individuals and families [58,63]. Children who are exposed to IPV have a higher tendency of experiencing certain challenges, more than their peers. The difficulties include emotional and behavioural struggles that have an impact on their social interactions with other children and adults, cognitive disorders which could interfere with school performance and skill development, and chronic physical and mental conditions [64]. Intimate Partner Violence on its own has a profound effect on children, as shown by studies. Association has been found between IPV targeting women, and its negative consequences on children like depression, anxiety, negative health outcomes, and poor school performance [65]. Exposure of a child to IPV directed against the mother, has been shown to be the most common factor associated with males as offenders, and the females as victims of IPV in later life [66,67]. Therefore, the interconnections between Intimate Partner Violence (IPV) and Violence Against Children (VAC) form a cycle that could continually occur in a lifetime and possibly generations, with VAC-affected children growing into adults who perpetrate IPV.

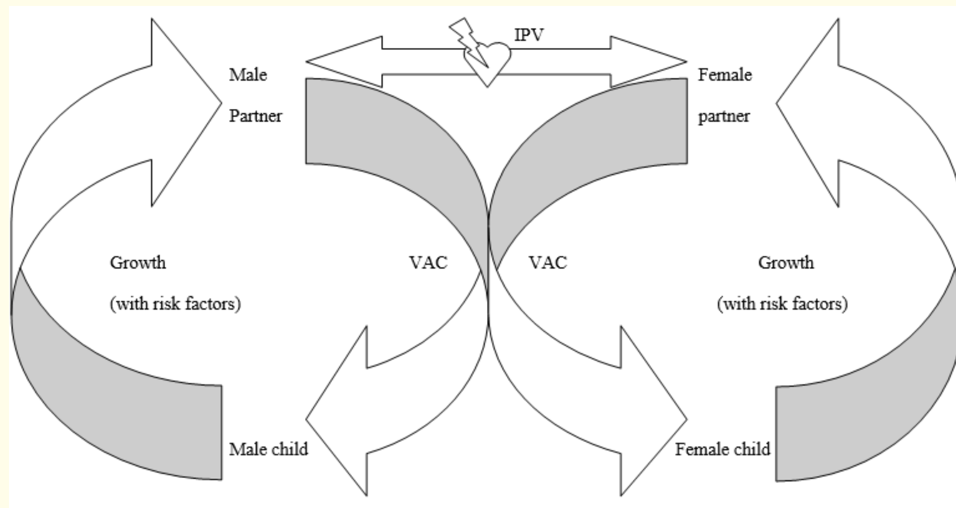

Figure 1: *A diagram illustrating the two-arm cycle of events interconnecting IPV and VAC [diagram by Akinbode, A.O.]*

On the other arm of the cycle of events surrounding IPV/VAC, studies have found an association between IPV and child maltreatment within a single household [68]. Some studies have revealed that children of abused mothers have less tendency of being immunized; have greater rates of diarrhea disease; and have a higher risk of under-five mortality [69,70]. Thus, it is becoming glaring that the interconnections between IPV and VAC form an interwoven network of one event leading to the other in a cycle.

Factors influencing IPV on children

The effect of IPV on children could be influenced by the form of IPV, child age and gender, child maltreatment, and duration of exposure to IPV. It is worthy of note that not every exposure to IPV possesses a negative effect, particularly if protective factors like supportive relationships with adults and social competence are in existence [71]. Therefore, establishing protective factors for IPV/VAC-affected children can enhance resilience, and promote survival skills, personal characteristics, and opportunities that lead to constructive long-term outcomes.

Mental health: Survivors of IPV are affected by different levels of mental impact. Some affected people can exhibit adaptive responses to the abuse they experience, while others may manifest vivid psychiatric symptoms. About 20% of the survivors can experience new mental disorders like generalized anxiety disorder (GAD), major depressive disorders (MDD), and post-traumatic stress disorder (PTSD) [3]. Others are suicidal ideation, alcohol use disorders, substance use disorders, and high-risk sexual behaviours [56,72-79]. The survivors often absorb the verbal abuse emanating from their partners. They can experience self-blame, fear, anger, and inward resentment. Long-term abuse can result in obsessive and compulsive behaviours, which could lead to self-destruction or suicide. Following enduring previous abuse, subsequent trauma reactions can lead to difficulties in forming stable new relationships. Abuse experienced from IPV can influence emotional regulation, reading social cues, and facial interpretation [3].

