IMPACT OF DOMESTIC VIOLENCE ON WOMEN'S MENTAL HEALTH IN BENIN CITY, EDO STATE, NIGERIA

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DEPARTMENT OF SOCIAL WORK

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CERTIFICATION

This is to certify that the project was conducted and submitted by **PRECIOUS EDEMAKHIONTA** with Mat. No. **SSC2013082** In part fulfilment of the requirement for the award of Bachelor of Science (B.Sc) Degree in Social Work.

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DEDUCATION

This research is dedicated to God Almighty, whose boundless love, mercy, and protection have been a constant source of strength. It is through His unending grace and support that this work has come to fruition. All glory belongs to Him, and I am deeply grateful for His presence in this journey

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ABSTRACT

This study examines the Impact of Domestic Violence on Women's Mental Health In Benin City, Edo State, Nigeria. The objective of the study is to assess the prevalence and forms of domestic violence experienced by women in Benin City to examine the mental health status of women who have experienced domestic violence, to explore the relationship between domestic violence and mental health disorders among women, to identify the socio-cultural and institutional barriers prevent women from seeking help.

The study employed a descriptive cross-sectional design also known as survey design. The sample size of two hundred (200) women within aged 18 to 60 years who have been or are currently in an intimate partner relationship whether formal (married), informal (cohabiting), or dating will be randomly selected from Oredo, Ikpoba-Okha, Egor, and Orhionmwon Local Government Areas, Benin City, Edo State.

The findings of this study revealed that most of the respondents are victims of domestic violence, domestic violence is a serious issue in most community in Benin City, societal attitudes towards domestic violence contribute to its prevalence, there are organisations and agencies that support victims of domestic violence in Benin City. This study concluded that the complex nature of domestic violence and its profound psychological consequences, which are worsened by cultural, social, and economic factors prevalent in the region. The recommendation of this study is to establish and enhance support centers that provide comprehensive services for victims of domestic violence, including counseling, legal aid, and medical assistance, and these centers should be easily accessible and equipped with trained professionals who understand the nuances of domestic violence and mental health.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Domestic violence (DV), also known as intimate partner violence (IPV), represents one of the most pervasive and insidious violations of human rights globally, with disproportionately severe consequences for women and girls. It encompasses a range of abusive behaviours including physical aggression, sexual coercion, psychological intimidation, and economic control perpetrated by current or former intimate partners or other household members (World Health Organization [WHO], 2021). While domestic violence transcends geographical, cultural, and socioeconomic boundaries, its prevalence, manifestations, and societal responses are deeply shaped by local contexts, particularly in patriarchal societies where gender inequality is entrenched and normalized through cultural, religious, and institutional practices (Heise, Ellsberg, & Gottemoeller, 1999). In Nigeria, a country marked by strong traditional values and evolving modern legal frameworks, domestic violence remains both endemic and underreported, especially in Southern regions such as Edo State.

Edo State, located in the South-South geopolitical zone of Nigeria, is home to the historic Benin Kingdom and is predominantly inhabited by the Edo (or Bini) people, a group with rich cultural traditions that emphasize communal harmony, respect for elders, and familial unity. While these cultural values can foster social cohesion, they may also inadvertently silence victims of

domestic abuse by promoting norms such as “a woman must endure for the sake of her children” or “family matters should not be aired in public” (Osisanwo, 2012; Odejide, 2006). These beliefs often discourage women from reporting abuse or seeking external intervention, thereby normalizing violence as a private or marital affair rather than a criminal or public health issue. Consequently, domestic violence in Benin City the bustling capital of Edo State with an estimated population exceeding 1.5 million (National Population Commission [NPC], 2023) persists largely in the shadows, despite growing national awareness and legislative efforts such as the Violence Against Persons Prohibition (VAPP) Act of 2015, which Edo State adopted in 2020. The psychological ramifications of domestic violence are profound and long-lasting. Women subjected to repeated abuse often experience a constellation of mental health disorders, including major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder (PTSD), suicidal ideation, and diminished self-worth (Devries et al., 2013; Abramsky et al., 2011). These conditions do not merely reflect transient emotional distress; they can severely impair a woman’s ability to function in daily life, engage in economic activities, care for children, or maintain social relationships. In low-resource settings like Benin City, where mental health services are scarce, stigmatized, and often unaffordable, these psychological wounds may go untreated for years or indefinitely leading to chronic disability and intergenerational trauma (Lund et al., 2018). A study by Abubakar, Ogunbameru, and Yusuf (2015) in Northern Nigeria found that over 60% of women exposed to intimate partner violence screened positive for depression, yet fewer than 10% had ever accessed mental health care. While similar dynamics are likely present in Edo State, there remains a critical gap in localized, empirical data on the

intersection of domestic violence and women's mental health specifically within the Benin City context.

Furthermore, the urban-rural continuum in Benin City introduces unique complexities. As a rapidly urbanizing center with a mix of formal and informal economies, educated professionals and informal traders, and traditional chieftaincy institutions alongside modern governance structures, Benin City embodies the tensions between tradition and modernity that shape gender relations in 21st-century Nigeria (Omoregie, 2018). Women in urban settings may have greater access to information, mobile phones, and social networks, potentially enhancing their capacity to seek help but they may also face heightened pressures related to economic survival, marital expectations, and social surveillance, which can increase vulnerability to coercive control and emotional abuse (Ajayi & Somefun, 2020). Understanding how these intersecting factors influence both the experience of domestic violence and its mental health outcomes is essential for designing contextually appropriate interventions.

Globally, the WHO (2021) estimates that nearly one in three women (27%) worldwide have experienced physical and/or sexual intimate partner violence in their lifetime, with regional prevalence in Africa reaching 33%. In Nigeria, the 2018 Nigeria Demographic and Health Survey (NDHS) revealed that 31% of women aged 15–49 have experienced physical violence since age 15, and 28% reported physical or sexual violence by a partner in the 12 months preceding the survey (NPC & ICF, 2019). Although disaggregated data for Edo State is limited, a state-level survey conducted by the Edo State Ministry of Women Affairs and Social

Development (2022) indicated that 38% of women in urban centers like Benin City reported at least one form of domestic violence in the past year, with emotional abuse being the most common (62%), followed by physical (43%) and sexual (18%) abuse. Alarmingly, only 12% of survivors sought formal help whether from police, health facilities, or NGOs highlighting systemic barriers to justice and care.

The mental health burden associated with such high levels of violence is exacerbated by Nigeria's severe shortage of mental health professionals and infrastructure. According to the WHO (2020), Nigeria has fewer than 300 psychiatrists for a population of over 200 million, with most concentrated in urban academic centers. In Benin City, mental health services are primarily offered at the University of Benin Teaching Hospital (UBTH), but stigma, cost, and lack of awareness prevent many women from accessing them. Moreover, frontline health workers in primary care settings are rarely trained to screen for domestic violence or provide psychosocial support, resulting in missed opportunities for early intervention (Abdulmalik et al., 2019). Against this backdrop, the need for a focused investigation into the relationship between domestic violence and women's mental health in Benin City is both urgent and timely. Existing national data provide useful benchmarks but fail to capture the nuanced sociocultural, economic, and institutional dynamics that define the lived experiences of women in this specific urban environment. Without localized evidence, policymakers, healthcare providers, and civil society organizations risk implementing generic or ineffective responses that do not address the root causes or lived realities of abuse and psychological suffering. This study, therefore, seeks to fill this critical knowledge gap by generating empirical, context-specific insights that can inform

culturally sensitive, trauma-informed, and gender-responsive strategies to protect women's rights and promote mental well-being in Benin City, Edo State.

1.2 Statement of the Problem

Domestic violence remains a deeply entrenched and systemic public health and human rights crisis in Nigeria, with particularly severe implications for women's physical safety, psychological well-being, and socioeconomic autonomy. Despite growing national discourse and legislative advancements such as the adoption of the Violence Against Persons Prohibition (VAPP) Act by Edo State in 2020 the reality on the ground in urban centers like Benin City reveals a stark disconnect between policy intentions and lived experiences. Women continue to endure various forms of intimate partner violence physical, sexual, emotional, and economic in silence, largely due to a complex web of sociocultural norms, institutional inadequacies, economic dependence, and pervasive stigma surrounding both domestic abuse and mental illness (National Population Commission [NPC] & ICF, 2019; Edo State Ministry of Women Affairs, 2022). This silence is not passive resignation but a survival strategy shaped by real fears of retaliation, abandonment, community ostracism, and disbelief from authorities (Olawale, Olanrewaju, & Adekunle, 2021).

The mental health consequences of domestic violence are among its most devastating yet least addressed outcomes. Research consistently demonstrates that women exposed to intimate partner violence are at significantly elevated risk of developing a range of psychiatric conditions, including major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder

(PTSD), substance use disorders, and suicidal ideation or attempts (Devries et al., 2013; Abramsky et al., 2011). In the Nigerian context, where mental health remains heavily stigmatized and professional services are grossly under-resourced, these psychological injuries often go unrecognized, untreated, and unacknowledged even by the victims themselves. A nationwide assessment by the WHO (2020) revealed that Nigeria has fewer than 300 psychiatrists and approximately 8 psychiatric nurses per 1 million people, with the majority concentrated in a few tertiary institutions. In Benin City, while the University of Benin Teaching Hospital (UBTH) offers psychiatric services, accessibility remains a major barrier due to cost, lack of awareness, transportation challenges, and cultural beliefs that attribute mental distress to spiritual causes rather than trauma (Abdulmalik et al., 2019; Gureje et al., 2015).

Compounding this crisis is the scarcity of localized, empirical evidence on the intersection between domestic violence and women's mental health in Benin City. While national surveys such as the Nigeria Demographic and Health Survey (NDHS, 2018) provide broad prevalence estimates indicating that 28% of Nigerian women aged 15–49 have experienced physical or sexual violence by an intimate partner in the past year these figures mask significant subnational variations shaped by ethnic, cultural, economic, and institutional contexts (NPC & ICF, 2019). For instance, a 2022 situational analysis by the Edo State Ministry of Women Affairs and Social Development reported that 38% of women in Benin City had experienced some form of domestic violence in the preceding 12 months, with emotional abuse being the most prevalent (62%), followed by physical (43%) and sexual (18%) abuse. However, this report did not assess the mental health status of survivors nor explore the pathways linking

abuse to psychological distress. Consequently, healthcare providers, social workers, law enforcement agencies, and policymakers in Benin City operate without robust, context-specific data to guide the design, implementation, or evaluation of integrated interventions that address both safety and mental health needs.

Moreover, the cultural landscape of the Edo people introduces unique dimensions to the problem. Traditional Edo values place a high premium on family cohesion, marital endurance, and respect for male authority within the household (Osisanwo, 2012). While these norms can foster stability, they also function as powerful deterrents against disclosure. Phrases such as "Ukpe okhuo" (a woman must keep quiet) or "Erha rhinmwon" (the husband is the head) are often invoked to justify tolerance of abuse and to shame women who seek external help (Omoregie, 2018). This cultural silencing is further reinforced by religious teachings that emphasize submission in marriage and by community leaders who prioritize reconciliation over accountability. The result is a social environment where domestic violence is normalized, minimized, or reframed as a private matter thereby shielding perpetrators from consequences and depriving survivors of validation and support (Odejide, 2006).

Institutional responses in Benin City remain fragmented and under-resourced. Although the Edo State VAPP Law criminalizes various forms of violence and mandates protection orders, implementation is hampered by limited awareness among both survivors and frontline responders, inadequate training of police and judicial personnel, and insufficient funding for shelters and psychosocial services (Edo State House of Assembly, 2020; Women's Rights

Advancement and Protection Alternative [WRAPA], 2021). Health facilities rarely screen for domestic violence during routine consultations, and when cases are identified, referral pathways to mental health or legal aid are either non-existent or poorly coordinated. Consequently, women who do muster the courage to seek help often encounter skepticism, victim-blaming, or procedural delays that retraumatize them and discourage further engagement with formal systems (Ajayi & Somefun, 2020).

This nexus of high violence prevalence, severe mental health consequences, cultural inhibition, and systemic neglect creates a critical gap in knowledge and practice. Without empirical data linking specific forms and frequencies of domestic violence to measurable mental health outcomes among women in Benin City, interventions remain speculative, generic, and potentially ineffective. The absence of such evidence also impedes advocacy efforts aimed at mobilizing political will, allocating resources, and reforming institutional protocols. Therefore, this study addresses a pressing and underexplored problem: the lack of comprehensive, localized understanding of how domestic violence impacts the mental health of women in Benin City, Edo State and how this understanding can inform more effective, compassionate, and culturally grounded responses.

1.3 Objectives of the Study

1. To assess the prevalence and forms of domestic violence experienced by women in Benin City.
2. To examine the mental health status of women who have experienced domestic violence.

3. To explore the relationship between domestic violence and mental health disorders among women.

4. To identify the socio-cultural and institutional barriers prevent women from seeking help.

1.4 Research Questions

1. What prevalence and forms of domestic violence experienced by women in Benin City?

2. What is the mental health status of women who have experienced domestic violence?

3. What are the relationship between domestic violence and mental health disorders among women?

4. What socio-cultural and institutional barriers prevent women from seeking help?

1.5 Significance of the Study

This study holds substantial theoretical, practical, policy-oriented, and social significance for multiple stakeholders including survivors of domestic violence, healthcare providers, policymakers, non-governmental organizations (NGOs), community leaders, researchers, and the broader society in Benin City and beyond. By generating empirical, context-specific evidence on the relationship between domestic violence and women's mental health, the study addresses a critical knowledge gap that has long impeded effective intervention and systemic reform in Edo State.

