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WhatWorks TO PREVENT VIOLENCE

Intersections of Gender-based Violence and Common Mental Health Problems:

Understanding the Evidence and Strengthening Integrated Action

POLICY BRIEF

JUNE 2026

Gender based violence (GBV) and common mental health problems are interconnected global challenges disproportionately affecting women, girls, and LGBTQI+ people. These linkages are bidirectional, and shaped by intersecting individual, social and structural factors.

New global data from 2026 reveals the scale of violence and its long-term impacts on survivors' mental health: 608 million women have experienced intimate partner violence (IPV), and over one billion people experienced childhood sexual abuse.[1] For survivors, the resulting psychological trauma, particularly anxiety, depression, and self-harm, is often the single largest long-term impact on their health and well-being. This underscores the need to integrate mental health strategies with GBV response to support recovery. This integration is also important for prevention, as untreated trauma and poor mental health can increase the risk of both experiencing and using violence.[2]

Like GBV, common mental health problems are widespread. In 2019, nearly one billion people globally lived with a mental health condition, with anxiety and depressive disorders being the most common.[3] This burden of poor mental health, exacerbated by COVID-19,[4] is further driven by conflict, climate change, economic instability, geopolitical events, and human rights violations.[5] In emergency settings, such as armed conflict and disasters, some form of psychological distress is nearly universal.[6] While many recover over time, a significant proportion of those affected by conflict develop enduring mental health problems, ranging from depression, anxiety, and post-traumatic stress disorder (PTSD), to more complex disorders like bipolar disorder and schizophrenia.[7]

While the links between GBV and poor mental health are receiving increased attention, most research is still based on Western medicalised approaches. These models often focus narrowly on clinical diagnoses – like PTSD or depression – using standards developed in high-income countries (HICs). As a result, they can overlook how people in different cultures understand mental health and wellbeing or describe their own distress. There is a

growing need to move beyond standard global models to ground research and approaches in local knowledge, including the community ties, spiritual health, and personal relationships that people rely on for healing.[8] These factors are especially relevant for GBV survivors, who often face stigma, isolation, and discrimination that can profoundly affect their mental health and well-being.

This brief synthesises findings on four key questions for understanding the links between GBV and common mental health problems:

- What are the mental health impacts of GBV?
- How can common mental health problems increase the risk of GBV perpetration?
- How can poor mental health increase the risk of experiencing GBV?
- How can the linkages between GBV and mental health be addressed?

The policy brief is accompanied by a longer report which provides further detail on the findings from a comprehensive evidence review on the topic.[9] To complement the literature, consultations were conducted with 22 stakeholders across women's rights organisations, mental health NGOs, LGBTQI+ organisations, INGOs, UN agencies, and universities. In-person roundtables in Nepal and Uganda with 34 participants further added contextual insight, practice-based knowledge, and informed recommendations.

This report contains reference to and descriptions of GBV and mental health problems, including suicide ideation and attempts. If you or someone you know needs support, please contact your local GBV support (such as a helpline, a women's shelter or a local women's- or LGBTQI+ rights organisation) or your local mental health service providers (such as a helpline, your local healthcare facility, or mental health charities and support groups).

These resources may be helpful for finding out information about services available:

- Visit lila.help for information about GBV support services available in your area.
- On findahelpline, you can find information about free, confidential helplines for mental health problems and other issues that may affect your wellbeing.
- ILGA World is an umbrella organisation of LGBTQI+ organisations. This list of their member organisations might help you identify an organisation in your country.

Key findings

What are the mental health impacts of GBV?

The mental health consequences of GBV are well-established. Survivors commonly face depression, anxiety, PTSD, and suicidality, alongside psychosocial impacts like shame, social withdrawal, and diminished self-worth. These harms are often compounded by pervasive stigma and victim-blaming. LGBTQI+ survivors often face additional mental health stressors linked to systemic discrimination, internalised stigma, and exclusion from services.