Physical impact: Greater rates of health issues are likely to be experienced by IPV survivors, and thus poor health status. Physical symptoms commonly manifested include headache, chronic pain, insomnia, hyperventilation, choking sensation, and gastrointestinal symptoms. Usually, undetected forms of IPV such as non-fatal strangulation (choking) and traumatic brain injury (TBI), can lead to neurological sequelae [80,81]. Furthermore, IPV can lead to unintended pregnancies and associated complications, resulting in poor health for mothers and their babies. IPV-affected people have higher comorbidity of HIV/AIDS and substance abuse [3].

Economic outcomes: Physical or mental issues can result in absenteeism, reduced work productivity, diminished access to opportunities, and lost earnings [82,83].

Quality of life: The quality of life being lived by the affected people may be compromised due to the need for advocate services, reduced sense of safety, and difficulty in attending work or school [44].

Violence against children

Violence against children (VAC) has been described as all forms of violence carried out against persons under 18 years of age. Younger children are stated to experience child maltreatment which entails emotional, physical, and sexual abuse, and neglect experienced in the company of parents or other guardians or authority figures. Girls and boys are at similar risk of sexual form of abuse, but as they grow older to reach adolescence, IPV, peer violence, and child maltreatment all become more prevalent. VAC is preventable, and the response to it requires collaborative efforts in society to systematically address the risks and protective influencing factors at each stage of risk (individual, relationship, community, and society) [84].

Protective factors for children against VAC

Individual level factors

Certain skills have been found with evidence to exhibit protective influence for children who are exposed to VAC, such as problem solving skills and self-regulatory skills.

Self-regulatory skills (SRS): These include anger management, emotional awareness, cognitive coping skills, and stress management. SRS has been associated with resiliency, supportive peers, enhanced cognitive functioning, low level of internalizing problems, and reduced mental disorders [81].

Problem-solving skills: These forms of skills have been noted to enhance mental health, and serve as protective factors for children who experienced VAC [85].

Parent and guardian level factors

There are relationship-level factors with significant evidence of protection for children exposed to VAC.

Parenting competencies: Parenting competencies are protective factors that refer to parental responsiveness, emotional support, maternal warmth, and strong parent-child bonds. They have been linked to positive outcomes regarding children exposed to VAC. The progressive outcomes include improved self-esteem, reduced anti-social behavior, lower levels of juvenile delinquency, and reduced teenage pregnancy. Parental competencies can be promoted through enhanced family management skills, fulfilling individual and developmental needs, and consolidating family relationships [85].

Caregiver well-being: Positive parental psychological functioning has been shown to be associated with greater resilience behaviours and better mental health status among children exposed to VAC. For instance, engaging parents in Project Support, an intervention for mothers who have experienced IPV is associated with a reduced risk of conduct disorders and higher positive social relationships among VAC-exposed children [85].

Community level factors

A positive and supportive school environment serves as a protective factor for VAC-exposed children. School-based interventions targeting VEC have shown reduced mental disorder [such as traumatic stress disorder, psychosocial dysfunction, depression] and physical dating violence [85].

Interconnections between IPV and VAC

The co-existence of IPV and VAC can occur in different forms. Complex relational dynamics are often at play within households impacted by domestic violence resulting in various risk factors for those experiencing the issues. For instance, an offending parent could create allegations of neglect or child abuse against the non-offending parent as a form of control tactic. In addition, an IPV survivor might decide to leave a relationship despite not possessing the financial capacity to care for the children. On the other hand, the survivor could remain within a treacherous household for fear of possible retaliation by a partner if (s)he leaves the relationship with the children [82]. IPV occurring within families can affect children through witnessing or overhearing confrontations, which results in emotional or physical injury. Children can also directly experience abuse while intervening or observing the event. The United Nations Children's Fund (UNICEF) reported that evidence revealed that women who experience IPV have a lower tendency to initiate breastfeeding early, or practice exclusive breastfeeding [87]. In the United States, data on the intersections of (domestic violence) IPV and child maltreatment (VAC) is obtainable from the 'National Survey of Children's Exposure to Violence' (NATSCEV). Fifty-seven percent of children who reported witnessing IPV also stated that they experienced maltreatment [88].