First, from a public health perspective, the findings will illuminate the magnitude and nature of mental health disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD) associated with different forms of domestic violence among women in Benin City. This is crucial because, despite the high prevalence of intimate partner violence in Nigeria (National Population

Commission [NPC] & ICF, 2019), mental health is rarely integrated into domestic violence response frameworks at the primary care level. By documenting the psychological burden borne by survivors, this research can catalyze the integration of routine mental health screening into antenatal, postnatal, and general outpatient services. For instance, validated tools such as the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7) could be adopted by nurses and community health workers to identify at-risk women early, thereby enabling timely psychosocial support or referral (Abdulmalik et al., 2019). This aligns with the WHO's Mental Health Gap Action Programme (mhGAP), which advocates for task-shifting mental health care to non-specialist providers in low-resource settings (World Health Organization [WHO], 2016).

Second, the study carries significant policy relevance. Although Edo State enacted the Violence Against Persons Prohibition (VAPP) Law in 2020 a landmark piece of legislation that criminalizes various forms of gender-based violence and provides for protection orders the law's implementation remains weak due to limited data-driven advocacy and monitoring (Edo State House of Assembly, 2020; Women's Rights Advancement and Protection Alternative [WRAPA], 2021). This research will provide concrete evidence to inform the Edo State Ministry of Health, Ministry of Women Affairs, and the Judiciary on the urgent need to strengthen multi-sectoral coordination. For example, findings on help-seeking barriers can guide the establishment of "one-stop centers" that co-locate medical, legal, counseling, and shelter services modeled after successful initiatives in Lagos and Kaduna thereby reducing the retraumatization that often occurs when survivors navigate fragmented systems (Federal Ministry of Women Affairs, 2022).

Third, the study contributes to community and cultural transformation. In Benin City, where traditional Edo values often discourage women from reporting abuse under the guise of preserving family honor (Osisanwo, 2012; Omoregie, 2018), this research can serve as a tool for community sensitization. By presenting data in accessible formats such as community dialogues, radio programs in the Bini language, and engagement with palace chiefs and religious leaders the study can challenge harmful norms that equate silence with virtue. Evidence showing the direct link between enduring abuse and severe mental health deterioration may shift public discourse from victim-blaming to survivor-centered empathy, thereby fostering a more supportive social environment.

Fourth, for non-governmental organizations (NGOs) and civil society groups working on gender-based violence (GBV) such as the Centre for Women's Rights and Development (CEWORD) and the Network of Edo Women this study offers baseline data to refine advocacy strategies, design targeted interventions, and measure impact over time. For instance, if the findings reveal that economic dependence is a key predictor of prolonged exposure to abuse and poor mental health outcomes, NGOs could prioritize livelihood training or microfinance programs alongside counseling services. Similarly, if stigma around mental illness emerges as a major barrier, organizations can develop culturally resonant mental health literacy campaigns that frame psychological distress as a normal response to trauma rather than a sign of weakness or spiritual failure (Gureje et al., 2015).

Fifth, the study makes a valuable academic and theoretical contribution. While global literature robustly documents the association between domestic violence and mental health (Devries et al., 2013; Abramsky et al., 2011), there is a dearth of localized research in Southern Nigeria, particularly in ethnically distinct urban centers like Benin City. This study will enrich the body of knowledge on how cultural context specifically Edo kinship structures, gender ideologies, and urbanization dynamics mediates both the experience of violence and its psychological consequences. It also advances the application of intersectional and ecological frameworks (Heise, 1998; Crenshaw, 1989) by examining how factors such as age, education, marital status, and employment status intersect to shape vulnerability and resilience among women.

Finally, the ethical and human rights dimension cannot be overstated. Every woman has the right to live free from violence and to enjoy the highest attainable standard of mental health, as enshrined in international instruments such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the African Charter on Human and Peoples' Rights. By giving voice to survivors and translating their experiences into actionable knowledge, this study upholds the principles of justice, dignity, and equity. It also aligns with Sustainable Development Goal (SDG) 3 (Good Health and Well-being), SDG 5 (Gender Equality), and SDG 16 (Peace, Justice, and Strong Institutions), thereby contributing to Nigeria's broader development agenda.

1.6 Scope and Limitations

This study is deliberately focused on examining the relationship between domestic violence and women's mental health within the specific geographic, demographic, and socio-cultural context of Benin City, the capital of Edo State, Nigeria. The scope of the research encompasses women aged 18 to 60 years who are currently or have previously been in intimate relationships (including marriage, cohabitation, or dating partnerships). The investigation covers four primary forms of domestic violence as defined by the World Health Organization (WHO, 2021): physical violence (e.g., slapping, kicking, choking), sexual violence (e.g., coerced sex, marital rape), emotional or psychological abuse (e.g., humiliation, threats, isolation), and economic control (e.g., withholding money, preventing employment). Mental health outcomes of interest include symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), and suicidal ideation, as measured by validated screening instruments the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and PTSD Checklist for DSM-5 (PCL-5). The study employs a cross-sectional design with mixed methods, combining structured household surveys across four Local Government Areas (LGAs) in Benin City Oredo, Ikpoba-Okha, Egor, and Orhionmwon with in-depth interviews and key informant discussions to capture nuanced lived experiences.

Geographically, the study is limited to Benin City due to its status as Edo State's urban epicenter, its heterogeneous population reflecting both traditional Edo values and modern Nigerian urban dynamics, and the relative accessibility of health and social services compared to

rural areas. This urban focus allows for an exploration of how rapid urbanization, digital connectivity, formal education, and exposure to national legal reforms (such as the Edo State VAPP Law) intersect with enduring cultural norms to shape women's vulnerability to violence and access to mental health support. However, this focus also means the findings may not be generalizable to rural or semi-rural communities in Edo State, where patriarchal structures may be more rigid, help-seeking pathways more limited, and forms of violence potentially more severe or underreported (Ajayi & Somefun, 2020).

Despite its strategic design, the study faces several limitations that must be acknowledged to contextualize its findings and guide future research. The cross-sectional nature of the study precludes causal inference. While statistical associations between domestic violence exposure and mental health outcomes can be established, it is not possible to definitively conclude that domestic violence caused the observed mental health conditions. Pre-existing mental health vulnerabilities may also increase a woman's risk of entering or remaining in abusive relationships a phenomenon known as "selection bias" (Devries et al., 2013). Longitudinal studies would be required to establish temporal sequencing and causality. Underreporting and social desirability bias are significant concerns. Domestic violence remains a highly stigmatized and sensitive topic in Benin City, where cultural norms emphasize family privacy and female endurance (Osisanwo, 2012; Omoregie, 2018). Even with assurances of confidentiality and the use of female interviewers trained in trauma-informed approaches, some respondents may minimize or deny their experiences due to fear of retaliation, shame, or internalized blame. This may lead to an underestimation of the true prevalence of violence and its mental health impacts.

To mitigate this, the study uses validated WHO instruments known for their sensitivity in low-resource settings and includes qualitative components that allow for deeper exploration of unspoken experiences.

The reliance on self-reported data introduces the possibility of recall bias. Participants are asked to recall experiences of abuse and mental health symptoms over the past 12 months, but memory accuracy can be influenced by current emotional state, ongoing stress, or dissociation common among trauma survivors (Brewin, Andrews, & Gotlib, 1993). While standardized instruments help improve consistency, they cannot fully eliminate subjective interpretation. Sampling limitations constrain generalizability. Although multi-stage random sampling enhances representativeness within the four selected LGAs, the study excludes certain vulnerable subpopulations such as women in informal settlements without fixed addresses, those institutionalized in psychiatric facilities, or migrants without stable residency. Additionally, the exclusion of women under 18 (minors) means that adolescent experiences of dating violence a growing concern in urban Nigeria are not captured, despite evidence that early exposure increases lifetime risk of mental health disorders (Ononokpono & Odimegwu, 2014).

Resource constraints affect the depth of mental health assessment. While screening tools like PHQ-9 and GAD-7 are reliable for identifying probable cases, they do not constitute clinical diagnoses. Due to the scarcity of psychiatrists in Benin City and ethical considerations around labeling, the study does not include clinical evaluations. Consequently, the findings reflect symptom prevalence rather than confirmed psychiatric disorders. Future studies with clinical

partnerships could address this gap. Cultural and linguistic nuances may affect instrument validity. Although efforts are made to translate questionnaires into the Bini language and pre-test them for cultural appropriateness, certain Western-derived constructs of mental health (e.g., "depression" as a clinical syndrome) may not fully align with local idioms of distress, which are often expressed somatically (e.g., "my body is heavy," "my head is not cool") or spiritually (Gureje et al., 2015). While qualitative interviews help bridge this gap, quantitative measures may still miss culturally specific manifestations of trauma.

Notwithstanding these limitations, the study is designed with rigorous methodological safeguards pilot testing, enumerator training, ethical protocols, and mixed-method triangulation to ensure reliability and contextual relevance. The limitations themselves highlight critical areas for future research, including longitudinal designs, inclusion of male perspectives, exploration of rural-urban disparities, and development of culturally adapted mental health screening tools. By transparently acknowledging these constraints, the study maintains scientific integrity while contributing valuable insights for local action in Benin City.

1.7 Definition of Key Terms

1. Domestic Violence (DV):

Domestic violence refers to any act of physical, sexual, emotional/psychological, or economic abuse perpetrated by a current or former intimate partner or other household member against a woman.

2. Women:

In this study, "women" refers to individuals who self-identify as female, aged 18 to 60 years, residing in Benin City, Edo State, and who have been or are currently in an intimate relationship (married, cohabiting, or dating).

3. Mental Health:

Mental health is defined as a state of well-being in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community (World Health Organization [WHO], 2022).

4. Depression:

Depression is a common mental disorder characterized by persistent sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration.

CHAPTER TWO

LITERATURE REVIEW

A comprehensive and critical examination of existing scholarly work is essential to situate this study within the broader discourse on domestic violence and women's mental health. This literature review systematically explores conceptual models, theoretical underpinnings, empirical findings, and contextual realities spanning global frameworks, national data from Nigeria, and localized insights from Edo State to build a robust foundation for investigating the nexus of domestic violence and psychological well-being among women in Benin City. By synthesizing and interrogating prior research, this section not only validates the relevance of the current study but also identifies critical gaps that justify its necessity and originality.

2.1 Conceptual Framework

Understanding the complex interplay between domestic violence and women's mental health requires more than a focus on individual pathology or isolated incidents of abuse; it demands a framework capable of capturing the multi-layered social, cultural, economic, and institutional forces that enable, sustain, and respond to violence. To this end, this study is grounded in the Ecological Model of Violence, a comprehensive conceptual framework originally developed by Lori Heise in 1998 and subsequently adopted and refined by the World Health Organization (WHO, 2021) for global application in violence prevention research and policy. This model moves beyond simplistic explanations that attribute domestic violence solely

to individual traits such as male aggression or female vulnerability and instead situates violence within a dynamic system of interacting factors that operate across four interrelated levels: individual, relationship, community, and societal. By analyzing these levels in concert, the ecological model provides a holistic lens through which to examine both the root causes of domestic violence and the contextual determinants of its psychological consequences among women in Benin City, Edo State.

At the individual level, the model considers personal characteristics and life experiences that may increase a woman's risk of experiencing violence or influence her mental health response to it. These include age, educational attainment, employment status, history of childhood abuse, substance use, and pre-existing mental health conditions. For instance, a woman with limited formal education may have fewer economic opportunities, increasing her dependence on an abusive partner and reducing her capacity to leave the relationship thereby heightening both exposure to violence and psychological distress (Heise, 1998; Abramsky et al., 2011). Similarly, survivors with prior trauma may be more susceptible to developing post-traumatic stress disorder (PTSD) or depression when re-exposed to abuse. However, the ecological model cautions against viewing these individual factors in isolation; rather, they are shaped by and interact with broader relational and structural contexts.

The relationship level focuses on the dynamics between intimate partners and within households. Key factors here include power imbalances, communication patterns, economic stress, male controlling behaviors (e.g., monitoring movements, restricting social contact), and

the presence of conflict or jealousy. Research consistently shows that relationships characterized by male dominance, economic dependence of women, and poor conflict-resolution skills are at higher risk for intimate partner violence (Jewkes, 2002). In the Edo context, where marriage is often viewed as a union not just of individuals but of families, relationship dynamics may be further complicated by interference from in-laws or expectations of female subservience, which can normalize coercive control as "discipline" or "guidance." The mental health impact of such relational environments is profound: chronic exposure to unpredictability, fear, and humiliation erodes self-worth, induces hypervigilance, and disrupts emotional regulation core features of anxiety and depression (Devries et al., 2013).

Moving outward, the community level encompasses the social environments and institutions that surround individuals and couples neighborhoods, workplaces, religious organizations, police stations, health clinics, and local leadership structures (e.g., palace chiefs, ward heads). Community norms about gender roles, the acceptability of violence, and the perceived responsiveness of formal institutions heavily influence both the occurrence of abuse and survivors' willingness to seek help. In Benin City, for example, if a local church consistently preaches that wives must "submit to their husbands" without addressing abusive interpretations of this doctrine, it may inadvertently discourage disclosure and reinforce victim-blaming (Osisanwo, 2012). Conversely, if a community health center trains its staff to screen for domestic violence and provide empathetic, non-judgmental referrals, it can become a critical entry point for mental health support. The ecological model underscores that even if a woman recognizes her

abuse, her help-seeking behavior will be shaped by whether she believes the police will take her seriously, whether her neighbors will gossip, or whether her family will support her or shame her.