Significant evidence gaps remain regarding the mental health impacts of certain forms of violence including child, early and forced marriage and technology-facilitated GBV (TFGBV), and the non-clinical psychosocial impacts that shape a survivor's long-term recovery. Existing evidence illuminates pathways between experiencing GBV and common mental health problems, yet survivors respond to trauma in diverse ways. Outcomes are shaped by context, support systems, individual factors, the severity, frequency or type of violence, as well as intersectional factors, including ethnicity, class, sexual orientation, gender identity, disability, age, and migrant status. These diverse patterns remain under-documented and require further research to ensure interventions are responsive to the diversity of survivors' needs.

Specific forms of violence and impacts:

- **Intimate partner violence (IPV):** Experiencing IPV is strongly linked to negative mental health outcomes, including depression, suicidal ideation, anxiety, and PTSD.[10] IPV often increases during conflict and humanitarian crises[11], with rates reported as high as 70% in some settings,[12] which heightens the risk of poor mental health in these areas. Women living with disabilities are at higher risk of IPV and face greater barriers to accessing help or appropriate mental health services,[13] increasing their likelihood of poor mental health outcomes.

  EVIDENCE FROM THE WHAT WORKS PROGRAMME

  What Works to Prevent Violence Against Women and Girls: Impact at Scale (What Works) is a seven-year initiative (2021-2028) funded by the UK's Foreign, Commonwealth and Development Office (FCDO) to scale global evidence-based and practice-informed efforts to prevent violence against women and girls. Evidence from the What Works programme across five low- and middle-income countries (LMICs) showed that women who had experienced IPV in the past 12 months had **2.5 times higher odds** of experiencing depressive symptoms compared with those who had not.[14]

- **IPV and violence against children (VAC):** GBV and VAC are deeply linked, frequently co-occurring within the same household and sharing risk factors. Children exposed to IPV face significantly higher risks of depression, anxiety, PTSD, and relationship challenges.[15] A recent randomised controlled trial (RCT) with adolescents in South Africa suggests that common mental health problems play a key role in explaining how violence is passed from one generation to the next.[16]

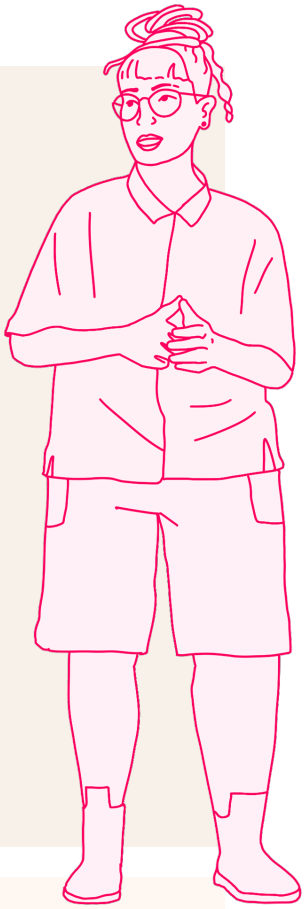
- **Sexual violence:** Sexual violence is linked to severe psychological consequences, including PTSD, depression, eating disorders, and suicidality.[17] Survivors may also experience anxiety and specific fears, including around the violence recurring, as well as shame, memory loss, and a sense of detachment that can disrupt the ability to work, care for children, or participate in daily life. Socially, survivors often face stigma, family rejection, and in some cases leave their communities to escape shame.[18] When violence results in pregnancy, the mental health burden is often exacerbated by hopelessness and pressure regarding reproductive choices. In humanitarian and conflict settings, women are more likely to face sexual violence perpetrated by multiple actors.