Policies on IPV and VAC

There are different policies on the complex menace of IPV and VAC depending on the geography and organization. Globally, various international conventions aimed at ending IPV and other gender-based violence forms, have been established between 1945 and 2017 [14]. The World Health Assembly in 2016 endorsed the 'Global plan of action on strengthening the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children'. The

plan aims to: (a) Monitor the global burden and peculiarities of VAC and support national efforts on the issue (b) Maintain an efficient electronic information system (c) Develop and disseminate evidence-based guidelines (d) Regularly publish global reports on VAC (e) Support partners and countries on implementation strategies like the INSPIRE: Seven strategies for ending violence against children, and (f) Collaborate with international organizations to significantly reduce and eliminate VAC globally [84]. The Health Resources and Services Administration established the 2023-2025 Strategy which recognizes the intersections existing between IPV and some other forms of violence that have an impact on people and communities attended by HRSA-supported care. The strategy highlights that the prevention and management of IPV requires the recognition and treatment of other types of violence increasing the risks and effects of IPV. Furthermore, the strategy also centres on exposure to IPV during the transition from adolescence into adulthood [89].

Managing the interconnections of IPV/VAC cycle

Intervention programmes

It has been pointed out that there is limited evidence to support the benefit of interventions to help women who screen positive for intimate partner violence (IPV) in healthcare settings [90]. The biopsychosocial factors associated with IPV are critical for intervention. However, the area of intervention has been a neglected research area [90,91]. More studies are required to establish this claim. Many providers do not routinely screen for IPV because they do not know what they should do if it is discovered [90,91]. This is unfortunate as studies have revealed that disclosure of abuse in a healthcare setting, even in the absence of a subsequent intervention, can reduce the incidence of additional violence. In an attitudinal survey of physicians, and obstetricians on managing IPV, most responders (85%) felt the work was significant, although few (11%) had overall positive feelings about it. A significant proportion felt helping IPV victims was stressful, difficult, and risky. In addition, a majority of the respondents reported no or minimal training in addressing IPV [7]. The RADAR protocol represents one of the earliest efforts to systematically address IPV in the clinical environment. The mnemonic RADAR consists of routinely screen for IPV; ask direct questions; document findings; assess safety; and respond, review options, and refer. It screens and addresses IPV [90].

Routine screening suggests screening during periodic health encounters (e.g., well-adult examinations, prenatal and postpartum visits), as well as when patients present with signs or symptoms that may indicate IPV exposure. Appropriate documentation can support patient advocacy because physician documentation of IPV is an exception to hearsay in many legal situations. The use of a body map can help in describing injuries and providing forensic documentation. Hegarty., *et al*. advocated brief counselling and the need for family doctors to be trained to ask about the safety of women and children and to provide supportive counselling for women experiencing abuse [91]. Several other studies have indicated that counselling interventions provide benefits. These included reducing IPV and improving birth outcomes for pregnant women, reducing IPV for new mothers, and reducing pregnancy coercion and unsafe relationships for women in family-planning clinics [92]. These interventions have been more thoroughly studied, and thus evidence about their effectiveness is more readily available. For instance, existing evidence suggests that shelter stay combined with advocacy counselling would decrease the threat of re-abuse and improve the quality of life of IPV victims. It was also thought that healthcare providers may be able to effectively manage IPV in their female patients and pregnant patients in particular, by becoming aware of both shelter and advocacy programs in their area, and encouraging patients they identify as experiencing IPV to use these services [93]. There is some evidence suggesting that the arrest of the perpetrator, and the use of protective orders, can be effective in some cases [94]. However, there is also data demonstrating that in some cases, this approach can actually lead to an escalation of violence, especially when the perpetrator is unemployed or otherwise has little to lose by not complying with the legal system [91]. As suggested by initial data, the protection orders combined with legal advocacy and counselling may reduce the incidence of re-perpetration for many men. Thus, healthcare providers can also help to manage IPV in patients by having information available about the legal system and local options for assistance for barterers.

A Cochrane review, conducted by Ramsay and colleagues, specifically examined the effectiveness of IPV interventions for women that involved advocacy. Overall, they found that intensive advocacy (12 hours or more total) as part of or after a shelter stay improved

quality of life at up to 12 months follow-up, and increased the chances of termination of physical abuse up to 24 months follow up. Intensive advocacy was not found to impact either depression or psychological distress. Brief advocacy interventions, they said also increased the use of safety behaviours in both short and long term, even for women who remain with the perpetrator. However, the authors concluded that while intensive advocacy is likely to be most effective, further research is needed to determine the utility of briefer advocacy interventions, both for women who leave or who remain with the perpetrating partner [93].