Finally, the societal level addresses the macro-structural forces that legitimize gender inequality and violence across a culture or nation. These include laws and policies (or their absence), economic systems, media representations, religious doctrines, and deeply entrenched cultural ideologies about masculinity and femininity. In Nigeria, despite the passage of the federal Violence Against Persons Prohibition (VAPP) Act in 2015, only a subset of states including Edo State in 2020 has domesticated the law, and enforcement remains weak due to limited political will, inadequate funding, and resistance from traditional and religious authorities (WRAPA, 2021). Simultaneously, patriarchal norms that equate manhood with control and womanhood with obedience are perpetuated through proverbs, folklore, and media, rendering violence "invisible" or "justified" (Omoregie, 2018). At this level, the ecological model highlights how societal tolerance of violence creates a permissive environment in which abuse flourishes, while also shaping the availability (or scarcity) of mental health services, shelters, and legal aid that could mitigate psychological harm.

Critically, the ecological model does not treat these levels as hierarchical or independent; rather, it emphasizes their reciprocal and dynamic interactions. For example, a national policy (societal level) mandating domestic violence training for police (community level) may empower a woman (individual level) to report abuse by her husband (relationship level). Conversely, strong community stigma against "airing family secrets" may nullify the protective intent of even

the most progressive laws. By mapping these interactions, the model avoids victim-blaming and instead directs attention to systemic intervention points from changing school curricula to reforming judicial procedures that can disrupt the cycle of violence and promote mental well-being.

In the specific context of Benin City, this framework is particularly apt because it allows researchers to explore how Edo cultural values such as the emphasis on family unity ("Erha rhinmwon" "the husband is the head") and female endurance (*"Ukpe okhuo" "a woman must keep quiet") intersect with urban modernity, including access to education, mobile technology, and national legal reforms like the VAPP Law. It enables an analysis of why two women with similar abuse experiences might have vastly different mental health outcomes one descending into severe depression due to isolation and economic dependence, the other finding resilience through support from a women's cooperative or a sympathetic health worker. As Heise (1998, p. 270) asserts, "Effective prevention requires interventions at multiple levels… because violence is sustained by a web of factors operating simultaneously." By adopting this conceptual framework, this study moves beyond documenting the problem to illuminating the structural and contextual levers that can be mobilized for meaningful, sustainable change in the lives of women in Benin City.

2.2 Theoretical Framework

To deepen the analytical lens beyond structural and contextual factors, this study draws upon two complementary theoretical paradigms that elucidate the mechanisms through which

domestic violence manifests, is perpetuated, and impacts women's mental health: Feminist Theory and Lazarus and Folkman's (1984) Stress and Coping Theory. While the Ecological Model (discussed in Section 2.1) provides a multi-level map of the environments in which violence occurs, these theories offer explanatory power at both the macro-societal and micro-psychological levels, respectively. Together, they enable a nuanced understanding of why domestic violence persists as a systemic phenomenon in patriarchal societies like Nigeria, and how individual women navigate, interpret, and respond to abusive experiences thereby shaping their mental health trajectories.

2.2.1 Feminist Theory

Feminist Theory serves as the foundational macro-theoretical perspective, framing domestic violence not as an aberration or private misfortune but as a structural expression of gender-based power inequality embedded in social, economic, legal, and cultural institutions. Rooted in the works of scholars such as Walby (2004) and Okeke-Ihejirika (2004), feminist theory posits that violence against women is a mechanism of social control designed to maintain male dominance and female subordination. In patriarchal societies including Nigeria masculinity is often constructed around authority, ownership, and discipline, while femininity is associated with obedience, sacrifice, and domesticity. This gendered social order legitimizes male control over women's bodies, labor, and choices, rendering violence a "normal" or even "justifiable" response to perceived female transgression (e.g., questioning a husband's decisions, refusing sex, or seeking independence) (Odejide, 2006).

In the Nigerian context, feminist analyses have critically examined how customary laws, religious interpretations, and traditional marriage practices reinforce women's legal and economic dependence, thereby increasing vulnerability to abuse. For instance, under many customary systems in Southern Nigeria including Edo State women are excluded from land inheritance and property ownership, making economic exit from abusive marriages nearly impossible (Omoregie, 2018). Similarly, religious teachings in both Christian and Islamic communities often emphasize wifely submission without adequately addressing the boundaries of mutual respect and safety, inadvertently silencing survivors (Ajayi & Somefun, 2020). Feminist theory thus explains not only the origins of domestic violence but also the systemic silencing that prevents reporting: challenging abuse is frequently perceived as challenging the very foundation of social order, inviting stigma, familial rejection, or even further violence.

Crucially, feminist theory also highlights the intersectionality of oppression, acknowledging that women's experiences of violence are shaped not only by gender but also by class, education, marital status, and urban-rural location (Crenshaw, 1989). In Benin City, for example, an educated, employed woman may possess greater social capital and financial autonomy to resist or leave an abusive partner, whereas a rural migrant with no formal education and dependent children may remain trapped due to intersecting vulnerabilities. By centering power and inequality, feminist theory moves beyond individual pathology to demand structural transformation including legal reform, economic empowerment, and cultural re-education as essential components of violence prevention and mental health promotion.

2.2.2 Lazarus and Folkman's (1984) Stress and Coping Theory

In contrast, Lazarus and Folkman's (1984) Stress and Coping Theory provides a micro-level psychological framework to understand individual variation in mental health outcomes among women who experience similar forms of abuse. This theory posits that psychological distress arises not merely from the stressor itself (e.g., physical assault or emotional degradation) but from an individual's cognitive appraisal of the event as threatening or uncontrollable, combined with the availability and effectiveness of coping resources. According to Lazarus and Folkman (1984), coping strategies fall into two broad categories: emotion-focused coping (e.g., seeking emotional support, prayer, avoidance) and problem-focused coping (e.g., seeking legal aid, planning to leave, accessing counseling). The choice and efficacy of these strategies significantly influence whether a woman develops depression, anxiety, PTSD or exhibits resilience.

In the context of domestic violence in Benin City, this theory helps explain why not all survivors develop severe mental health disorders. A woman with strong kinship networks, access to a women's cooperative, or prior exposure to gender-based violence (GBV) awareness campaigns may appraise her situation as challenging but surmountable, mobilizing problem-focused strategies such as reporting to the police or seeking shelter. Conversely, a woman who is

socially isolated, economically dependent, and internalizes cultural messages that "a good wife endures" may perceive the abuse as inevitable and herself as powerless, leading to learned helplessness a key cognitive precursor to depression (Seligman, 1975). Furthermore, in settings where mental health services are scarce and stigmatized as in much of Nigeria coping may be limited to informal, culturally sanctioned mechanisms (e.g., prayer, traditional healing), which may provide comfort but do not address the underlying trauma (Gureje et al., 2015).

The synergy between these two theories is profound: Feminist Theory explains why the stressor (domestic violence) exists at all, while Stress and Coping Theory explains why it affects women differently. Feminist analysis reveals that the "lack of coping resources" experienced by many Nigerian women is not accidental but structurally produced through gendered policies, economic exclusion, and cultural norms. Thus, enhancing coping is not merely an individual therapeutic task but a sociopolitical imperative requiring the expansion of social, legal, and psychological support systems. By integrating these theoretical perspectives, this study avoids both victim-blaming (which attributes poor mental health solely to personal weakness) and structural determinism (which denies individual agency). Instead, it adopts a dialectical approach that recognizes women as both shaped by and capable of acting within indeed, transforming their social worlds. This theoretical duality is essential for designing interventions in Benin City that are not only trauma-informed but also gender-just, empowering women not just to survive abuse but to reclaim autonomy, dignity, and psychological well-being in a society still grappling with the legacies of patriarchy.

2.3 Domestic Violence: Forms, Causes, and Prevalence

Domestic violence (DV) also referred to as intimate partner violence (IPV) when occurring within spousal or romantic relationships is a pervasive global public health crisis and a grave violation of human rights. It is not a singular act but a pattern of coercive and controlling behaviors used by one partner to assert power and dominance over the other. The World Health Organization (WHO, 2021) operationally defines domestic violence as "any behavior within an intimate relationship that causes physical, psychological, or sexual harm," and it categorizes violence into four primary forms: physical, sexual, emotional/psychological, and economic abuse. Each form, often overlapping and mutually reinforcing, inflicts profound and lasting damage on survivors, with mental health consequences being among the most debilitating yet under-addressed outcomes.

Physical violence encompasses acts such as slapping, hitting, kicking, choking, burning, or the use of weapons to cause bodily harm. It may also include denying medical care or forcing the ingestion of harmful substances. Sexual violence involves any sexual act committed against a person's will, including marital rape, coerced sex, reproductive coercion (e.g., sabotaging contraception), and forced participation in degrading sexual acts. Critically, in many Nigerian communities including parts of Edo State marital rape is not legally recognized or socially acknowledged as violence, leaving countless women without recourse (Okeke-Ihejirika & Salami, 2020). Emotional or psychological abuse, though invisible to the eye, is often the most insidious form. It includes verbal degradation, threats of harm (to the woman, her children, or her

loved ones), isolation from family and friends, extreme jealousy, gaslighting (making the victim doubt her own reality), and constant surveillance. Research by Ellsberg et al. (2008) from the WHO Multi-country Study found that emotional abuse alone without physical or sexual violence strongly associated with depression, anxiety, and suicidal ideation, challenging legal and social systems that prioritize visible injury over psychological torment. Finally, economic abuse involves controlling a woman's access to financial resources, preventing her from working or pursuing education, confiscating her earnings, or running up debt in her name. In contexts of high female unemployment and economic dependence common in both urban and rural Nigeria economic abuse effectively traps women in violent relationships by eliminating their means of escape (Ononokpono & Nto, 2018).

2.3.1 The global prevalence of domestic violence

The global prevalence of domestic violence is staggering. According to the WHO's (2021) landmark analysis of data from 161 countries, approximately 27% of women aged 15–49 worldwide have experienced physical and/or sexual intimate partner violence in their lifetime. The African region reports the highest regional prevalence at 33%, reflecting deep-seated gender inequalities, weak legal protections, and cultural norms that tolerate male control (WHO, 2021). In Nigeria, national data from the 2018 Nigeria Demographic and Health Survey (NDHS) reveal that 31% of women aged 15–49 have experienced physical violence since age 15, and 28% reported physical or sexual violence by an intimate partner in the 12 months preceding the survey (National Population Commission [NPC] & ICF, 2019). These figures, however, likely

underestimate the true burden, as the NDHS does not systematically capture emotional or economic abuse forms that are often more common and equally damaging.

2.3.2 Causes of Domestic Violence

The causes of domestic violence in Nigeria are multifaceted, rooted in a nexus of sociocultural, economic, and institutional factors. Foremost among these is patriarchal ideology, which constructs masculinity around dominance and femininity around submission. In many Nigerian cultures, including the Edo of Benin City, a man's authority over his wife is seen as natural and divinely ordained, rendering violence a "disciplinary" tool rather than a crime (Osisanwo, 2012; Omoregie, 2018). Proverbs such as *"Erha rhinmwon"* ("the husband is the head") and norms emphasizing female endurance ("Ukpe okhuo" "a woman must keep quiet") normalize abuse and silence victims. Economic stress and unemployment further exacerbate tensions within households. In urban centers like Benin City, where the cost of living is rising and job insecurity is high, financial strain often triggers or intensifies violent conflict, particularly when men perceive their provider role as threatened (Ajayi & Somefun, 2020). Alcohol and substance abuse by male partners is another documented risk factor, impairing judgment and increasing aggression (Ononokpono & Nto, 2018).

Equally significant is women's structural vulnerability, shaped by limited access to education, economic resources, and legal rights. Women with low educational attainment are less

likely to be employed, more economically dependent on partners, and less aware of their rights or support services factors that increase both risk of victimization and barriers to exit (Okeke-Ihejirika & Salami, 2020). In Edo State, customary inheritance laws often exclude women from owning land or property, further entrenching dependence and reducing bargaining power within marriage (Omoregie, 2018). Additionally, weak institutional responses perpetuate impunity. Police often dismiss domestic violence as a "family matter," courts lack specialized training, and shelters are virtually non-existent outside a few urban centers, signaling to perpetrators that consequences are unlikely (WRAPA, 2021).

At the subnational level, emerging data suggest significant regional variation. While national surveys provide useful benchmarks, they mask localized realities. For instance, a 2022 situational analysis by the Edo State Ministry of Women Affairs and Social Development reported that 38% of women in Benin City had experienced at least one form of domestic violence in the past year higher than the national average (Edo State Ministry of Women Affairs, 2022). Notably, emotional abuse was the most prevalent (62%), followed by physical violence (43%) and sexual violence (18%). This pattern underscores the need for context-specific research: emotional abuse, though rarely criminalized, may be the most common entry point into cycles of control and psychological deterioration in urban Edo settings. Domestic violence in Nigeria and particularly in Benin City is not an isolated or random phenomenon but a systemic outcome of intersecting patriarchal norms, economic pressures, legal gaps, and cultural silencing. Its forms are diverse and interlocking, its causes deeply structural, and its prevalence alarmingly high. Understanding this complexity is essential not only for accurate measurement but for designing

interventions that address the root drivers of violence and its devastating mental health consequences.

2.4 Women's Mental Health: Disorders and Indicators

Mental health is a fundamental component of overall well-being, defined by the World Health Organization (WHO, 2022) as "a state of well-being in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community." For women who experience domestic violence, this state of well-being is systematically undermined, often leading to a constellation of psychological disorders that impair daily functioning, erode self-worth, and increase vulnerability to further harm. In the Nigerian context and particularly in urban centers like Benin City, Edo State women's mental health remains critically neglected due to stigma, inadequate services, and cultural misinterpretations of psychological distress. Understanding the specific disorders that commonly arise from exposure to domestic violence, as well as how they manifest in local contexts, is essential for effective screening, intervention, and support.