- **Technology-facilitated GBV (TFGBV):** While evidence from LMICs is still emerging, research shows that TFGBV, including sharing of private images without consent, is linked to depression, anxiety, suicidal ideation, and PTSD.[19]

LGBTQI+ specific violence: LGBTQI+ people experience both common forms of GBV and forms of violence rooted in intersecting gender-based and SOGIESC[20]-based oppression, including:

- **So-called "conversion" practices[21]:** These encompass a wide range of harmful acts – perpetrated by religious leaders, medical and mental health professionals, traditional healers, self-help groups, families, and community members – aimed at "curing," "treating," or "converting" LGBTQI+ individuals to cisgender and/or heterosexual identities. These practices are linked to profound psychological harms including depression, suicidality, feelings of shame and internalised phobia.[22]

- **"Corrective" rape:** A form of conversion practice intended to forcibly "correct" a person's sexual orientation or gender identity through sexual violence. Survivors describe severe mental health consequences including flashbacks, low self-esteem, suicidal ideation, concentration difficulties, and persistent fear of recuring sexual violence.[23]



Framing GBV and mental health carefully: Why it matters

While the evidence linking GBV and mental health is robust, there are important sensitivities to consider:

- **Risk of victim-blaming:** Mental health has been misused to blame survivors of violence and minimise the violence.[24] These dynamics persist, and perpetrators can weaponise mental health diagnoses to justify abuse and exercise control – a form of psychological abuse.[25]

- **Risk of downplaying perpetrator accountability:** Focusing narrowly on mental health in GBV perpetration can unintentionally reduce accountability if treated as a casual factor rather than one of multiple interacting risks. It is critical to situate mental health within the broader socio-ecological framework to avoid justifying violence.[26]

- **Limitations of diagnostic frameworks:** Standard diagnostic frameworks may not capture the full experiences of GBV survivors, such as how trauma, overlapping health problems, environmental factors, or other circumstances shape a survivor's mental health.[27] For example, severe PTSD from IPV can cause symptoms that resemble psychosis (losing touch with reality), leading to misdiagnosis or fragmented care where providers focus on one set of symptoms for treatment rather than survivors' holistic needs.[28]

- **Risk of reinforcing stigma:** Identifying the linkages between poor mental health and GBV perpetration or experience may unintentionally heighten stigma around mental health, deepening existing barriers to seeking help and care.

Given these concerns, it is essential to apply a survivor-centred, feminist approach when exploring GBV–mental health linkages. This includes maintaining perpetrator accountability, and appreciating how these linkages are shaped by broader structural drivers such as gender inequality, patriarchal norms, poverty, food insecurity, childhood trauma, conflict, and substance abuse.[29] [30] A clearer understanding of these intersections can ultimately strengthen prevention and response efforts across both fields.

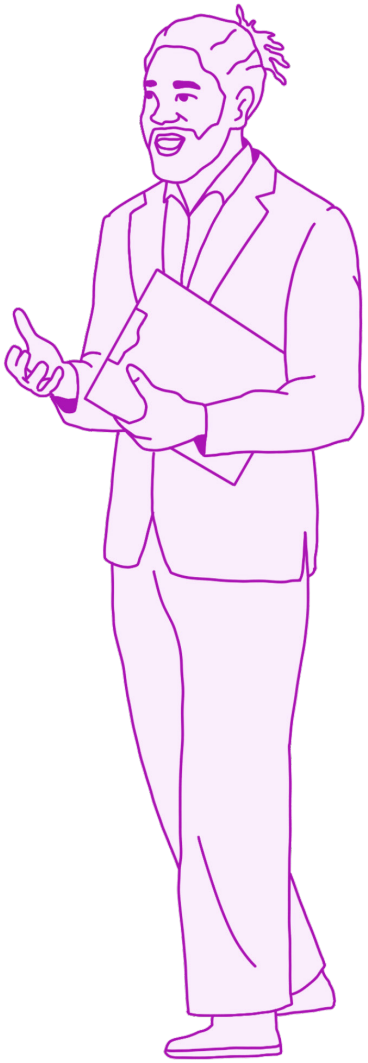
How can common mental health problems increase the risk of GBV perpetration?

While some evidence suggests common mental health problems can increase the risk of experiencing or perpetrating GBV – particularly in combination with other risk factors such as harmful alcohol use, economic stress, or histories of childhood abuse – this must be interpreted carefully to avoid reinforcing stigma. In practice, this means recognising that poor mental health is a linked risk factor, but not a direct cause.