Dissolving the precipitating events of IPV/VAC complex

Various technical expertise have been put together to proffer solutions to the complex menace of violence affecting partners and children. Strategies based on available evidence have been established to assist affected communities and institutions in refining their efforts to prevent the precipitants of IPV/VAC and associated complications across the lifespan of people. The strategies comprises educating people on healthy and safe relationship skills; interrupting the pathway leading to IPV/VAC complex; enabling a protective atmosphere for vulnerable populations; providing economic support for affected families; and assisting survivors to be safe [63]. Therefore, a multi-sectorial approach involving stakeholders in education, health care, public health, justice, business and labour, social services, and government can foster successful solutions to addressing the interconnected issues of IPV/VAC.

The Obstetrician-Gynaecologists have been identified to be core health specialists who could make significant impact in the management of IPV survivors [95]. The broad overlap existing between IPV and VAC requires a coordinated approach to manage the problems. Certain guiding principles form the foundation for child protection actions for families experiencing IPV [96-98].

1. Assess and Identify IPV and VAC at each stage of child protection services regarding all child welfare issues.
2. Ensure that children are kept with the non-offending parent if possible.
3. Render services to families with IPV and VAC, including assisting survivors to obtain protection using supportive interventions when possible.
4. Help violent partners stop their behavior and link them with supportive services that will address their negative actions.
5. Promote collaboration with community partners.

Screening and counselling for IPV have been recommended as a component of women's preventive health care and to be conducted at periodic intervals, especially during obstetric care visits. Healthcare providers are to offer continuous support, and assess existing prevention and referral options [95]. Certain screening tools have been recommended by the USPSTF, which are patient-directed, self-administered, and usable in the clinician interview modality [96]. The most reliable screening tools are:

(a) Ongoing violence assessment tool

(b) Hurt, insult, threaten, scream

(c) Slapped, things and threaten

(d) Modified childhood trauma questionnaire-short form

(e) Woman abuse screen tool

(f) Humiliation, afraid, rape, kick.

The consequences resulting from IPV spread past the people who are exposed to violence themselves, it also affects children within the household, friends, extended family, and employers [100-103]. Various reasons may deter the affected persons from seeking care, which could be individual, socio-cultural, organizational, and structural barriers [89].

The holistic approach

Within the health care system, the holistic care entails developing an in-depth understanding of the patient's problems and needs for care, which address the patient's emotional, social and spiritual needs, in addition to the physical needs which they usually request [104,105]. Health professionals and social workers can play a significant role in identifying people who have experienced IPV and VAC or are at risk of the issues. Professional expertise can help in halting the cycle of events that result in IPV/VAC through screening, offering support, and utilizing available care options of prevention and referral means. Healthcare workers form the first line of caregivers and support providers to the victims of IPV [95]. Adequate training and continuous education for health professionals would provide the skills needed to collaborate with patients, colleagues, and health care systems in order to solve the issues of IPV/VAC [106].

The Holistic approach offered in this article is a reflection of the holistic care which is practised in the health care system. For a broader range of care, the Family physician/General practitioner who manages patients through a holistic model of care, and serves as a gatekeeper in health care settings, would be a key professional avenue for offering the needed care and support to those affected by IPV/VAC. Care needed by IPV victims, that could be offered by family doctors include annual examinations, screenings for medical and mental conditions, family planning services, and follow-up visits. Therefore, team work is essential through collaboration with other health workers, social workers, psychologists, and mental health rehabilitation specialists. Comprehensive and continuous care is provided by family doctors who view the patient in the bio-psycho-social pattern, and who care for a patient who has a disease holistically, and not only manage the disease in a patient. Therefore, using the holistic approach in addressing victims of IPV and VAC would enhance the identification and management of the victims as it encompasses the biomedical, psychological, social, and spiritual components of care.

Conclusion

The interconnections between Intimate partner Violence (IPV) and violence against children (VAC) constitute a serious bio-psycho-social dilemma with a wide range of consequences for those affected. For a comprehensive response to dissolving the precipitating issues arising from the duo, concerned professionals need a holistic approach to the complex and interwoven array of problems posed by IPV and VAC. Family, societal, and institutional changes can positively influence the pathway to eliminating IPV and VAC when service providers incorporate their expertise, services, and resources into an extensive network. As new practices are enhancing cross-system understanding of the menace by communities and institutions, a multi-disciplinary approach can promote safety, resilience and positive outcomes for families and children that have experienced intimate partner violence and/or violence against children.