Among the most prevalent mental health conditions linked to domestic violence are major depressive disorder (MDD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), and suicidal ideation or behavior. Depression is characterized by persistent

sadness, loss of interest or pleasure in activities, feelings of worthlessness or excessive guilt, fatigue, difficulty concentrating, changes in appetite or sleep, and, in severe cases, thoughts of death or suicide (American Psychiatric Association [APA], 2013). In Nigeria, community-based studies estimate that the lifetime prevalence of depression among women ranges from 18% to 22%, significantly higher than among men, and strongly correlated with experiences of intimate partner violence (Gureje et al., 2015). For survivors of abuse, depression often stems from chronic exposure to unpredictability, humiliation, and powerlessness conditions that foster learned helplessness and a diminished sense of agency (Seligman, 1975).

Anxiety disorders, particularly generalized anxiety, are equally common. Symptoms include excessive worry, restlessness, irritability, muscle tension, sleep disturbances, and difficulty controlling fear. In the context of domestic violence, anxiety is frequently rooted in hypervigilance the constant anticipation of the next abusive episode and a pervasive sense of insecurity, even in seemingly calm moments (Devries et al., 2013). Women may avoid certain topics, behaviors, or social interactions out of fear of triggering their partner's anger, leading to social withdrawal and further isolation.

Post-Traumatic Stress Disorder (PTSD), though less commonly diagnosed in Nigerian clinical settings, is a well-documented consequence of severe or prolonged abuse. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), PTSD develops after exposure to actual or threatened death, serious injury, or sexual violence and is marked by four core symptom clusters: intrusion (e.g., flashbacks, nightmares), avoidance (of

trauma-related thoughts or places), negative alterations in cognition and mood (e.g., persistent fear, distorted blame, inability to experience positive emotions), and hyperarousal (e.g., irritability, exaggerated startle response, sleep problems) (APA, 2013). A meta-analysis by Devries et al. (2013) found that women exposed to intimate partner violence are three times more likely to develop PTSD than non-abused women. In Benin City, where repeated physical and sexual violence often occurs behind closed doors, many survivors likely experience subclinical or full PTSD without ever receiving a diagnosis.

Perhaps most alarming is the strong association between domestic violence and suicidal behavior. Studies across sub-Saharan Africa consistently show that women who experience intimate partner violence are at significantly elevated risk of suicidal ideation, suicide attempts, and completed suicide (Abubakar et al., 2015; WHO, 2021). This risk is amplified when abuse is combined with social isolation, economic dependence, and lack of access to mental health care conditions prevalent in many Nigerian households. In a study conducted in Kano, Northern Nigeria, Abubakar et al. (2015) found that 42% of women who experienced physical or sexual violence reported suicidal thoughts, compared to only 8% of non-abused women a stark disparity that likely reflects a national pattern.

Critically, the expression of mental distress in Nigerian communities often diverges from Western diagnostic categories. Rather than articulating feelings of sadness or anxiety, women in Benin City and similar settings frequently somatize their psychological pain reporting physical symptoms such as “my body is heavy,” “my head is not working,” “I have no strength,” or

chronic pain without biomedical cause (Gureje, 2019). This phenomenon, well-documented in transcultural psychiatry, arises from cultural norms that stigmatize mental illness as a sign of weakness, spiritual affliction, or moral failing, while legitimizing physical complaints as "real" suffering (Patel, 2000). Consequently, healthcare providers in primary care settings who constitute the first point of contact for most women may treat headaches or fatigue without recognizing the underlying trauma, leading to misdiagnosis, inadequate care, and prolonged suffering (Abdulmalik et al., 2019).

Moreover, mental health services in Nigeria are severely under-resourced and inaccessible to the majority of survivors. According to the WHO Mental Health Atlas (2020), Nigeria has only 0.06 psychiatrists per 100,000 people far below the global average and most are concentrated in urban academic hospitals like the University of Benin Teaching Hospital (UBTH). Even when services exist, stigma remains a formidable barrier. Mental illness is commonly attributed to spiritual attacks, witchcraft, or ancestral curses, leading families to seek help from churches, mosques, or traditional healers instead of mental health professionals (Gureje et al., 2015). While faith-based and traditional support can provide comfort, they rarely address the psychological trauma of abuse or offer evidence-based therapies like cognitive-behavioral therapy (CBT) or trauma-focused counseling.

In sum, women exposed to domestic violence in Benin City face a high risk of depression, anxiety, PTSD, and suicidal ideation but these conditions are often hidden behind somatic complaints, cultural silence, and systemic neglect. Recognizing the local idioms of distress,

validating survivors' experiences, and integrating mental health screening into routine health and social services are urgent priorities. Without such efforts, the psychological wounds of domestic violence will continue to fester, undermining not only individual lives but also family stability, community health, and national development.

2.5 Link Between Domestic Violence and Mental Health Outcomes

A robust and consistent body of empirical evidence from global, regional, and national studies confirms a strong, bidirectional, and often dose-dependent relationship between domestic violence and adverse mental health outcomes among women. Far from being merely a correlate, domestic violence functions as a significant independent risk factor for a range of psychological disorders, including depression, anxiety, post-traumatic stress disorder (PTSD), substance use, and suicidal behavior. This relationship is not incidental but causal in nature: the chronic exposure to fear, humiliation, unpredictability, and loss of autonomy inherent in abusive relationships directly disrupts neurobiological stress-response systems, erodes self-esteem, and impairs cognitive and emotional regulation thereby precipitating or exacerbating mental illness (Devries et al., 2013; WHO, 2021). Understanding the mechanisms, magnitude, and specificity of this link is critical for developing trauma-informed interventions in contexts like Benin City, where mental health services are scarce and cultural stigma silences suffering.

One of the most compelling pieces of evidence comes from a landmark meta-analysis by Devries et al. (2013), which synthesized data from 22 studies across 16 countries involving over 23,000 women. The analysis revealed that women who experienced intimate partner violence were 2.5 times more likely to suffer from depression and 3.0 times more likely to develop PTSD compared to women who had not experienced such violence. The association remained significant even after controlling for socioeconomic status, education, and other confounding variables, underscoring the independent contribution of violence to psychological morbidity. Notably, the study also found that the risk increased with the severity and frequency of abuse demonstrating a clear dose-response relationship. Women exposed to multiple forms of violence (e.g., physical, sexual, and emotional) consistently reported the highest levels of psychological distress, highlighting the compounding trauma of coercive control.

Crucially, emotional or psychological abuse often dismissed as "not real violence" by legal systems and even by some survivors emerges as equally damaging as physical or sexual violence. In the WHO Multi-country Study on Women's Health and Domestic Violence, Ellsberg et al. (2008) found that women who experienced emotional abuse alone (without physical or sexual violence) were just as likely to report symptoms of depression and anxiety as those who endured physical assault. This challenges dominant paradigms that prioritize visible injury and underscores the insidious nature of psychological control: constant criticism, threats, isolation, and gaslighting can systematically dismantle a woman's sense of reality, self-worth, and hope for the future. In Benin City, where overt physical violence may be concealed but emotional domination is culturally normalized under the guise of "discipline" or "guidance," this

form of abuse may be the most pervasive yet least recognized driver of mental health deterioration.

Longitudinal research further strengthens the case for causality. A study by Dillon, Hussain, Loxton, and Rahman (2013) tracked Nigerian women over time and found that those who exited abusive relationships showed significant improvements in mental health, including reduced depressive symptoms and increased self-efficacy, whereas those who remained in violent partnerships experienced worsening psychological outcomes. This temporal sequencing—where mental health improves after the removal of the stressor provides strong evidence that domestic violence is not merely associated with but actively causes mental health decline. Conversely, while pre-existing mental illness can increase vulnerability to entering or remaining in abusive relationships (a phenomenon known as "selection bias"), it does not account for the majority of cases; most women develop mental health symptoms after the onset of abuse (Golding, 1999).

The psychological mechanisms linking domestic violence to mental illness are well-documented in trauma theory. Chronic exposure to interpersonal violence activates the hypothalamic-pituitary-adrenal (HPA) axis, leading to prolonged elevation of stress hormones like cortisol, which can impair hippocampal function (involved in memory and emotion regulation) and increase amygdala reactivity (associated with fear and hypervigilance) (Yehuda, 2002). Over time, this neurobiological dysregulation manifests as hypervigilance, emotional numbing, intrusive memories, and difficulty trusting others core features of PTSD and complex

trauma. Simultaneously, the learned helplessness that develops when a woman perceives her situation as inescapable a common reality in contexts of economic dependence and social isolation directly contributes to the anhedonia, hopelessness, and cognitive distortions characteristic of major depression (Seligman, 1975).

In the Nigerian context, these global patterns are acutely reflected but compounded by systemic gaps in care. Abubakar, Ogunbameru, and Yusuf (2015) conducted a community-based study in Kano, Northern Nigeria, and found that 61% of women who reported intimate partner violence screened positive for moderate-to-severe depression using the PHQ-9, and 42% reported suicidal ideation. Yet, fewer than 10% had ever sought mental health services, citing stigma, cost, lack of awareness, and fear of disclosure as primary barriers. Although Kano differs culturally from Edo State, the structural constraints limited mental health infrastructure, weak integration of psychosocial support into primary care, and cultural attribution of distress to spiritual causes are nationwide. In Benin City, where similar conditions prevail, it is highly probable that a comparable proportion of abused women suffer in silence, their psychological wounds untreated and their resilience eroded over time. Moreover, the intersection of domestic violence and mental health creates a vicious cycle: poor mental health reduces a woman's capacity to seek help, assert boundaries, or secure economic independence, thereby increasing her entrapment in abusive relationships. Depression saps energy and motivation; anxiety fuels fear of retaliation; and PTSD triggers avoidance of anything associated with trauma including police stations, courts, or even supportive friends. This cycle is particularly pernicious in settings like Edo State, where help-seeking is already discouraged by cultural norms emphasizing family

privacy and female endurance (*“Ukpe okhuo” “a woman must keep quiet”) (Osisanwo, 2012; Omoregie, 2018). Without external intervention, the psychological toll accumulates, leading to chronic disability, intergenerational trauma (as children witness or internalize the abuse), and, in extreme cases, suicide.

The link between domestic violence and women’s mental health is not speculative but empirically well-established, biologically plausible, and contextually reinforced in Nigeria. Recognizing this link is not merely an academic exercise but a moral and public health imperative. Integrating mental health screening into domestic violence response systems whether in health clinics, police stations, or community NGOs is essential to breaking the cycle of silence and suffering. In Benin City, such integration could mean training community health workers to use the PHQ-9 or GAD-7 during routine visits, establishing referral pathways to counseling services at UBTH, or launching public awareness campaigns that frame psychological distress as a normal response to trauma not a sign of weakness. Only by addressing both the violence and its invisible wounds can survivors truly heal and reclaim their lives.

2.6 Domestic Violence and Mental Health in the Nigerian Context

While domestic violence and its psychological consequences constitute a global public health crisis, their manifestation, interpretation, and response in Nigeria are profoundly shaped by the country’s unique confluence of patriarchal cultural norms, fragmented legal frameworks, under-resourced health systems, and pervasive socio-religious influences. In this context, domestic violence is not merely a private or interpersonal issue but a systemic phenomenon

entrenched in historical, economic, and institutional structures that simultaneously normalize abuse and obstruct redress. The intersection of gender inequality, poverty, and weak governance creates an environment where women particularly in urban centers like Benin City, Edo State are disproportionately exposed to violence and systematically denied access to mental health care, resulting in a hidden epidemic of psychological suffering that remains largely invisible to policymakers and the public alike.

At the legislative level, Nigeria has made symbolic progress through the enactment of the Violence Against Persons Prohibition (VAPP) Act in 2015, a comprehensive federal law that criminalizes physical, sexual, psychological, and economic abuse; prohibits harmful traditional practices; mandates protection orders; and calls for the establishment of shelters and counseling services for survivors (Federal Republic of Nigeria, 2015). However, the implementation of the VAPP Act remains deeply uneven due to Nigeria's federal structure, which requires individual states to domesticate the law before it becomes enforceable within their jurisdictions. As of 2025, only 27 of Nigeria's 36 states have adopted the VAPP Law including Edo State in 2020 (Edo State House of Assembly, 2020). Even where domesticated, enforcement is hampered by limited awareness among survivors, inadequate training of law enforcement and judicial personnel, lack of dedicated funding for shelters and psychosocial services, and active resistance from traditional and religious leaders who view domestic matters as private and beyond state intervention (Women's Rights Advancement and Protection Alternative [WRAPA], 2021). Consequently, many women in Benin City remain unaware of their legal rights, and those who do report abuse often encounter police officers who dismiss their complaints as "marital issues" or urge

reconciliation rather than investigation a response that retraumatizes survivors and reinforces impunity (Ajayi & Somefun, 2020).

Compounding this legal gap is the severe underdevelopment of Nigeria's mental health infrastructure, which leaves survivors without recourse for psychological healing. According to the World Health Organization (WHO) Mental Health Atlas (2020), Nigeria has only 0.06 psychiatrists per 100,000 people far below the WHO-recommended minimum of 1 per 100,000 and fewer than 300 psychiatrists nationwide for a population exceeding 220 million. Mental health services are largely concentrated in a few tertiary institutions, such as the University of Benin Teaching Hospital (UBTH), which serves as the primary referral center for psychiatric care in Edo State. However, access to UBTH is constrained by cost, distance, transportation challenges, and long waiting times, rendering it inaccessible to the majority of women, particularly those from low-income households (Abdulmalik et al., 2019). More critically, primary healthcare centers the first point of contact for most Nigerians rarely integrate mental health screening or domestic violence protocols into routine care. A situational analysis by Abdulmalik et al. (2019) found that fewer than 15% of primary care providers in Nigeria had received any training in mental health, and even fewer were equipped to identify or respond to trauma related to gender-based violence. As a result, opportunities for early intervention are routinely missed, and psychological symptoms are either ignored or misattributed to physical ailments.