EVIDENCE FROM THE WHAT WORKS PROGRAMME

Analysis of data from the *What Works* programme across four countries (South Africa, Ghana, Rwanda and Palestine) found that men reporting PTSD had nearly double the odds of perpetrating physical IPV in the past year, while those with depressive symptoms had more than twice the odds. Across three studies, men with PTSD were more than twice as likely to perpetrate non-partner sexual violence (NPSV) compared to men without PTSD.[31]

Poor mental health can play a role in men's use of violence, particularly intimate partner violence. Analysis of evidence from the What Works programme across four countries (South Africa, Ghana, Rwanda and Palestine) found that men reporting PTSD were nearly twice as likely of perpetrating physical IPV in the past year, while those with depressive symptoms also had double the odds of using violence.[32] These findings align with other studies including a UN multi-country study[33] in Asia and the Pacific, which found that men's depression was associated with physical and/or sexual IPV perpetration.[34]

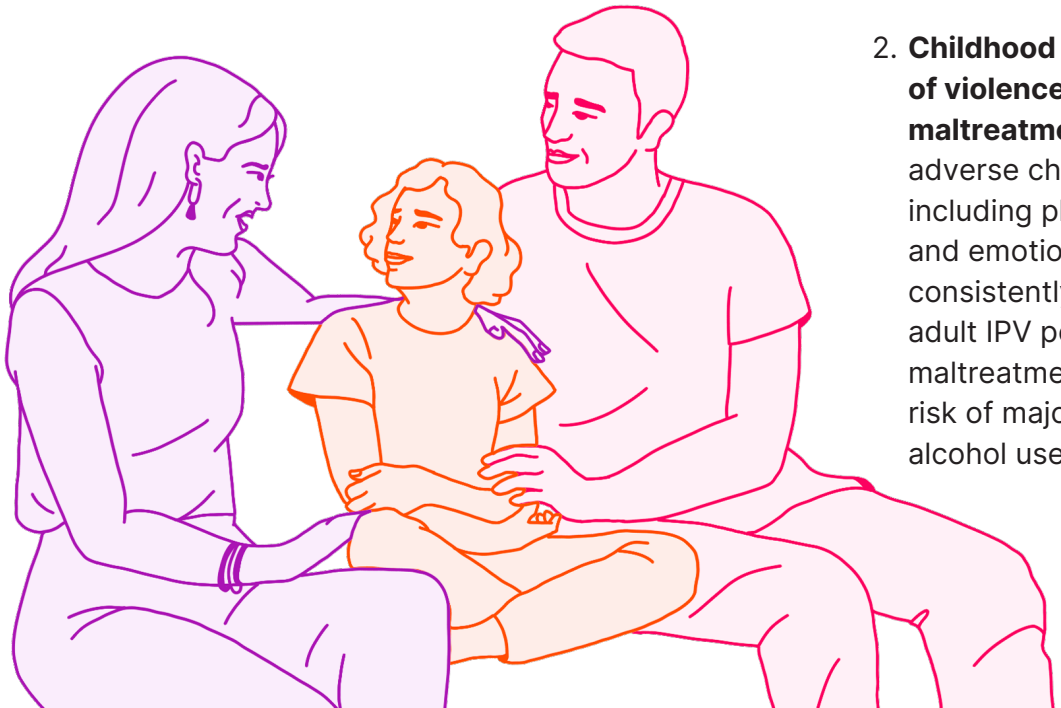


Less is known about how men's poor mental health relates to non-partner sexual violence (NPSV), particularly in LMICs. However, available studies suggest a similar pattern: men with common mental health problems are more likely to perpetrate NPSV.[35] Across three studies, men with PTSD were more than twice as likely to perpetrate NPSV compared to men without the condition.