Bibliography

1. United Nations. "What is Domestic Abuse?" Covid-19 Response (2019).
2. United Nations High Commission for Refugee (UNHCR). "Gender-based violence" (2023).
3. Benavides MO., *et al*. "Definition, Epidemiology and Risk Factors of IPV". *American Psychiatry Association* (2019).
4. Krug EG., *et al*. "World report on Violence and Health". World Health Organization Geneva (2002): 1-325.
5. Coll CVN., *et al*. "Intimate partner violence in 46 low-income and middle-income countries: an appraisal of the most vulnerable groups of women using national health surveys". *BMJ Global Health* 5.1 (2020): e002208.
6. Garcia-Moreno C., *et al*. "WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses". World Health Organization: Geneva (2005).
7. Bailey BA. "Partner violence during pregnancy: prevalence, effects, screening, and management". *International Journal of Womens Health* 2 (2010): 183-197.

8. Lopez-Neira I., *et al*. "Internet of things: how abuse is getting smarter". *Safe* 63 (2019): 22-26.

9. Woodlock D. "The abuse of technology in domestic violence and stalking". *Violence Against Women* 23 (2017): 584-602.

10. Brown C., *et al*. "Technology-facilitated abuse in relationships: victimisation patterns and impact in young people". *Computers in Human Behavior* 124 (2020).

11. Fissel ER., *et al*. "A New frontier: The development and validation of the intimate partner cyber abuse instrument". *Social Science Computer Review* 40.4 (2021).

12. Taylor S and Xia Y. "Cyber partner abuse: a systematic review". *Violence and Victims* 33.6 (2018): 983-1011.

13. Bazargan-Hejazi S., *et al*. "Patterns of Intimate Partner Violence: a study of female victims in Malawi". *Journal of Injury Violence Research* 5.1 (2013): 38-50.

14. Oram S., *et al*. "The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy". *Lancet Psychiatry* 9 (2022): 487-524.

15. Hindin LJ., *et al*. "Intimate partner violence among couples in 10 DHS Countries: Predictors and Health outcomes". DHS Analytical Studies number 18. United States Agency for International Development (2008).

16. World Health Organization. "Violence against women". (2021).

17. Yaya S., *et al*. "Intimate partner violence: a potential challenge for women's health in Angola". *Challenges* 10.1 (2019): 21.

18. Alangea DO., *et al*. "Prevalence and risk factors of intimate partner violence among women in four districts of the central region of Ghana: baseline findings from a cluster randomised controlled trial". *PLoS ONE* 13.7 (2018): e0200874.

19. Benebo FO., *et al*. "Intimate partner violence against women in Nigeria: a multilevel study investigating the effect of women´s status and community norms". *BMC Women's Health* 18.1 (2018): 136.

20. National Center for Injury Prevention and Control (NCIPC). "National Intimate Partner and Sexual Violence Survey: Data Brief – Updated Release," (2015).

21. Gosangi B., *et al*. "Exacerbation of Physical Intimate Partner Violence During COVID-19 lockdown". *Radiology Society of North America* 298.1 (2020): E38-E45.

22. Violence Policy Center (VPC). When Men Murder Women: An Analysis of 2018 Homicide Data (2023).

23. Leemis RW., *et al*. "The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Intimate Partner Violence". National Center for Injury Prevention and Control Centers for Disease Control and Prevention (2022).

24. Walters ML., *et al*. "The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation". National Center for Injury Prevention and Control and Centers for Disease Control and Prevention (2013).

25. Roberts T., *et al*. "Between a gay and a straight place: Bisexual individuals' experiences with monosexism". *Journal of Bisexuality* 15.4 (2015).

26. Friedman RM., *et al*. "From bias to bisexual health disparities: attitudes toward bisexual men and women in the United States". *LGBT Health* 1.4 (2014): 309-318.

27. James SE., *et al*. "The report of the 2015 U.S. Transgender Survey". *National Center for Transgender Equality* (2016).

28. National Coalition of Anti-Violence Programs (NCAVP). "Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-affected hate violence". (2014).