Culturally, the patriarchal values embedded in Nigerian societies including the Edo of Benin City play a pivotal role in both perpetuating violence and silencing its victims. In Edo cosmology, the family is viewed as a sacred unit whose harmony must be preserved at all costs. Proverbs such as "Erha rhinmwon" ("the husband is the head") and "Ukpe okhuo rhie erha" ("a woman's silence pleases her husband") reinforce gender hierarchies and equate female endurance with virtue (Omoregie, 2018; Osisanwo, 2012). These norms are further amplified by religious teachings in both Christian and Islamic communities, where sermons often emphasize wifely submission without adequately addressing the boundaries of mutual respect or the unacceptability of abuse. Consequently, women who experience violence are frequently counseled by pastors, imams, or family elders to "pray harder," "be more obedient," or "endure for the sake of the children" messages that pathologize the victim rather than the perpetrator (Odejide, 2006). This culture of silence not only prevents reporting but also inflicts secondary trauma, as survivors internalize blame and view their suffering as deserved or inevitable.

Moreover, mental illness itself is heavily stigmatized in Nigerian society, often interpreted through spiritual or moral lenses rather than biomedical or psychological ones. Psychological distress is commonly attributed to witchcraft, ancestral curses, demonic possession, or moral failing, leading families to seek help from churches, mosques, or traditional healers instead of mental health professionals (Gureje et al., 2015). While faith-based coping can offer emotional comfort, it rarely addresses the trauma of abuse or provides evidence-based therapeutic interventions. In some cases, religious leaders may even exacerbate the problem by framing a woman's depression as a sign of "lack of faith" or "spiritual attack," further isolating

her from supportive networks (Abdulmalik et al., 2019). This cultural misattribution of mental distress results in prolonged suffering, delayed care, and chronic disability particularly for survivors of domestic violence, whose psychological wounds are compounded by social rejection and economic marginalization.

Empirical evidence from Nigeria underscores the gravity of this dual crisis. The 2018 Nigeria Demographic and Health Survey (NDHS) revealed that 28% of women aged 15–49 experienced physical or sexual violence by an intimate partner in the 12 months preceding the survey (NPC & ICF, 2019). A subnational study by the Edo State Ministry of Women Affairs (2022) found an even higher prevalence in Benin City, with 38% of women reporting at least one form of domestic violence in the past year, and emotional abuse being the most common (62%). Yet, despite this high burden, fewer than 12% of survivors sought formal help from police, health facilities, or NGOs highlighting the chasm between need and service access. Qualitative studies further reveal that women who do seek help often face victim-blaming, procedural delays, and lack of confidentiality, which deter future disclosure (Olawale, Olanrewaju, & Adekunle, 2021).

In sum, the Nigerian context particularly in Benin City is characterized by a toxic convergence of high violence prevalence, cultural silencing, legal fragmentation, and mental health neglect. Domestic violence is enabled by patriarchal norms and weak institutions, while its psychological consequences are exacerbated by stigma, lack of services, and misinterpretation of distress. Without context-specific, culturally resonant, and system-wide interventions that

integrate legal protection, psychosocial support, community education, and economic empowerment, the cycle of violence and mental suffering will persist. This reality not only violates women's fundamental human rights but also undermines Nigeria's commitments to the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), and SDG 16 (Peace, Justice, and Strong Institutions).

2.7 Gaps in Existing Literature

While a growing body of research has documented the prevalence of domestic violence and its association with adverse mental health outcomes among women in Nigeria, significant lacunae persist particularly in the Southern geopolitical zones and among ethnic groups outside the dominant Yoruba, Hausa, and Igbo narratives. These gaps not only limit the generalizability of existing findings but also hinder the development of contextually appropriate, culturally resonant, and effective interventions in regions like Edo State. A critical review of the literature reveals five major deficiencies that justify the necessity and originality of this study focused on Benin City.

First, there is a pronounced geographic and ethnic bias in Nigerian domestic violence research. The vast majority of empirical studies have been conducted in the Northwest (e.g., Kano, Kaduna) or Southwest (e.g., Lagos, Ibadan) regions, with minimal scholarly attention paid to the South-South, where Edo State is located (Omoregie, 2018). This imbalance is problematic because cultural norms, kinship systems, legal traditions, and gender ideologies vary significantly across Nigeria's over 250 ethnic groups. The Edo people, for instance, possess a

distinct sociohistorical identity rooted in the ancient Benin Kingdom, with unique marriage practices, inheritance customs, and community governance structures that shape both the expression of gender-based violence and responses to it. As Omoregie (2018) observes, urban Edo women navigate a complex interplay between traditional expectations of female subservience and modern aspirations for autonomy a dynamic that is unlikely to be captured by studies conducted in Hausa-Fulani or Yoruba contexts. Without localized data, interventions risk being culturally misaligned or even counterproductive.

Second, existing studies frequently employ inadequate or non-validated measures of mental health. Many Nigerian surveys on domestic violence rely on single-item questions (e.g., "Have you felt sad or hopeless in the past two weeks?") or unstructured interviews to assess psychological well-being, lacking the reliability, validity, and clinical utility of standardized screening instruments (Abubakar et al., 2015; Gureje et al., 2015). This methodological weakness compromises the accuracy of prevalence estimates and limits comparability across studies and global benchmarks. In contrast, international best practices endorsed by the World Health Organization (WHO, 2021) recommend the use of validated tools such as the Patient Health Questionnaire-9 (PHQ-9) for depression, the Generalized Anxiety Disorder-7 (GAD-7) for anxiety, and the PTSD Checklist for DSM-5 (PCL-5) for post-traumatic stress symptoms. To date, no known study in Edo State has utilized this suite of instruments to systematically assess the mental health burden among survivors of domestic violence, leaving a critical evidence gap regarding the severity and specificity of psychological morbidity in this population.

Third, there is insufficient attention to the unique dynamics of urban settings like Benin City. While rural domestic violence has been somewhat explored, the urban experience characterized by rapid modernization, digital connectivity, formal education, and exposure to national legal reforms remains undertheorized. Benin City is not a traditional village but a bustling metropolis with a mixed economy, diverse social classes, and access to national media and advocacy networks. Women here may possess mobile phones, attend university, or work in formal employment, yet still face intense social control from partners, families, or community gatekeepers. This paradox modernity coexisting with entrenched patriarchy creates new forms of coercive control (e.g., digital surveillance, economic sabotage in informal markets) and novel barriers to help-seeking (e.g., fear of social media exposure, workplace stigma). Current literature fails to capture these nuanced urban realities, often treating "Nigerian women" as a homogenous group rather than recognizing the intersection of place, class, and technology in shaping vulnerability and resilience.

Fourth, there is a dearth of research on help-seeking behaviors and support system preferences among women in Edo State. While national surveys like the NDHS (NPC & ICF, 2019) report overall low rates of formal help-seeking, they do not explore why women in specific contexts choose (or refuse) to report abuse, which support systems they trust most (e.g., family, religious leaders, NGOs, police), or what types of interventions they find culturally acceptable. Qualitative insights from Benin City are especially scarce. Understanding these preferences is crucial for designing accessible services: for instance, if women overwhelmingly prefer confiding in market women's associations or church mothers rather than police, then

interventions should leverage these informal networks rather than investing solely in formal institutions that may be distrusted or inaccessible (Olawale, Olanrewaju, & Adekunle, 2021). Without such granular data, service provision remains speculative and supply-driven rather than demand-responsive.

Fifth, and perhaps most critically, there is a near-total absence of research evaluating the impact of the VAPP Law on survivors' mental health outcomes in Edo State. Although Edo State domesticated the Violence Against Persons Prohibition (VAPP) Law in 2020, no peer-reviewed study has examined whether this legal reform has translated into improved psychological well-being for survivors. Did awareness of the law empower women to seek help? Did protection orders reduce re-victimization and, consequently, anxiety or PTSD symptoms? Did the establishment (or absence) of shelters and counseling units affect depression rates? Answering these questions requires mixed-methods research that links legal implementation with mental health metrics a gap this study directly addresses. Without such evidence, policymakers cannot assess the law's effectiveness, allocate resources strategically, or advocate for necessary reforms.

In conclusion, the existing literature on domestic violence and women's mental health in Nigeria, while valuable, suffers from significant geographic, methodological, and contextual limitations that obscure the realities of women in Benin City. By generating empirical, instrument-based, culturally grounded, and policy-relevant data, this study fills these critical gaps. It moves beyond national averages to illuminate local patterns, employs validated mental health measures to ensure diagnostic rigor, explores urban-specific dynamics, centers survivors' voices

in help-seeking analysis, and evaluates the real-world impact of legal reforms. In doing so, it contributes not only to academic knowledge but to the practical advancement of women's rights, mental health equity, and violence prevention in Edo State and similar settings across Nigeria.

CHAPTER THREE

3.0 METHODOLOGY

This chapter describe the step that was followed in realizing the goals and objectives of the research, it laid out the methods that employed in the study to obtain relevant data for the study. In addition, methodology outlined the study area, research design, population of the study, sample and sampling sizes, types and sources of data, instrument of data collection, reliability/validity of the research instrument, methods of data analysis and ethical consideration.

3.1 Study Area

The study were conducted in Benin City, the capital of Edo State, Nigeria. Located in the South-South geopolitical zone, Benin City is a historic urban center with an estimated population of over 1.5 million (National Population Commission [NPC], 2023). It serves as the cultural and administrative heart of the Edo people and features a mix of traditional institutions (e.g., the Benin Royal Palace, ward chiefs) and modern governance structures. The city is characterized by rapid urbanization, a vibrant informal economy, and a relatively high literacy rate compared to rural Edo communities.

For sampling purposes, the study focused on four Local Government Areas (LGAs) that constitute the core urban and peri-urban zones of Benin City:

- Oredo (central business district, high population density),
- Ikpoba-Okha (industrial and residential),

- Egor (educational hub, home to the University of Benin), and
- Orhionmwon (peri-urban, transitioning from rural to urban).

These LGAs will be selected to ensure socioeconomic and geographic diversity while maintaining feasibility in data collection.

3.2 Research Design

A research design is a plan on how data were collected, analysed and the extent to which conclusions reached are applicable and generalizable. It is the blue print that shows the method to be adopted in research process (Omorogiuwa, 2006). The choice of a research design to be adopted depends on the relevance and availability of data. Hence, the study employed a descriptive cross-sectional design also known as survey design. This research design is suited for the assessment of a large population through the collection of information from a sample considered to be representative of the population. Furthermore, the design will be adopted because it is cost effective and has improved efficiency.

3.3 The Population of Study

The population of this study were consist of women aged 18 to 60 years who reside in Oredo, Ikpoba-Okha, Egor, and Orhionmwon, Local Government Areas, Benin City, Edo State, and who have been or are currently in an intimate partner relationship whether formal (married), informal (cohabiting), or dating. This age range is deliberately selected to encompass women of reproductive and economically active life stages, who are statistically most at risk of

experiencing intimate partner violence and its associated mental health consequences. However, the population of the selected local government areas according to the 2006 population census is as follows: Oredo 532,526, Ikpoba-Okha 372,080, Egor 429,897, and Orhionmwon LGA, 206,717 (National Population Commission of Nigeria, NPCN, 2006). This figures therefore will form our target population.

3.4 Sampling Techniques

This study employed the simple random sampling of the probability sampling technique, where every respondents has an equal and a fair chance of being selected in the sample. This method ensures that the sample is representative of the entire population, minimising bias in the selection process. This sampling technique was chosen by the researcher because it is a fundamental technique in statistics that provides a straightforward way of obtaining a representative sample and it helped draw valid conclusions about the larger population.

3.5 Sample Size

The sample size of two hundred (200) women within aged 18 to 60 years who have been or are currently in an intimate partner relationship whether formal (married), informal (cohabiting), or dating will be randomly selected from Oredo, Ikpoba-Okha, Egor, and Orhionmwon Local Government Areas, Benin City, Edo State. These will be selected from four local government areas in Benin City.

The table below represented the population at a glance:

Table 3.1: Sampled Respondents

S/N	Community	Sample Size
1	Oredo	50
2	Ikpoba Okha	50
3	Egor	50
4	Orhionmwon	50
	Total	**200**

Source: Researcher's Compilation, (2025)

Note: The sample size above comprises only of women within aged 18 to 60 years who have been or are currently in an intimate partner relationship whether formal (married), informal (cohabiting), or dating.

3.6 Instruments of Data Collection

The study utilised the quantitative methods of data collection and data were gathered through structured questionnaires. Quantitative methodology is a structured and systematic approach to research that emphasises the collection and analysis of measureable data. This methodology is typically used to establish patterns, and make generalizations about larger populations based on sample data, and the primary focus is on measuring variables and determining relationships between them through statistical analysis. To this end, the instruments to be used for data collection was "Women Questionnaires on Domestic Violence" which was administered to women within aged 18 to 60 years who have been or are currently in an intimate partner relationship whether formal (married), informal (cohabiting), or dating.

3.7 Validation and Reliability of Research Instrument

Validity is a concept used to describe how well the measuring system is accurate. The variables it sets out to carry out the intended measurement. To determine the content validity of the quantitative instrument, a draft copy of questionnaire was given to my supervisor for scrutiny, and two other experts in social work to also validate the instrument. The reliability of the quantitative instrument was determined by adopting the internal consistency reliability. Thus, the data collected will be subjected to Crobach Alpha formula and the reliability coefficient were obtained.