Links between mental health and other forms of violence are also beginning to emerge. A systematic review found adverse mental health outcomes among young perpetrators of non-consensual sharing of intimate images.[36] Another study among 520 Lebanese adolescents aged 13-16 found that perpetrators of sexual cyberbullying reported significantly higher levels of anxiety and depression than non-perpetrators.[37] Depression has also been linked to perpetration of school violence and bullying, with systematic reviews showing higher depression levels among children and adolescents who engage in these behaviours.[38] However, this evidence is not gender-disaggregated and does not specifically examine the gendered dimensions of this violence.

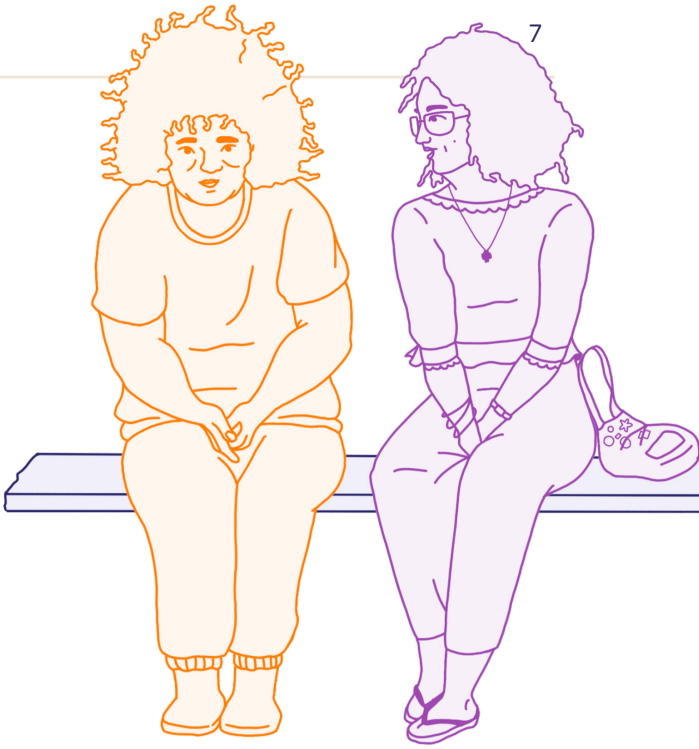
While more research is needed on how men's experiences of common mental health problems contribute to GBV perpetration, evidence points to two prominent pathways:

1. **Harmful alcohol use:** Depression often co-occurs with harmful alcohol use, which can be strongly linked with IPV and NPSV perpetration.[39] The first What Works to Prevent Violence programme found high levels of harmful alcohol use among male perpetrators of past year physical and/ or sexual IPV and NPSV in two studies in South Africa and one study in Ghana. The two South African studies also found that poverty and childhood abuse or neglect increased men's depressive symptoms and harmful alcohol use, which in turn were associated with higher IPV perpetration.[40]



2. **Childhood experiences of violence, trauma and maltreatment:** Exposure to adverse childhood experiences including physical, sexual, and emotional violence is consistently linked with men's adult IPV perpetration.[41] Childhood maltreatment also increases the risk of major depression and alcohol use later in life.[42]