29. Izugbara CO., *et al*. "Correlates of intimate partner violence among urban women in sub-Saharan Africa". *PLoS One* 15.3 (2020): e0230508.

30. Roldos M and Phaedra C. "The Economic Burden of Intimate Partner Violence in Ecuador: Setting the Agenda for Future Research and Violence Prevention Policies". *West Journal of Emergency Medicine* 14.4 (2013): 347-353.

31. Ojifinni OO and Ibisomi L. "Preconception care practices in Nigeria: a descriptive qualitative study". *Reproductive Health* 17 (2020): 1-3.

32. Dillon G., *et al*. "Mental and physical health and intimate partner violence against women: a review of the literature". *International Journal of Family Medicine* 2013 (2013): 15.

33. Okenwa LE., *et al*. "Exposure to intimate partner violence amongst women of reproductive age in Lagos, Nigeria: prevalence and predictors". *Journal of Family Violence* 24 (2009): 517-530.

34. Fawole OI., *et al*. "Intimate partner abuse: wife beating among civil servants in Ibadan, Nigeria". *African Journal of Reproductive Health* 9.2 (2005): 54-64.

35. Owoaje ET and Olaolorun FM. "Women at risk of physical intimate partner violence: a cross-sectional analysis of a low-income community in southwest, Nigeria". *African Journal of Reproductive Health* 16.1 (2012): 43-54.

36. Ameh N and Abdul MA. "Prevalence of domestic violence amongst pregnant women in Zaria, Nigeria". *Annals of African Medicine* 3.1 (2004): 4-6.

37. Gyuse A and Ushie AP. "Pattern of domestic violence among pregnant women in Jos, Nigeria". *South African Family Practice* 51.4 (2009): 343-345.

38. Oche OM., *et al*. "Intimate partner violence in pregnancy: knowledge and experiences of pregnant women and controlling behavior of male partners in Sokoto, Northwest Nigeria". *International Journal of Reproductive Medicine* 2020 (2020): 7626741.

39. Oluwole EO., *et al*. "Prevalence and determinants of intimate partner violence among adult women in an urban community in Lagos, Southwest Nigeria". *Pan African Medical Journal* 25.36 (2020): 345.

40. García-Moreno C., *et al*. "Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence". *World Health Organization* (2013).

41. Family Violence Prevention Fund. "The health care costs of domestic and sexual violence". San Francisco (CA): FVPF (2010).

42. National Center for Injury Prevention and Control. Intimate partner violence. Centers for Disease Control and Prevention (2011).

43. Slep AMS., *et al*. "An ecological model of intimate partner violence perpetration at different levels of severity". *Journal of Family Psychology* 28.4 (2014): 470.

44. Smith SG., *et al*. "The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief-Updated Release". *National Center for Injury Prevention and Control Centers for Disease Control and Prevention* (2018).

45. Capaldi DM., *et al*. "A Systematic Review of Risk Factors for Intimate Partner Violence". *Partner Abuse* 3.2 (2012): 231-238.

46. Walton-Moss BJ., *et al*. "Risk factors for intimate partner violence and associated injury among urban women". *Journal of Community Health* 30.5 (2005): 377-389.

47. Tang CSK and Lai BPY. "A review of empirical literature on the prevalence and risk markers of male-on-female intimate partner violence in contemporary China, 1987-2006". *Aggression and Violent Behavior* 13.1 (2008): 10-28.

48. Ekhator-Mobayode UE., *et al*. "The effect of armed conflict on intimate partner violence: Evidence from the Boko Haram insurgency in Nigeria". *World Development* 153 (2022): 105780.

49. Global Women's Institute and International Rescue Committee. "Evidence brief: What works to prevent and respond to violence against women and girls in conflict and humanitarian settings?" The George Washington University and the International Rescue Committee (2016).

50. Breiding MJ and Armour BS. "The association between disability and intimate partner violence in the United States". *Annals of Epidemiology* 25.6 (2016): 455-457.

51. Hahn JW., *et al*. "Examining the impact of disability status on intimate partner violence victimization in a population sample". *Journal of Interpersonal Violence* 29.17 (2014).

52. National Advisory Committee on Rural Health and Human Services (NACRHHS). "Intimate Partner Violence in Rural America". *Policy Brief* (2015).

53. Halpern CT., *et al*. "Patterns of intimate partner violence victimization from adolescence to young adulthood in a nationally representative sample". *Journal of Adolescent Health* 45.5 (2009): 508-516.