3.8 Method of Data Collection

The questionnaire was personally administered to the respondents after obtaining their permission. The respondents were advised to answer the questions honesty after administering the questionnaire to them. The researcher equally guided the respondents with regards to filing the questionnaire. The questionnaires were then collected from the respondents after completion for the purpose of analysis.

3.9 Method of Data Analysis

The responses from the questionnaire was analysed using descriptive statistics. The descriptive method described the demography of respondents using frequency and percentage and this was supported by charts. The analysis was conducted using the Statistical Packages for Social Sciences (SPSS 22.0) software.

3.10 Ethical Consideration

It is possible to identify ethical considerations as one of the research's most crucial components. However, prior to the study, participants were asked to give their full consent, and the information provided was treated with privacy and confidentiality. Respondents and participant's identities was not disclosed.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

This chapter presents the data analysis, interpretation and the discussion of results which is discussed under the following headings; socio-demographic characteristics, answering research question, and discussion of findings.

4.1 Description of respondents' demographic attributes

This section described the different background information of the respondents which include age, marital status, religion, highest level of education, and occupation of the respondents. However, out of the two-hundred (200) questionnaires distributed, one hundred and ninety-seven (197) were successfully retrieved and used for the analysis. The results are presented in Tables 4.1 below.

Table 4.1: Demographic Attributes of Respondents

S/N	Variable	Category	Frequency	Percent (%)	Cumulative Percent
1	Age at last birthday	18 – 25yrs	13	6.6	6.6
		26 – 35yrs	25	12.7	19.3
		36 – 45yrs	52	26.4	45.7
		46 – 55yrs	71	36.0	81.7
		56 – 60yrs	36	18.3	100.0
		TOTAL	**197**	**100.0**	
2.	Marital Status	Single	53	26.9	26.9
		Married	94	47.7	74.6
		Divorced	39	19.8	94.4
		Widowed	11	5.6	100.0
		TOTAL	**197**	**100.0**	
3.	Religion	Christianity	144	73.1	73.1
		Islam	13	6.6	79.7
		Traditional	23	11.7	91.4

		Others	17	8.6	100.0
		TOTAL	**197**	**100.0**	
4.	Highest level of Education	No Education	0	0.0	0.0
		Primary Education	11	5.6	5.6
		Secondary Education	26	13.2	18.8
		Tertiary Education	92	46.7	65.5
		Vocational	68	34.5	100.0
		TOTAL	**197**	**100.0**	
5.	Occupation	Business/Petty trading	80	40.6	40.6
		Civil/Public servant	78	39.6	80.2
		Housewife	12	6.1	86.3
		Student	18	9.1	95.4
		Others	09	4.6	100.0
		TOTAL	**197**	**100.0**	

***Source: Researcher's field Work* (2025)**

Table 4.1 shows that 197 copies of the questionnaire were retrieved and found usable.

Age of Respondents: Table 4.1 shows that 13 respondents, which accounted for 6.6% were between 18 to 25 years old. Then, 25 respondents, which accounted for 12.7% were between the age bracket of 26 – 35 years. Also, 52 respondents, which accounted for 26.4% were between the age bracket of 36 – 45 years. 71 respondents, which accounted for 36.0% were between the age bracket of 46 – 55 years. While the remaining 36 respondents, which accounted for 18.3% were between the age bracket of 56 – 60 years respectively. This implies that different age groups of the respondents were represented in the study.

Marital Status: Table 4.1 shows that majority of the respondents were married. These respondents, which are 94, account for 47.7% of the total respondents. This is followed by 53

respondents who were single and they accounted for 26.9% of the total respondents. Then, 39 respondents, which accounted for 19.8% were divorced. While 11 respondents, which accounted for 5.6% of the total respondents were widowed. This study captured different marital status of respondents, and this added value to the study.

Religion of Respondents: Table 4.1 shows that majority of the respondents 144, were Christians and they accounted for 73.1% of the total respondents. This is followed by 23 respondents who practice African Traditional Religion, and they accounted for 11.7% of the total respondents. Then 13 respondents, which accounted for 6.6% were Muslim. While the remaining 17 respondents, which accounted for 8.6% practice other religions which was not stated by the respondents.

Level of Education: Table 4.1 shows that most respondents has attained tertiary level of education. These respondents who were 92, accounted for 46.7% of the total respondents. This is followed by respondents who had Vocational training. These respondents were 68 in numbers, and accounted for 34.5%. This is also followed by respondents who had Secondary School Education. These respondents were 26 in numbers, and accounted for 13.2%. And 11 respondents which accounted for 5.6% had Primary Education. This implies that respondents with different educational qualifications were represented in the study.

Occupation of Respondents: Table 4.1 shows that majority of respondents are into business/petty trading. These respondents who were 80 in numbers, accounted for 40.6%. This is followed by respondents who were civil/public servants. These respondents were 78 in numbers,

which accounted for 39.6%. Also, 18 respondents, which accounted for 9.1% were students. Then, 12 respondents, which accounted for 6.1% were housewife. While the remaining respondents 09, which accounted for 4.6% were into other form of business or employment respectively.

4.2 Descriptive Analysis: Answering of Research Questions

RESEARCH QUESTION 1: *What prevalence and forms of domestic violence experienced by women in Benin City?*

To answer research question 1, questions 1-5 of the questionnaire was employed as presented in the table 4-2 below:

Table 4.2: The Prevalence And Forms Of Domestic Violence Experienced By Women In Benin City.

Variables		SA	A	D	SD	Total
I have experience domestic violence from my partner before.	N	79	60	31	27	197
	(%)	(40.1)	(30.5)	(15.7)	(13.7)	(100)
Domestic violence is a serious issues in my community.	N	45	34	57	61	197
	(%)	(22.8)	(17.3)	(28.9)	(30.9)	(100)
Societal attitudes towards domestic violence contribute to its prevalence.	N	81	63	33	20	197
	(%)	(41.1)	(31.9)	(16.8)	(10.2)	(100)
There are organisations and agencies that support victims of domestic violence in Benin City.	N	92	57	31	17	197
	(%)	(46.7)	(28.9)	(15.7)	(8.6)	(100)
There should be more awareness programs conducted to address domestic violence.	N	102	95	0	0	197
	(%)	(51.8)	(48.2)	(0.0)	(0.0)	(100)

Source: Field Survey, 2025

Table 4.2 above showed the prevalence and forms of domestic violence experienced by women in Benin City. In response to item one, majority of the respondents 79, which accounted for

40.1% and 60 respondents, which accounted for 30.5% were of the view that they have experience domestic violence from their partner before. Then, 31 respondents which accounted for 15.7% and 27 respondents, which accounted for 13.7% disagreed with the statement. Therefore, in line with the responses, it can be said that most of the respondents are victims of domestic violence.

Responses to item two revealed that 45 respondents, which accounted for 22.8% and 34 respondents which accounted for 17.3% were of the view that, domestic violence is a serious issue in their community. Then, majority of the respondents 57, which accounted for 28.9% and 61 respondents, which accounted for 30.9% disagreed with the issue raised. Therefore, in view of the responses above, it can be said that domestic violence is a serious issue in most community in Benin City.

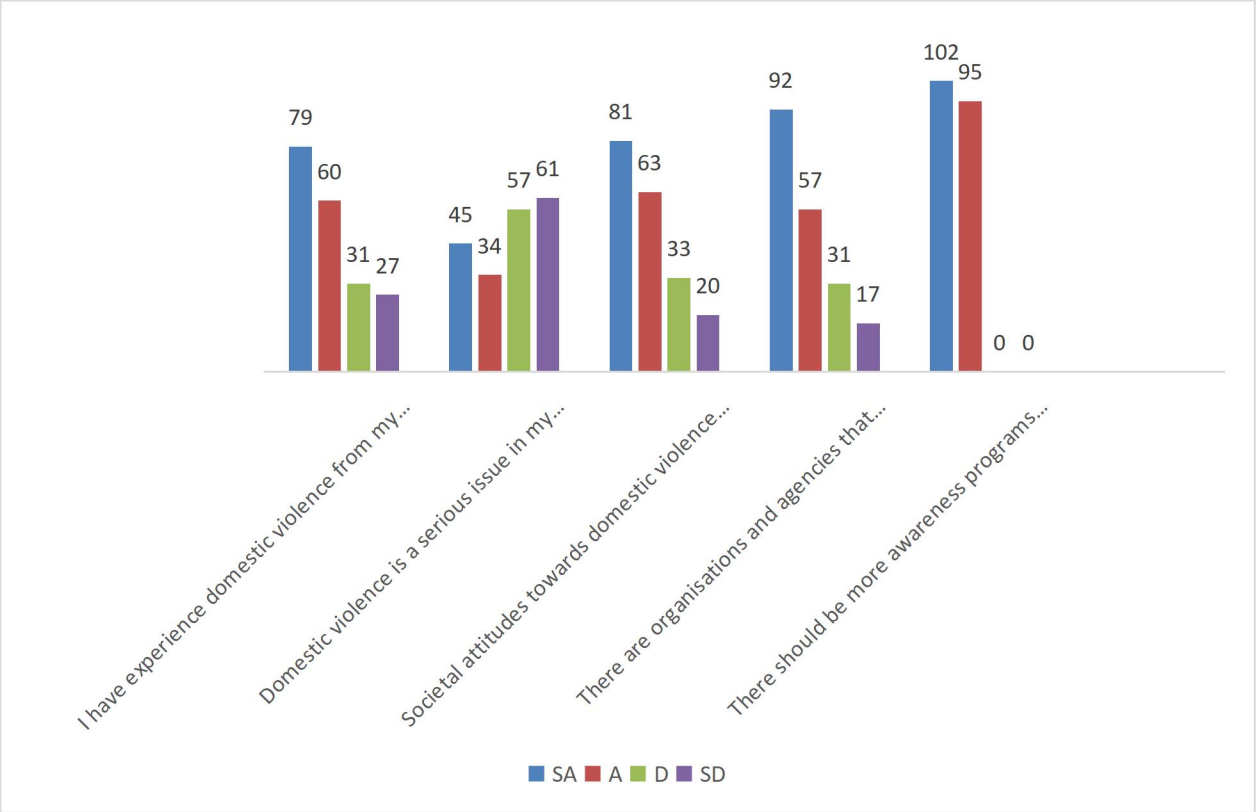
Furthermore, in item three, a majority of the respondents 81 which accounted for 41.1% and 63 respondents, which accounted for 31.9% were of the view that societal attitudes towards domestic violence contribute to its prevalence. Then, 33 respondents which accounted for 16.8% and 20 respondents, which accounted for 10.2% were indifferent. Therefore, in view of the responses, it can be stated that societal attitudes towards domestic violence contribute to its prevalence.

In item four, majority of the respondents 92 which accounted for 46.7% and 57 respondents which accounted 28.9% were of the view that there are organisations and agencies that support victims of domestic violence in Benin City. Then, 31 respondents, which accounted for 15.7%

and 17 respondents, which accounted for 8.6% disagreed with the statement. Therefore, in view of the responses, it can be concluded that there are organisations and agencies that support victims of domestic violence in Benin City.

In item five from table 4.2 above, majority of the respondents 102, which accounted for 51.8% and 95 respondents which accounted for 48.2% were of the view that there should be more awareness programs conducted to address domestic violence. Then, none of the respondents disagreed with the statement. Therefore, in view of the responses, it can be said that there should be more awareness programs conducted to address domestic violence.

Fig. 4.1: The Prevalence And Forms Of Domestic Violence Experienced By Women In Benin City.



RESEARCH QUESTION 2: *What is the mental health status of women who have experienced domestic violence?*

To answer the research question 2 above, questions 6 – 10 of the questionnaire was employed as presented in table 4.3 below:

Table 4.3: The Mental Health Status Of Women Who Have Experienced Domestic Violence.

Variables		**SA**	**A**	**D**	**SD**	**Total**
Victims of domestic violence experience increased stress and anxiety related to their mental health.	N	101	75	15	6	197
	(%)	(51.3)	(38.1)	(7.6)	(3.0)	(100)

Mental health resources should be made available for victims of domestic violence.	N	110	87	0	0	197
	(%)	(55.8)	(44.2)	(0.0)	(0.0)	(100)
Seeking support from friends and family helps cope with stress and emotional pain from domestic violence.	N	103	82	5	7	197
	(%)	(52.3)	(41.6)	(2.5)	(3.6)	(100)
Engaging in physical activities/exercise helps cope with mental health challenges of domestic violence.	N	67	53	42	35	197
	(%)	(34.0)	(26.9)	(21.3)	(17.8)	(100)
Victims of domestic violence experience post-traumatic stress disorder and depression.	N	113	55	18	11	197
	(%)	(57.4)	(27.9)	(9.1)	(5.6)	(100)

Source: Field Survey, 2025

Table 4.3 above showed the mental health status of women who have experienced domestic violence. In response to question one, 101 respondents which accounted for 51.3% and 75 respondents which accounted for 38.1% were of the view that, victims of domestic violence experience increased stress and anxiety related to their mental health. Then 15 respondents which accounted for 7.6% and 6 respondents which accounted for 3.0% thinks otherwise. Hence, in view of the responses, it can be concluded that victims of domestic violence experience increased stress and anxiety related to their mental health.

In questions two from table 4.3 above, majority of the respondents 110 which accounted for 55.8% and 87 respondents, which accounted for 44.2% were of the view that mental health resources should be made available for victims of domestic violence. Then none of the

respondents disagreed with the statement. However, in view of the responses, it can be stated that mental health resources should be made available for victims of domestic violence.