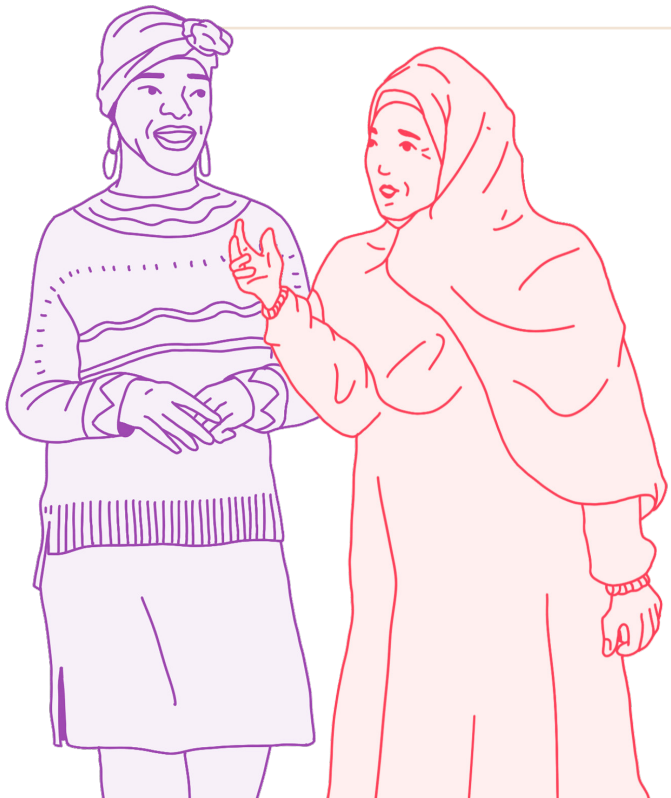
How can poor mental health increase the risk of experiencing GBV?



Poor mental health may increase the risk of experiencing certain forms of GBV, although research in this area remains limited. Most existing studies focus on women who have experienced IPV, with far less evidence on experiences for LGBTQI+ people or other forms of violence. What is known suggests that women living with common mental health problems, particularly depression, may face a higher risk of controlling behaviours and IPV, or may find it harder to leave abusive relationships.[43] Women living with severe mental illness face substantially higher risks of IPV.[44]

One explanation for the association between poor mental health and experiences of IPV is the presence of common, co-occurring risk factors, including childhood trauma, poverty, and harmful alcohol use. Evidence also points to the ways in which living with common mental health problems may increase vulnerability to IPV. An evidence review by the Prevention Collaborative highlights that symptoms of depression – such as feelings of worthlessness, low motivation, hopelessness, and persistent sadness – can affect a person's ability to manage disagreements and arguments in relationships, triggers of violence, and to leave abusive relationships.[45]

Women living with severe mental illness are also at increased risk of sexual violence. A systematic review and meta-analysis found that about 10% of women living with severe mental illness had experienced sexual violence in the past three years.[46] Women residing in mental health inpatient units may also experience GBV perpetrated by both patients and staff, arising from institutional conditions including under-resourced health systems and power imbalances within care relationships.[47]



How can the linkages between GBV and mental health be addressed?

GBV prevention and mental health interventions can deliver mutual benefits, even when they are not intentionally integrated.[48] Addressing the linkages between different forms of GBV and common mental health problems requires action at multiple levels. While most existing evidence focuses on individual and interpersonal interventions, a comprehensive approach must also address wider community and structural drivers.

Addressing GBV and mental health linkages across the socioecological model[1]

INDIVIDUAL APPROACHES	INTERPERSONAL APPROACHES	COMMUNITY APPROACHES	STRUCTURAL AND SOCIETAL APPROACHES
• Mental health and psychosocial support • GBV case management • Psychotherapy • Mindfulness and body focused approaches • Livelihoods and mental health approaches	• Couples' interventions • Family focused interventions • Parenting interventions • Peer-led mental health support	• Addressing stigma and taboo around GBV and common mental health problems • Strengthening community-based services, support structures and safe spaces	• Cash transfers • Social protection • School-based approaches • Strengthening health infrastructure

Individual approaches

GBV case management, mental health and psychosocial support (MHPSS), and access to specialised mental health care are essential for recovery from GBV. A range of psychotherapy approaches have demonstrated effectiveness in reducing common mental health problems among survivors, though many were not originally designed for GBV survivors and lack clear guidance for adaptation. In low-resource and humanitarian settings, many of these effective psychotherapy interventions have been delivered by trained lay providers, demonstrating feasibility where specialist services are scarce. However, quality and safety depend on sustained training, supervision, and referral pathways to support survivors with more complex mental health needs.

