Gender-Based Violence & Intimate Partner Violence

Overview:

What are Gender-Based Violence (GBV) and Intimate Partner Violence (IPV)?
GBV is an umbrella term for harmful acts that are rooted in a system of unequal gender power. These acts are perpetrated against a person or group of people due to their actual or perceived gender and disproportionately affect gender-minoritized people (cis girls and women, and non-binary and trans people) but may also occur when cis boys or men are demeaned or abused for failing to conform to gender norms (Pandea et al., 2019). The behaviors include: physical, verbal, sexual, psychological, socioeconomic, financial, vicarious and cultural abuse, coercion, and/or stalking of a former, current or prospective romantic partner (International Rescue Committee, 2023). GBV may be threatened or actual, occur in public or private and may be perpetrated by individuals, organizations, or states. The classification of harmful acts as GBV is independent of the perpetrator's gender or intention. All forms of GBV can threaten physical and psychological wellbeing and have acute and chronic effects on physical, mental, social, sexual, and reproductive health (Pandea et al., 2019).

IPV, a subset of GBV, refers to physical, sexual, emotional or financial abuse; coercion; controlling behaviors; or stalking of a former, current, or prospective intimate partner. IPV and other forms of chronic GBV may occur in cycles, which are called "the cycle of violence."

What is the Cycle of Violence?
Like other forms of abuse, GBV and IPV are often cyclical on the individual, familial, and systemic levels. At the individual level, violence often occurs in a cycle, consisting of four stages: tension building, acute violence, reconciliation/honeymoon, and calm (Etzhold, 2022, citing Walker, 1979). This pattern contributes to survivors' difficulties disengaging with abusers, as both survivors and others in their communities may observe the reconciliation/honeymoon and calm periods and discount or disbelieve the abuse.

On the familial level, GBV occurs cyclically in families and communities due to intergenerational transmission. Though it has long been assumed that children exposed to GBV are also more likely to perpetrate it in adulthood, this claim lacks an evidence base (see Kimber et al, 2018). However, data supports intergenerational transmission of witnessing IPV. In this case, people who witness IPV as children are more likely to have children who also witness IPV (Cannon et al, 2009). Proposed mechanisms of transmission include a perception of IPV as normative, imitation or modeling, as well as perinatal trauma exposure, neurobiology, and developmental psychopathology (Ehrensaft & Langhinrichsen-Rohling, 2022).

On the systemic level, support for GBV survivors is often contingent on their conformity to the role of the 'ideal' victim, who is completely adherent to rigid moral standards and is passive and submissive (Bumiller, 2008). For example, survivors' accounts of GBV may be deemed less credible if they are perceived as having failed to adequately meet gendered cultural morality standards by, for instance, consuming alcohol, expressing themselves sexually or initially providing and then subsequently withdrawing consent (Ricciardelli et al., 2021). Survivors are also expected to submit to their abusers and to others completely. Survivors may also only be considered victimized if they can claim to have been innocent of any aggression towards their abusers, even in self-defense (e.g. Delgado-Álvarez & Sánchez-Prada, 2022). In order to obtain justice or supportive resources, survivors are expected to willingly expose themselves and submit to imaginal or real revictimization, such as by reliving their trauma in multiple interviews to obtain state protection, legal advocacy, and social support services, or re-describing their trauma in court settings without resistance while re-exposing themselves to their abusers, which often results in increasing their abusers' aggression and their GBV exposure (Bumiller, 2008; Romero & Staudenraus, 2024). Thus, support from legal and social systems often requires the same loss of control, submission, and exposure to imaginal and real re-victimization that underpinned the GBV experience itself.

Prevalence

As GBV patterns reflect prevailing gender-based power inequalities, women, girls and gender minorities are the most frequent targets. However, this human rights violation can affect anyone, regardless of age, sex, gender identity, sexual orientation, ethnicity, nationality, religion, cultural background or social, economic, or civil status (*2023 Gender Equality and Women's Empowerment Policy*, 2023; Pandea et al., 2019).

- Globally, **one in three women between the ages of 15 and 49 years** has experienced intimate partner physical or sexual violence and/or non-partner sexual violence (World Health Organization, 2021).
- Experiences start from a young age, with **almost one quarter** of girls aged 15–19 years estimated to have already experienced physical or sexual violence from intimate partners (World Health Organization, 2021).
- Reported rates of IPV against women vary with higher lifetime and past-year prevalence estimates in low- compared to high-income countries. Data on GBV and IPV in low-income countries is scarce, preventing calculation of accurate prevalence rates. This is due, in part, to the challenges that low-income countries may face including variation in stigma surrounding IPV and GBV (World Health Organization, 2021).
- In the USA, **more than 40% of both cis men and cis women** reported experiencing IPV, in the form of physical or sexual violence, stalking and/or psychological aggression, in their lifetimes (Leemis et al., 2022).
- Prevalence estimates for GBV **among trans populations in the US range widely, from 7—89%** (Wirtz et al., 2020).
- Trans people in the US also experience **alarmingly high rates of psychological (42.0%) and physical (39.9%) IPV, as well as IPV specific to trans people (30.4%), such as denying access to hormones**, threatening to disclose gender identity without consent, or denying their gender identity (King et al., 2021).
- While international GBV prevalence estimates are not yet available for trans people, this research gap highlights the need for further inquiry in this area.