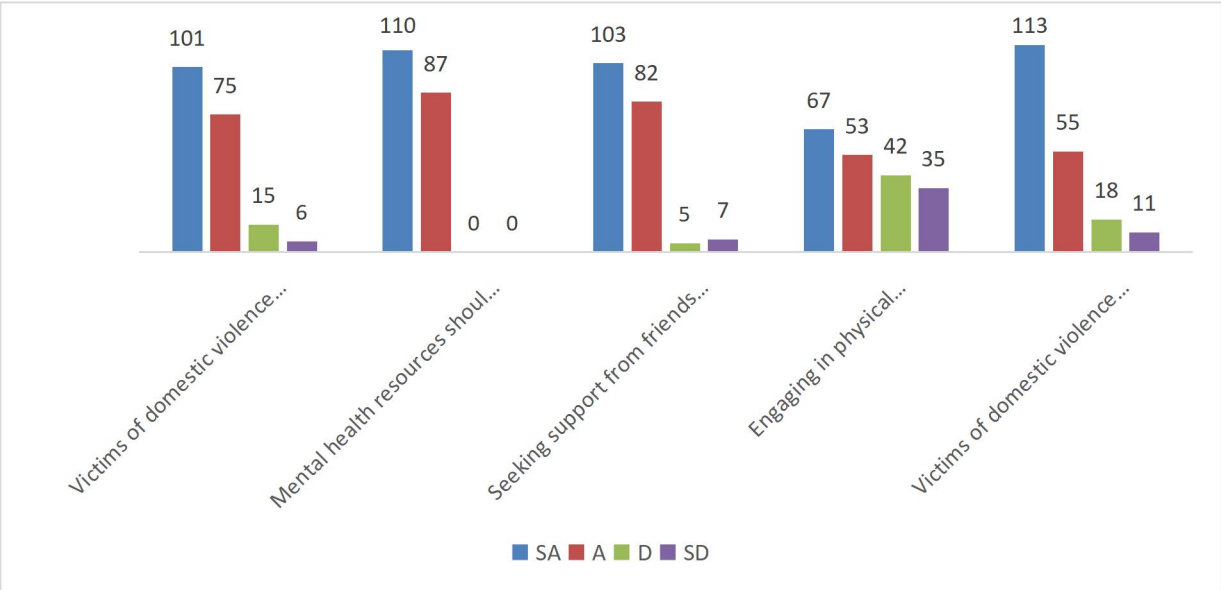
In response to question three, 103 respondents, which accounted for 52.3% and 82 respondents, which accounted for 41.6% were of the view that seeking support from friends and family helps cope with stress and emotional pain from domestic violence. Then, 5 respondents, which accounted for 2.5% and 7 respondents, which accounted for 3.6% disagreed with the issue raised. However, in view of the responses, it can be stated that seeking support from friends and family helps cope with stress and emotional pain from domestic violence.

Responses to question four showed that majority of respondents 67 respondents, which accounted for 34.0% and 53 respondents, which accounted for 26.9% were of the view that engaging in physical activities/exercise helps cope with mental health challenges of domestic violence. Then, 42 respondents, which accounted 21.3% and 35 respondents, which accounted for 17.8% disagreed and stated that engaging in physical activities/exercise does not help cope with mental health challenges of domestic violence. Therefore, in view of the responses above, it can be stated that engaging in physical activities/exercise helps cope with mental health challenges of domestic violence.

In item five from table 4.3 above, it was revealed that majority of the respondents 113, which accounted for 57.4% and 55 respondents, which accounted for 27.9% were of the view that victims of domestic violence experience post-traumatic stress disorder and depression. Then, 18 respondents, which accounted for 9.1% and 11 respondents, which accounted for 5.6% thinks

otherwise. Hence, in view of the responses, it can be stated that victims of domestic violence experience post-traumatic stress disorder and depression.

Figure 4.2: The Mental Health Status Of Women Who Have Experienced Domestic Violence.



RESEARCH QUESTION 3: *What are the relationship between domestic violence and mental health disorders among women?*

To answer the research question 3 above, questions 11 – 15 of the questionnaire was employed as presented in table 4.4 below:

Table 4.4: The Relationship Between Domestic Violence And Mental Health Disorders Among Women.

Variables		**SA**	**A**	**D**	**SD**	**Total**
There is a direct link between domestic violence and mental health disorder among women.	N	115	77	4	1	197
	(%)	(58.4)	(39.1)	(2.0)	(0.5)	(100)
Victims of domestic violence are adequately	N	57	35	42	63	197

supported in addressing mental health issues.	(%)	(28.9)	(17.8)	(21.3)	(31.9)	(100)
There is a stigma associated with seeking help for mental health issues related to domestic violence.	N	89	69	23	16	197
	(%)	(45.2)	(35.0)	(11.7)	(8.1)	(100)
More awareness programs should be implemented to address the mental health needs of victims of domestic violence.	N	104	93	0	0	197
	(%)	(52.8)	(47.2)	(0.0)	(0.0)	(100)
There should be mental health services specifically for women who have experienced domestic violence.	N	119	78	0	0	197
	(%)	(60.4)	(39.6)	(0.0)	(0.0)	(100)

Source: Field Survey, 2025

Table 4.4 showed the relationship between domestic violence and mental health disorder among women. In response to question one, a majority of the respondents 115, which accounted for 58.4% and 77 respondents, which accounted for 39.1% were of the view that there is a direct link between domestic violence and mental health disorder among women. Then, 4 respondents, which accounted for 2.0% and 1 respondent, with 0.5% disagreed with the statement. Hence, in view of the responses, it can be stated that there is a direct link between domestic violence and mental health disorder among women.

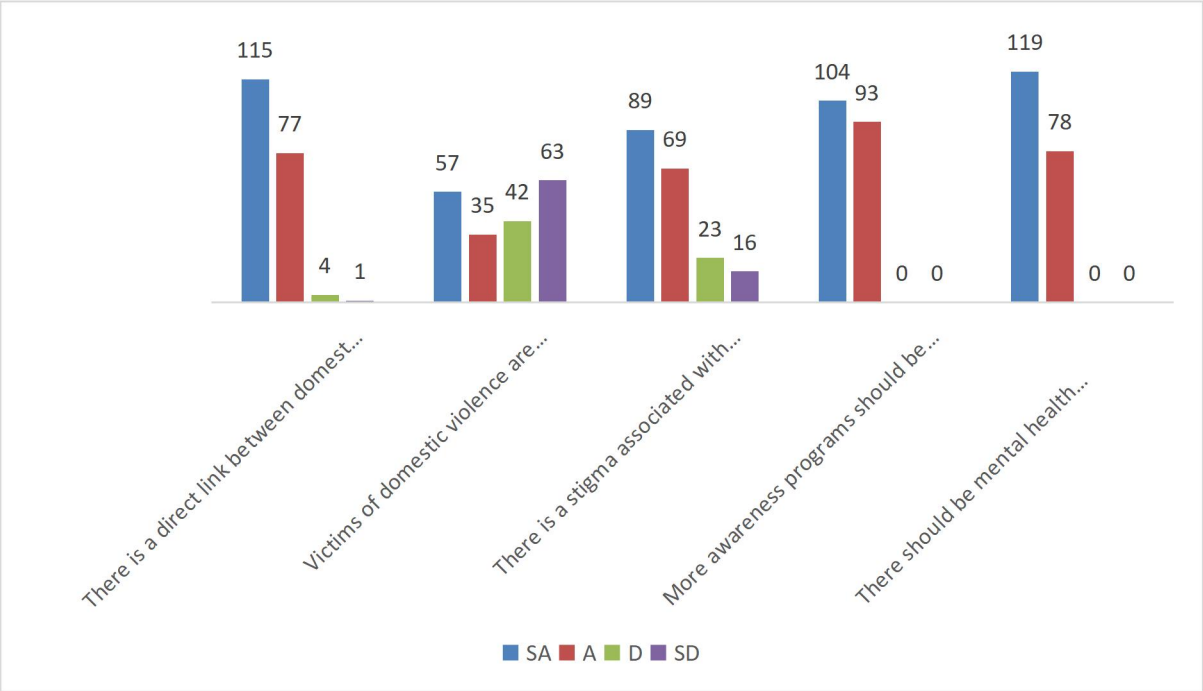
Also, in question two, 57 respondents, which accounted for 28.9% and 35 respondents, which accounted for 17.8% were of the view that victims of domestic violence are adequately supported in addressing mental health issues. Then, majority of the respondents 42, which accounted for 21.3% and 63 respondents, which accounted for 31.9% disagreed with the statement. However, in view of the responses above, it can be stated that victims of domestic violence are not adequately supported in addressing mental health issues.

In response to questions three, majority of the respondents 89, which accounted for 45.2% and 69 respondents, which accounted for 35.0% were of the view that there is a stigma associated with seeking help for mental health issues related to domestic violence. Then, 23 respondents, which accounted for 11.7% and 16 respondents, which accounted for 8.1% disagreed with the statement. However, in view of the responses, it can be stated that there is a stigma associated with seeking help for mental health issues related to domestic violence.

Responses to question four revealed that a higher proportion of the respondents 104, which accounted for 52.8% and 93 respondents, which accounted for 47.2% were of the view that more awareness programs should be implemented to address the mental health needs of victims of domestic violence. Then, none of the respondents disagreed with the statement. However, in view of the responses, it can be stated that more awareness programs should be implemented to address the mental health needs of victims of domestic violence.

Moreso, in questions five, majority of the respondents 119, which accounted for 60.4% and 78 respondents, which accounted for 39.6% were of the view that there should be mental health services specifically for women who have experienced domestic violence. Then none of the respondents disagreed with the statement. However, in view of the responses, it can be stated that there should be mental health services specifically for women who have experienced domestic violence.

Fig. 4.3: The Relationship Between Domestic Violence And Mental Health Disorders Among Women.



RESEARCH QUESTION 4: *What socio-cultural and institutional barriers prevent women from seeking help?*

To answer research question 4 above, questions 16 – 20 of the questionnaire was employed as presented in table 4.5 below:

Table 4.5: Identify The Socio-Cultural And Institutional Barriers Prevent Women From Seeking Help.

Variables		SA	A	D	SD	Total
Cultural norms discourage women (victim of domestic violence) from seeking help.	N	86	77	21	13	197
	(%)	(43.7)	(39.1)	(10.7)	(6.6)	(100)
The fear of social stigma prevent victim of domestic violence from seeking necessary assistance.	N	107	72	7	11	197
	(%)	(54.3)	(36.5)	(3.6)	(5.6)	(100)
Community attitudes towards women influence their decision to seek help after experiencing domestic violence.	N	116	54	12	15	197
	(%)	(58.9)	(27.4)	(6.1)	(7.6)	(100)
More awareness is needed to help women understand their rights and the resources available to them.	N	119	78	0	0	197
	(%)	(60.4)	(39.6)	(0.0)	(0.0)	(100)
Community leaders and social workers have a role to play in encouraging women to seek help.	N	105	92	0	0	197
	(%)	(53.3)	(46.7)	(0.0)	(0.0)	(100)

Source: Field Survey, 2025

Table 4.5 showed identifying the socio-cultural and institutional barriers that prevent women from seeking help. However, in response to question one, majority of the respondents 86, which accounted for 43.7% and 77 respondents, which accounted for 39.1% were of the view that, cultural norms discourage women (victims of domestic violence) from seeking help. Then, 21 respondents, which accounted for 10.7% and 13 respondents, which accounted for 6.6% disagreed with the statement. However, in view of the responses, it can be stated that cultural norms discourage women (victims of domestic violence) from seeking help.

In questions two, 107 respondents, which accounted for 54.3%, and 72 respondents, which accounted for 36.5% were of the view that the fear of social stigma prevent victims of domestic violence from seeking necessary assistance. Then, 7 respondents, which accounted for 3.6% and 11 respondents, which accounted for 5.6% disagreed with the statement. However, in view of the responses, it can be stated that the fear of social stigma prevents victims of domestic violence from seeking necessary assistance.

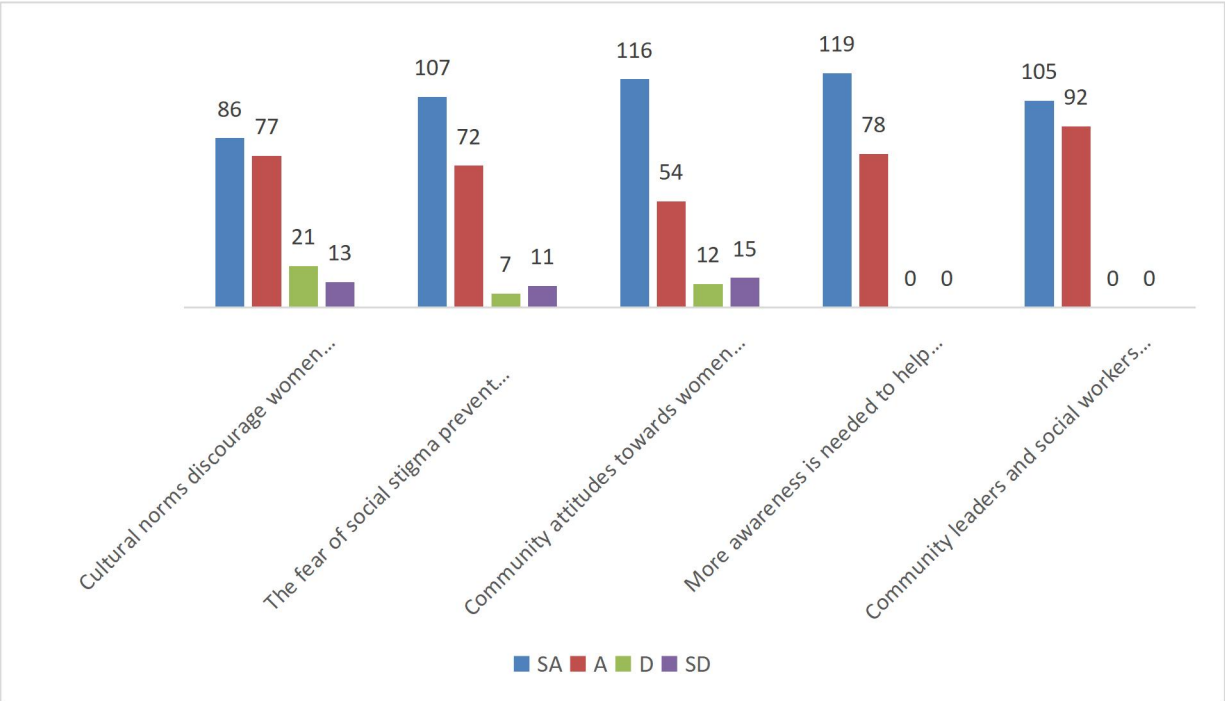
Responses in questions three revealed that 116 respondents, which accounted for 58.9% and 54 respondents, which accounted for 27.4% were of the view that community attitudes towards women, influences their decisions to seek help after experiencing domestic violence. Then, 12 respondents, which accounted for 6.1% and 15 respondents, which accounted for 7.6% disagreed with the statement. Therefore, in view of the responses above, it can be stated that community attitudes towards women, influences their decision to seek help after experiencing domestic violence.