54. Taylor BG and Mumford EA. "A National Descriptive Portrait of Adolescent Relationship Abuse: Results from the National Survey on Teen Relationships and Intimate Violence". *Journal of Interpersonal Violence* 31.6 (2016): 963-988.

55. Brown TNT and Herman JL. "Intimate Partner Violence and Sexual Abuse Among LGBT People: A Review of Existing Research". *The Williams Institute* (2015).

56. Alhusen JL., *et al*. "Intimate partner violence during pregnancy: Maternal and neonatal outcomes". *Journal of Women's Health* 24.1 (2015): 100-106.

57. Centers for Disease Control and Prevention. "Intersection of intimate partner violence and HIV in women". (2014).

58. Centers for Disease Control and Prevention. "Fast facts: Preventing intimate partner violence". (2021).

59. Machtinger EL., *et al*. "Psychological trauma and PTSD in HIVpositive women: A meta-analysis". *AIDS and Behavior* 16.8 (2012): 2091-2100.

60. Schafer KR., *et al*. "Intimate partner violence: A predictor of worse HIV outcomes and engagement in care". *AIDS Patient Care and STDs* 26.6 (2012): 356-365.

61. Siemieniuk RAC., *et al*. "The clinical implications of high rates of intimate partner violence against HIV-positive women". *Journal of Acquired Immune Deficiency Syndromes* 64.1 (2013): 32-38.

62. Addiction Resource Editorial Staff. "Relationship Between Substance Abuse and Domestic Violence". *Addiction Resource* (2021).

63. Niolon PH., *et al*. "Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices". National Center for Injury Prevention and Control Centers for Disease Control and Prevention (2017).

64. Child Welfare Information Gateway (CWIG). "Domestic violence: A primer for child welfare professionals". U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (2020).

65. Heise L and Garcia-Moreno C. “Violence by intimate partners”. In: Krug EG et al., eds. World report on violence and health. Geneva, World Health Organization (2002): 87-121.

66. Abramsky T., *et al*. “What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women’s health and domestic violence”. *BioMed Central Public Health* 11 (2011): 109.

67. Kishor S and Johnson K. “Profiling domestic violence – a multi-country study”. Calverton, MD, ORC Macro (2004).

68. Holt S., *et al*. “The impact of exposure to domestic violence on children and young people: a review of the literature”. *Child Abuse and Neglect* 32.8 (2008): 797-810.

69. Asling-Monemi K., *et al*. “Violence against women increases the risk of infant and child mortality: a case-referent study in Nicaragua”. *Bulletin of the World Health Organization* 81.1 (2003): 10-16.

70. Silverman JG., *et al*. “Maternal experiences of intimate partner violence and child morbidity in Bangladesh: evidence from a national Bangladeshi sample”. *Archives of Pediatrics and Adolescent Medicine* 163.8 (2009):700-705.

71. Martinez-Torteya G., *et al*. “Resilience among children exposed to domestic violence: The role of risk and protective factors”. *Child Development* 80.2 (2009): 562-577.

72. Breiding MJ., *et al*. “Chronic disease and health risk behaviors associated with intimate partner violence-18 U.S. states/territories, 2005”. *Annals of Epidemiology* 18.7 (2008): 538-544.

73. Cafferky BM., *et al*. “Substance use and intimate partner violence: A meta-analytic review”. *Psychology of Violence* 8.1(2018): 110-131.

74. Warshaw C., *et al*. “Mental Health Consequences of Intimate Partner Violence”. In C. Mitchell and D. Anglin (Editions.), Intimate Partner Violence: A Health-Based Perspective Oxford University Press (2009): 147-170.

75. Alhusen JL., *et al*. “Intimate partner violence and suicidal ideation in pregnant women”. *Archives of Women’s Mental Health* 18.4 (2015): 573-578.

76. Rivera EA., *et al*. “An applied research paper on the relationship between intimate partner violence and substance use”. *National Center on Domestic Violence Trauma and Mental Health* (2015).

77. Devries KM., *et al*. “Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis”. *Addiction* 109.3 (2014): 379-391.

78. Smith PH., *et al*. “Intimate partner violence and specific substance use disorders: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions”. *Psychology of Addictive Behaviors* 26.2 (2012): 236-245.

79. Gutierres SE and Van Puymbroeck C. “Childhood and adult violence in the lives of women who misuse substances”. *Aggression and Violent Behavior* 11.5 (2006): 497-513.