Considerations for **Vulnerable Populations**

- As predicted by intersectionality theory (Crenshaw, 1989) and the minority stress model (Meyer, 2003), adverse experiences or outcomes may be compounded by belonging to more than one minoritized group. People with multiple minoritized racial, ethnic, gender, and/or sexual orientation identities experience higher levels of discrimination, stress, and anxiety and depression symptomatology (Weiss et al, 2024). This can in turn impede survivors' escape from GBV (Petersson & Thunberg, 2022).
- **Minoritized communities** may feel a need to demonstrate "respectability" in some cases by not disclosing conflict within the community/family.
- **Transgender people** may face violence stemming from transphobia, misgendering, and discrimination. Furthermore, criminalization of the gender expression of trans and gender diverse populations in certain countries limits access to services (Injustice Exposed: The criminalization of Transgender People and Its Impacts, 2019).
- The intersection of race, socioeconomic status, and gender identity further complicates experiences and access to care for survivors (Grant et al., 2011).
- **Undocumented people** may fear reporting violence due to potential legal consequences and deportation (Menjivar & Salcido, 2002).
- **Men** may uniquely experience being a victim of GBV due to not meeting societal expectations of masculinity. This can provoke shame and stigma and increase the difficulty in acknowledging or reporting abuse (Cook et al., 2015).

Compounding Social Risk Factors: Intersectionality, Environment, Institutional Betrayal

GBV is a complex phenomenon. At an individual level, people affected by GBV may also experience other forms of discrimination (e.g., based on sexual orientation, race, or socioeconomic status) with multiple forms of discrimination amplifying inequality and generating cumulative disadvantage (Pandea et al., 2019) and onset of new mental health disorders (Weiss et al, 2024). Environmental factors such as conflicts, natural disasters, extreme weather and climate events, health emergencies (e.g., COVID) and displacement may heighten existing gender inequalities and raise the risk of GBV (Markan et al., 2022; Murphy et al., 2023; van Daalen et al., 2022).

In some cases, the state may inflict or facilitate GBV through acts of commission or omission. This may include control over reproductive care, laws that exempt prosecution of spouses for sexual assault, criminalization of homosexuality, non-recognition of trans people, and criminalization of trans identity expression (Kollodge & Vereinte Nationen, 2021; O'Connor et al., 2022).

Stigma and Myths

Stigma and myths surrounding GBV can substantially affect disclosure and access to care and treatment (Pandea et al., 2019). Stigmatizing beliefs that experiencing GBV is a sign of weakness, can be partially attributable to the actions or behaviors of the victim, or should remain a personal matter between partners can impose substantial barriers. Narratives that focus on the victim "just leaving" as a solution to GBV fail to take into account the multiple psychological, social, economic and legal factors that keep individuals in abusive relationships. The lack of alternative options and the possibility that the victim may be the target of retaliation, with research showing that attempting to leave an IPV relationship radically increases the likelihood of intimate partner homicide (Sheehan et. al. 2015). Furthermore,

fears around whether people will doubt the veracity of GBV claims and inadequate medicolegal services can contribute to underreporting and ultimately increase the likelihood of impunity for perpetrators (Pandea et al., 2019).

Evidence-Based Approaches to Treatment and Service Provision

Trauma-informed approaches such as centering the survivor's agency and perspectives, focusing on validation and affirmation, and trusting survivors' judgment are key to beginning to reinstate survivors' power and control over their own lives and supporting psychological recovery (Chu et al, 2023). Current legal and social service provision policy, which demands survivors to tell their stories repeatedly to strangers, publicly, in front of their abuser and/or in hostile environments, such as while being cross-examined, contrasts sharply with these principles (Chu et al, 2023). Trauma-informed care for GBV survivors became part of some US medical practices with the onset of Sexual Assault Nurse Examiner (SANE) nurses in the 1970s, but further education and innovation is needed to integrate understandings of GBV and traumatic stress into medicolegal systems (Morse, 2019).

In particular, experts in IPV homicide assessment emphasize that survivors know their abuser and their cycle of violence best, and therefore survivors are best positioned to assess their own risk for revictimization and homicide (Messing, 2019). A growing body of evidence shows that the integration of mental health services into other supports for IPV and the co-location of multiple services (e.g. advocacy, case management) in one location facilitate survivors' access to care and services (Berry et al, 2023). Further research, practice, and policy innovation is needed to accommodate survivors' mental health within treatment and service provision.

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