There is comparatively less but growing evidence that mindfulness, yoga and other body-centred approaches can improve GBV survivors' mental health and reduce trauma-related physical symptoms.[49] These interventions are particularly promising for GBV survivors to access and manage how trauma is stored in the body – aspects of recovery that psychotherapy or cognitive-only approaches cannot always reach. Recognising that GBV has profound social and economic consequences, some organisations integrate psychosocial support with skill-building – often termed 'livelihoods therapy' – to support recovery through both economic agency and wellbeing.[50] Evidence gaps remain on tailoring individual level interventions to diverse survivors, including LGBTQI+ populations, and on overcoming barriers to access.

1 The socio-ecological model is a framework used to understand how violence is influenced by factors at multiple levels: the individual, interpersonal relationships, the community, and wider society. It emphasises that sustainable change requires addressing the complex interplay between these levels rather than focusing on any single factor in isolation.

Interpersonal and community approaches

Social support – including through group-based interventions – emerged as a key mechanism for healing and collective resilience, described by practitioners as "the power of social contact". Peer-led counselling approaches draw on the support of friends, family, or people with shared experiences to improve mental health.[51] GBV prevention interventions can improve mental health by interrupting the pathways linking poor mental health with GBV perpetration and victimisation; these include group-based couples and parenting programmes to reduce IPV and VAC, and integrated approaches to strengthen mental health.

Community-based approaches play a critical role in challenging stigma, improving mental health literacy, and shifting harmful social norms, including through awareness raising activities, education initiatives, and social norms change initiatives. Schools, religious groups, and the health sector are critical entry points for promoting more supportive attitudes and norms, particularly in contexts where service providers themselves may hold harmful misconceptions.

EXAMPLE OF AN INTEGRATED INTERPERSONAL APPROACH

A family-based intervention to support young married women in Nepal

MILAP is a family-based intervention designed to reduce IPV and depression among young Nepali women by strengthening communication, coping skills, and family relationships.[52] The intervention is delivered by trained psychosocial counsellors and consists of four joint sessions for mothers-in-law and daughters-in-law focused on gender norms and allyship; four sessions of couples therapy for the woman and her husband; and a final session with all three family members. Pilot studies found the intervention to be acceptable, feasible, and effective in reducing IPV as well as symptoms of depression and PTSD among young married women.[53]

Structural and societal approaches

Structural approaches seek to address the root causes of both poor mental health and GBV, such as poverty and gender inequality. Mainstreaming GBV prevention and mental health considerations into other sectors, such as health, education, and economic empowerment, has the potential to strengthen multiple outcomes.

Economic and social protection programmes have significant potential to improve mental health and prevent GBV. A systematic review and meta-analysis found that a range of economic interventions – including conditional and unconditional cash transfers, poverty graduation programmes, asset transfers, housing vouchers, and health insurance – can improve mental health, with the strongest evidence for unconditional cash transfers.[54] Economic-plus interventions that combine economic strengthening with gender transformative components have been shown to reduce IPV and strengthen mental health simultaneously, while addressing related risk factors for both.[55]

EXAMPLE OF A STRUCTURAL APPROACH

A social cash transfer programme in Malawi

The Social Cash Transfer Programme (SCTP) provides unconditional cash support to ultra-poor households in Malawi, which is mainly used for food, small-scale farming, and children's education.[56] Evidence from an evaluation conducted ten years after the programme started shows that its benefits extend beyond reducing poverty.[57] Adolescents living in households receiving the cash transfers reported better mental health and fewer experiences of sexual violence, with notable reductions in depression among girls.[58] Stronger family support and reduced financial pressure likely contributed to a safer and more supportive environment for young people – caregivers reported lower stress levels (an 11% reduction) and a 22% improvement in their overall quality of life.