80. Black MC. “Intimate partner violence and adverse health consequences: Implications for clinicians”. *American Journal of Lifestyle Medicine* 5.5 (2011): 428-439.

81. Liu LY., *et al*. “Interplay between traumatic brain injury and intimate partner violence: Data driven analysis utilizing electronic health records”. *BMC Women’s Health* 20 (2020).

82. National Center for Injury Prevention and Control. “Costs of intimate partner violence against women in the United States”. Atlanta (GA): Centers for Disease Control and Prevention (2003).

83. Reeves C and O'Leary-Kelly AM. "The effects and costs of intimate partner violence for work organizations". *Journal of Interpersonal Violence* 22.3 (2007): 327-344.

84. World Health Organization. Violence against children. World health Organization, Geneva (2023).

85. Development Services Group, Inc., and Child Welfare Information Gateway. "Promoting protective factors for children exposed to domestic violence: A guide for practitioners". Washington, DC: U.S. Department of Health and Human Services, Administration on Children (2015).

86. Quality Improvement Center on Domestic Violence in Child Welfare. "Child welfare and domestic violence: The impact on children and families" (2018).

87. United Nations Children Fund (UNICEF). "Intimate Partner Violence and Breastfeeding: a Summary of the evidence" (2022).

88. Hamby SL., *et al*. "The overlap of witnessing partner violence with child maltreatment and other victimization in a nationally representative survey of youth". *Child Abuse and Neglect* 34.10 (2010): 734-741.

89. Health Resources and Services Administration, Office of Women's Health. "2023-2025 HRSA Strategy to Address Intimate Partner Violence". Rockville, Maryland (2023).

90. Cronholm PF., *et al*. "Intimate partner violence". *American Family Physician* 83.10 (2011): 1165-1172.

91. Hegarty K., *et al*. "Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial". *The Lancet* 382.9888 (2013): 249-258.

92. Nelson HD., *et al*. "Screening women for intimate partner violence: a systematic review to update the US Preventive Services Task Force recommendation". *Annals of Internal Medicine* 156.11 (2012): 796-808.

93. Ramsay J., *et al*. "Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial wellbeing of women who experience intimate partner abuse". *The Cochrane Database of Systematic Reviews* 3 (2009): CD005043.

94. Duterte EE., *et al*. "Correlates of medical and legal help seeking among women reporting intimate partner violence". *Journal of Womens Health* 17.1 (2008): 85-95.

95. American Congress of Obstetricians and Gynecologists (ACOG). Committee Opinion: Intimate Partner Violence (2012).

96. U.S. Preventive Services Task Force. "Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults". U.S. Preventive Services Task Force Recommendation Statement (2013).

97. Toussaint J. "Domestic violence and its role in child welfare" (2006).

98. Turner W., *et al*. "Interventions to improve the response of professionals to children exposed to domestic violence and abuse: A systematic review". *Child Abuse Review* 26.1 (2015): 19-39.

99. Greenbook National Evaluation Team. The Greenbook Initiative final national evaluation report (2008).

100. Gregory AC., *et al*. "The impact on informal supporters of domestic violence survivors: A systematic literature review". *Trauma, Violence, and Abuse* 18.5 (2016): 562-580.

101. Bender AE., *et al*. "Childhood exposure to intimate partner violence and effects on social emotional competence: A systematic review". *Journal of Family Violence* 37(2022): 1263-1281.

102. Lee H., *et al*. "The effect of childhood intimate partner violence (IPV) exposure on bullying: A systematic review". *Journal of Family Violence* 37.8 (2022): 1283-1300.

103. Kimber M., *et al*. "The association between child exposure to intimate partner violence (IPV) and perpetration of IPV in adulthood-A systematic review". *Child Abuse and Neglect* 76 (2018): 273-286.

104. Jasemi M., *et al*. "A concept analysis of holistic care by hybrid model". *Indian Journal of Palliative Care* 23.1 (2017):71-80.

105. Bullington J and Fagerberg I. "The fuzzy concept of 'holistic care': a critical examination". *Scandinavian Journal of Caring Science* 27 (2013): 493-494.

106. Ambuel B., *et al*. "Competencies needed by health professionals for addressing exposure to violence and abuse in patient care". Eden Prairie (MN): Academy on Violence and Abuse (2011).

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