Also, in questions four, 119 respondents, which accounted for 60.4% and 78 respondents, which accounted for 39.6% were of the view that more awareness is needed to help women understand their rights and the resources available to them. Then none of the respondents disagreed with the statement. Therefore, in view of the responses, it can be stated that more awareness is needed to help women understand their rights and the resources available to them.

Finally, responses in item five from table 4.5 revealed that 105 respondents, which accounted for 53.3% and 92 respondents, which accounted for 46.7% were of the view that community leaders

and social workers have a role to play in encouraging women to seek help. Then none of the respondents disagreed with the statement. However, in view of the responses, it can be stated that community leaders and social workers have a role to play in encouraging women to seek help.

Fig. 4.4: Identify The Socio-Cultural And Institutional Barriers Prevent Women From Seeking Help.



4.3 Discussion of Finding

This study investigates the impact of domestic violence on women's mental health in Benin City, Edo State, Nigeria. The study adopted a descriptive cross-sectional design also known as survey design. The data for the study was analysed using descriptive method to describe the

demography of respondents using frequency, percentage and charts, conducted using the Statistical Package for Social Sciences (SPSS 22.0) software. Hence, the findings of this study revealed that most of the respondents are victims of domestic violence, domestic violence is a serious issue in most community in Benin City, societal attitudes towards domestic violence contribute to its prevalence, there are organisations and agencies that support victims of domestic violence in Benin City, there should be more awareness programs conducted to address domestic violence, victims of domestic violence experience increased stress and anxiety related to their mental health, mental health resources should be made available for victims of domestic violence. The study further revealed that seeking support from friends and family helps cope with stress and emotional pain from domestic violence, engaging in physical activities/exercise helps cope with mental health challenges of domestic violence, and that victims of domestic violence experience post-traumatic stress disorder and depression. These findings correlate with the studies of Abubakar, Ogunbameru and Yusuf (2015) who posited that intimate partner violence have significant effects on the mental health of women in Nigerian communities. Ajayi and Somefun (2020) added that intimate partner violence among women is prevalence in urban Nigerian communities and this have detrimental effects on the mental health of victims. Also, Blevins, Weathers, Davis, Witte and Domino (2015) supported by stating that post-traumatic stress disorder is associated with domestic violence among victims.

Furthermore, the study revealed that, There is a direct link between domestic violence and mental health disorder among women, victims of domestic violence are not adequately supported in addressing mental health issues, there is a stigma associated with seeking help for mental

health issues related to domestic violence, more awareness programs should be implemented to address the mental health needs of victims of domestic violence, there should be mental health services specifically for women who have experienced domestic violence, cultural norms discourage women (victims of domestic violence) from seeking help. The study further revealed that the fear of social stigma prevents victims of domestic violence from seeking necessary assistance, community attitudes towards women, influences their decision to seek help after experiencing domestic violence, more awareness is needed to help women understand their rights and the resources available to them, and that community leaders and social workers have a role to play in encouraging women to seek help. These findings correlate with the studies of Dillon, Hussain, Loxton and Rahman (2013) in their systematic review reported intimate partner violence impact women's physical and mental health. Lund et al., (2018) stated that domestic violence is a social determinants of mental disorders among victims. He further added that culturally, the patriarchal values embedded in Nigerian societies play a pivotal role in both perpetuating domestic violence and silencing its victim, and these norms are further amplified by religious teachings in both Christian and Islamic communities, where sermons often emphasise wifely submission without adequately addressing the boundaries of mutual respect or the unacceptability of abuse.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

This chapter is premised on the overview of the study's results, conclusion, and recommendations.

5.1 Summary of Findings

This study investigates the impact of domestic violence on women's mental health in Benin City, Edo State, Nigeria. The study adopted a descriptive cross-sectional design also known as survey design. The study adopted a descriptive cross-sectional design also known as survey design. The data for the study was analysed using descriptive method to describe the demography of respondents using frequency, percentage and charts, conducted using the Statistical Package for Social Sciences (SPSS 22.0) software. Hence, the findings of this study revealed that most of the respondents are victims of domestic violence, domestic violence is a serious issue in most community in Benin City, societal attitudes towards domestic violence contribute to its prevalence, there are organisations and agencies that support victims of domestic violence in Benin City, there should be more awareness programs conducted to address domestic violence, victims of domestic violence experience increased stress and anxiety related to their mental health, mental health resources should be made available for victims of domestic violence. The study further revealed that seeking support from friends and family helps cope with stress and emotional pain from domestic violence, engaging in physical activities/exercise helps cope with mental health challenges of domestic violence, and that victims of domestic violence experience post-traumatic stress disorder and depression.

5.2 Conclusion

The impact of domestic violence on women's mental health presents a significant public health concern that warrants urgent attention. This study highlights the complex nature of domestic violence and its profound psychological consequences, which are worsened by cultural, social, and economic factors prevalent in the region. Most women who experience domestic violence often face numerous mental health disorders, including anxiety, depression, post-traumatic stress disorder (PTSD), and other stress-related conditions. The perpetuation of these mental health challenges not only diminishes the overall quality of life for affected women but also impairs their ability to engage in daily activities, maintain relationships, and fulfill their roles within families and communities. The stigma associated with both domestic violence and mental health further complicates the situation, deterring victims from seeking help and support. Many women are reluctant to disclose their experiences due to fear of judgment, societal backlash, or a lack of understanding about their rights and available resources.

Several socio-cultural norms contribute to the prevalence and trivialization of domestic violence, viewing it as an acceptable aspect of marital life. Consequently, this cultural mindset creates a hostile environment for women, where seeking help is often met with skepticism or outright hostility. The initially supportive mechanisms within the community may transform into barriers when confronted with broader societal attitudes that perpetuate silence around domestic violence. Institutionally, the inadequacy of support systems poses significant barriers to recovery and healing. Access to mental health services remains limited due to insufficient funding, a lack of trained professionals, and the inconsistency of available services. Women who seek help often

encounter unfriendly or untrained staff, reinforcing their distress and reluctance to pursue further assistance. This highlights the urgent need for comprehensive training programs for healthcare providers, law enforcement, and community leaders to improve responses to victims of domestic violence.

However, in Benin City, there is a pressing need for concerted efforts from government agencies, civil society organizations, and community leaders to address the complex relationship of domestic violence and mental health issues. Initiatives should focus on increasing awareness, fostering supportive community networks, and establishing accessible mental health services tailored to the needs of women. Educational campaigns aimed at changing societal attitudes towards domestic violence and mental health are crucial to creating an environment where victims feel empowered to seek help. Finally, addressing the impact of domestic violence on women's mental health requires a universal and collaborative approach. By creating a supportive ecosystem that prioritizes women's rights and mental well-being, significant strides can be taken toward alleviating the consequences of domestic violence that can lead to healthier individuals, families, and communities. The psychological scars left by domestic violence can be profound and long-lasting; thus, effective intervention and support systems are vital in promoting recovery and enhancing the overall mental health landscape for women in the region.

5.3 Recommendations

Based on the above findings and conclusion of this study, the following recommendations were made:

1. There is need to establish and enhance support centers that provide comprehensive services for victims of domestic violence, including counseling, legal aid, and medical assistance, and these centers should be easily accessible and equipped with trained professionals who understand the nuances of domestic violence and mental health.
2. There is need to implement community-based awareness programs to educate the public about the impacts of domestic violence on mental health. Use media, workshops, and community gatherings to disseminate information about available resources and the importance of supportive community networks.
3. It is important to develop and conduct training programs for healthcare professionals on recognizing and responding to domestic violence, which can includes equipping them with skills to provide empathetic care, mental health interventions, and appropriate referrals to specialized services.
4. It is important to advocate for stronger legal protections for women experiencing domestic violence, which includes ensuring the enforcement of existing laws, the creation of more victim-centered policies, and the establishment of streamlined processes for reporting abuse and accessing legal recourse.

5. There is need to encourage collaboration between government agencies, non-governmental organizations (NGOs), and community leaders to create a unified response to domestic violence. These partnerships can enhance resource allocation, share best practices, and create a more robust support system for victims.
6. There is need to incorporate mental health education into school curricula and community programs to reduce stigma and promote understanding. Teaching young people about mental health and healthy relationships can help foster a culture that supports victims and discourages violence.
7. There is need to facilitate the formation of self-help and support groups where survivors can share their experiences and provide mutual support. These groups can serve as vital sources of strength and healing, helping women regain their confidence and mental well-being.

5.4 Suggestions for Further Studies

In future studies, researchers should carry out studies that compare other socio-economic factors that can lead to domestic violence and adversely mental health challenges among victims. They should also try to expand the scope of their study by using different variables that were not considered in the current research. Additionally, it would be beneficial for future studies to look at other parts of Nigeria to see if their findings would align with what was found in this study.

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DEPARTMENT OF SOCIAL WORK

FACULTY OF SOCIAL SCIENCES

UNIVERSITY OF BENIN

BENIN CITY

QUESTIONNAIRE

Dear Respondents,

INFORMED CONSENT

RE: Impact of Domestic Violence on Women's Mental Health in Benin City, Edo State, Nigeria.

I am a student of the above-named department and institution, currently conduction research on "Impact of Domestic Violence on Women's Mental Health in Benin City, Edo State, Nigeria".

As part of the requirement for the award of Bachelor of Science (B.Sc.) Degree in Social Work, this research is purely academic, and your anonymity is guaranteed. I would appreciate it if you could carefully read and answer the questions as honest as possible.

Thank you for your anticipated cooperation.

Precious Edemakhionta

Researcher

INSTRUCTION

Please [ ] or [√] the correct response(s) for the given close-ended items, and where applicable, fill the blank spaces.

SECTION A: DEMOGRAPHIC DATA

1. Age at last birthday (a) 18 - 25 yrs ( ) (b) 26 - 35 yrs ( ) (c) 36 - 45 yrs ( )(d) 46 - 55 yrs ( ) 56 – 60 yrs ( )
2. Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )
3. Religion (a) Islam ( ) (b) Christianity ( ) (c) Traditional ( ) (d) Others (specify)…….…
4. Level of education: (a) No education ( ) (b) Primary ( ) (c) Secondary ( )(d) Tertiary ( ) (e). Vocational
5. Occupation a) Business / petty trading ( ) (b) civil/public servant ( ) (c) Housewife ( ) (d) Student ( ) (e) others (specify) ……

Rating Scale: Strongly Agree (SA); Agree (A); Disagree (D) and Strongly Disagree (SD)

SECTION B:

S/N	Item	SA	A	D	SD
	The Prevalence And Forms Of Domestic Violence Experienced By Women In Benin City.				
1	I have experience domestic violence from my partner before.				
2	Domestic violence is a serious issues in my community.				
3	Societal attitudes towards domestic violence contribute to its prevalence.				
4	There are organisations and agencies that support victims of domestic violence in Benin City.				
5	There should be more awareness programs conducted to address domestic violence.				

SECTION C:

S/N	**The Mental Health Status Of Women Who Have Experienced Domestic Violence.**	SA	A	D	SD
6	Victims of domestic violence experience increased stress and anxiety related to their mental health.				
7	Mental health resources should be made available for victims of domestic violence.				
8	Seeking support from friends and family helps cope with stress and emotional pain from domestic violence.				
9	Engaging in physical activities/exercise helps cope with mental health challenges of domestic violence				
10	Victims of domestic violence experience post-traumatic stress disorder and depression.				

SECTION D:

S/N	**The Relationship Between Domestic Violence And Mental Health Disorders Among Women.**	**SA**	**A**	**D**	**SD**
11	There is a direct link between domestic violence and mental health disorder among women.				
12	Victims of domestic violence are adequately supported in addressing mental health issues.				
13	There is a stigma associated with seeking help for mental health issues related to domestic violence.				
14	More awareness programs should be implemented to address the mental health needs of victims of domestic violence				
15	There should be mental health services specifically for women who have experienced domestic violence.				

SECTION E:

S/N	Identify The Socio-Cultural And Institutional Barriers Prevent Women From Seeking Help	SA	A	D	SD
16	Cultural norms discourage women (victim of domestic violence) from seeking help				
17	The fear of social stigma prevent victim of domestic violence from seeking necessary assistance				
18	Community attitudes towards women influence their decision to seek help after experiencing domestic violence				
19	More awareness is needed to help women understand their rights and the resources available to them.				
20	Community leaders and social workers have a role to play in encouraging women to seek help				