Schools are a good entry point for promoting mental health and preventing violence among children and adolescents. Whole-school approaches engage multiple stakeholders to address GBV in and around schools in a holistic way and have shown positive impacts on both strengthening mental health and reducing violence, including peer violence and children's exposure to violence at home.[59] Evidence from high-income settings shows that school-based violence prevention interventions can also contribute towards educational outcomes.[60] In less well-resourced settings, preventing violence alone is not sufficient to improve educational outcomes, but can play an important role to create safer and more conducive learning environments.[61]

Expanding access to mental health care requires strengthened health systems, including policies, budgets, specialised services, and integration into primary care.[62] Yet mental health remains severely underfunded, and LMICs face particularly large treatment gaps.[63] Providers need a strong understanding of the gendered dynamics of violence, its mental health impacts and intersections with other forms of oppression to deliver survivor-centered care. Without organisational support and practical guidance, survivors may find services harmful or re-traumatising.[64]

Recommendations

CROSS-CUTTING

- **Centre women, girls, and gender-diverse people** by prioritising survivor-led, locally grounded approaches that recognise lived experience and community knowledge as critical forms of expertise.
- **Strengthen collaboration** across GBV, mental health, health, social protection and economic sectors and better link research, policy, and practice.
- Invest in approaches that **actively reduce stigma** around both GBV and mental health at individual, community and structural levels.
- Prioritise the **mental health and collective care** of staff, activists, and researchers to sustain safe and effective programming.

DONORS AND GOVERNMENTS

- Invest in **integrated approaches** that address both mental health and GBV across prevention and response efforts, including through mainstreaming in health, education, and livelihoods programmes.
- Support **national mental health and GBV systems strengthening,** including workforce development, supervision, and referral pathways.
- Fund **research alongside programming,** including to capture practice-based knowledge, culturally relevant adaptation, implementation quality in LMICs, and ethical scaling.
- Provide **long-term, flexible funding** to local women's rights organisations, civil society organisations, and survivor-led groups as core delivery and accountability actors.
- Apply a **twin-track approach** to reach structurally marginalised groups, embedding inclusion within mainstream services while supporting targeted interventions for those facing heightened GBV and mental health risks.
- Use **diplomatic, policy and convening influence** to advance trauma-informed, survivor-centered systems and to elevate promising, locally-led models.

MENTAL HEALTH AND GBV PRACTITIONERS

- Systematically **integrate attention to GBV and mental health linkages** within programme design, delivery, and monitoring.
- Apply **survivor-centred, trauma-informed approaches** and tailor support to diverse needs, identities, and healing pathways.
- Invest in **sustained training, supervision and referral** mechanisms to ensure quality and safety, especially when employing non-specialist or lay providers.

RESEARCHERS

- Address **key evidence gaps** on the mental health impacts of diverse forms of GBV and on how poor mental health acts as a risk factor for GBV perpetration or victimisation.
- Examine how programmes **address social and structural determinants** of mental health and their intersections with GBV.
- Strengthen **implementation science** to improve adaptation of interventions in LMICs.
- Ensure **survivor and practitioner engagement,** intersectional analysis, and disaggregated data across all research priorities.

About this Brief

This brief is based on an evidence review which focused on understanding the intersections of GBV and mental health and identifying promising interventions and practice for integrated programming. For the full report, see: Ahlenback, V., Stern, E., and Fraser, E. (2026) Intersections of Gender-based Violence and Common Mental Health Problems: Understanding the Evidence and Strengthening Integrated Action, What Works to Prevent Violence: London UK.

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Endnotes

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20 SOGIESC stands for sexual orientation, gender identity and expression, and sex characteristics. Everyone has a SOGIESC, but people who do not conform to heteronormative or gender-binary norms often face discrimination and violence. SOGIESC terminology recognises that there are people and experiences across the world which cannot be neatly labelled or captured by LGBTQI+ terminology – for instance, non-binary people or third gender groups who may not identify within a LGBTQI+ framework.

21 The evidence report this brief is based on uses so-called "conversion" practices to describe efforts intended to change or suppress the SOGIESC of LGBTQI+ people. The prefix "so-called" signals that these are not therapeutic or evidence-based interventions, but harmful practices that constitute serious human rights violations, and in some cases, may amount to torture, as recognised by the UN Independent Expert on SOGI. The term "practices" is used in place of "therapies" to reflect their abusive nature.

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