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Research Article

Intimate Partner Violence as Predictor of Mental Well-Being among Married Individuals

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Abstract

Several studies have shown that Intimate Partner Violence (IPV) has a negative influence on the mental well-being of married individuals in the contexts where they were conducted. However, the influence of intimate partner violence (IPV) on the mental well-being of married individuals in many developing countries, especially those in Africa, have been under-reported. The study reported here should thus add much value to the pool of literature aimed at exploring the predictive influence of IPV on mental well-being among married individuals in developing contexts. This cross-sectional survey adopted a purposive sampling technique to select 686 married individuals. The results showed that demographic variables (age, educational level, and marriage duration) and IPV dimensions (humiliation and afraid) jointly and independently predicted mental well-being with a variation of 11%. Regarding the contributions of each variable to mental well-being, age, educational level, marriage duration, humiliation, and afraid predicted mental well-being. Based on these findings it is recommended that more relevant training on attitudinal change programs and mechanisms to prevent and respond to violence among married individuals should be strengthened by relevant stakeholders.

Keywords: Intimate partner violence; married individuals; mental well-being.

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Intimate partner violence (IPV) is a public health crisis with a serious effect on individuals, families, and communities (Potter et al., 2021; van Gelder et al., 2020). It is mostly experienced by women globally and is associated with physical, mental, sexual, and reproductive health problems, and death (Huecker et al., 2022; Morgan & Thompson, 2021; World Health Organisation "WHO" 2017). Intimate partner violence refers to any behaviour perpetrated against a current or previous intimate partner that causes physical, psychological, or sexual harm, including physical violence, emotional abuse, sexual violence, and controlling and coercive behaviours (Ntoimo et al., 2021). To a large extent, IPV is under-reported and under-addressed in both international and national forums (Fredericksen et al., 2022). Determining the actual prevalence rates and their influences on mental well-being varies from one region to another, thus the data reported here should be adding much value in expanding the pool of knowledge in this field.

Globally, the World Health Organisation (WHO) has reported 27% prevalence rate among married women (WHO, 2021). In the United States, a 3.5% IPV prevalence rate was reported between 2016-2019 (Kozhimannil et al., 2023). In a similar study, an estimated 27% of ever-married partners or once cohabitated women aged 15 years or older have experienced one form of IPV in their lifetime (Sardinha et al., 2018). In Egypt, the prevalence rate of IPV among married women is 29.4% (Yaya et al., 2021). In Nigeria, Oluwole et al. (2020) reported a lifetime prevalence rate of 73.3% for adult women in the South-Western region. Ojeahere et al. (2022) have also reported that the prevalence of IPV ranged from 7.2% to 13.5% among households across 31 states in Nigeria during the COVID-19 lockdown.

Overwhelming evidence has shown that the burden of IPV falls on women (Sardinha et al., 2018; Lacey et al., 2021; Morgan & Thompson, 2021; Huecker et al., 2022). Despite the fact

women are always the victims of IPV, they can play the role of perpetrators in some cases (Sardinha et al., 2018). In a study conducted during the COVID-19 pandemic, IPV prevalence rate of 57.7% was reported for women, and 42.5% for men (Oloniniyi et al., 2022).

Mental well-being is described as the experience of good mental states and being liberated from disabling elements such as stress, depression, anxiety, anger, fear, etc., and being able to function optimally daily (WHO, 2001; Seligman & Csikszentmihalyi, 2000). According to WHO (2004), mental well-being is a state in which an individual is able to realize his/her potential, cope with normal stresses of life, work productively and fruitfully and is able to contribute to the society.

Experiences of IPV have negative mental health effects on victims (van Gelder et al., 2020; Krigel & Benjamin, 2021). The study by Bolarinwa et al. (2022) has revealed that women who reside in North-Eastern Nigeria and those who live in communities with medium socioeconomic status were more at risk of IPV. To the best of the researchers' knowledge, studies on IPV are relatively few in North-Eastern region. This region has been affected as a result of the unabated insurgency since 2009, and Maiduguri town and its environment were the most affected. In crisis environments, life becomes more burdensome for everyone, especially married individuals because of several challenges associated with daily needs which have implications on interpersonal relationships.

Evidence from previous research placed emphasis on the negative influence of intimate partner violence on well-being (Klencakova et al., 2023; Palamuleni, 2022; van Gelder et al., 2020; Krigel & Benjamin, 2021). In a systematic review, Klencakova et al. (2023) found that IPV leads to enormous negative outcomes such as mental health decline, economic insecurity and academic underachievement.

Palamuleni (2022) studied the relationship between IPV and antenatal visits among 3,389 currently married women of reproductive age. Data were extracted from the 2015-2016 Malawi Demographic and Health Survey. The study found that sexual, physical and emotional abuse were experienced by 18.2%, 22.9% and 26.7% of the participants respectively. Further analyses revealed a significant influence of sexual and emotional abuse on antenatal visits. The study also revealed that married women who never experienced sexual violence were more regular with their antenatal visits compared to those with a history of sexual violence. Being regular to a greater extent has a relationship with the mental health stability of the women in this study.

Audet et al. (2022) examine the extent to which psychological distress symptoms related to the perpetration of IPV. Data were collected on psychological distress among 335 participants online. The path analysis model revealed a strong association between IPV and mental distress. The dimensions of the distress showed that depressive symptoms were directly and indirectly linked with different dimensions of IPV. While anxiety symptoms directly linked to the dimensions of IPV. In Audet et al. (2022) study's, the dimensions of IPV were considered as physical assault, emotional abuse, and coercive control. Humiliation and afraid might be considered as dimensions of emotional abuse and coercive control. The participants of this study which are only men might have influenced the study findings.

Adebowale and James (2020) examined the magnitude of IPV, and its relationship with psychiatric morbidity and partner alcohol use among 395 women receiving regular ante-natal care at a healthcare center in Nigeria. The study found 24.8% prevalence rate of IPV, and emotional abuse was the commonest type of abuse being perpetrated. Among the participants, 46% were at risk of psychiatric illness.

Ojeahere et al. (2022) examined IPV and its health implications amid COVID-19 lockdown among 474 couples across 31 states in Nigeria. The study found that 22.2% of the participants indicated that they experienced psychological distress as a result of IPV.

Furthermore, Mapayi et al. (2013) researched IPV, anxiety and depression among three hundred and seventy-three women attending antenatal clinics and welfare units at a primary healthcare center in South-Western Nigeria. The study adopted a cross-sectional design, and data were collected using the Composite Abuse Scale, and the Hospital Anxiety and Depression Scale. Among the participants, 36.7% reported IPV within the past year, six percent and sixteen percent reported psychological-related symptoms such as anxiety and depressive symptoms as a result of the IPV experienced. It was further stated that women in toxic relationships are more likely to report being depressed than being anxious.

On the contrary, Gresham et al., (2021) investigated the extent to which IPV victimization is associated with health behaviours among 1,813 participants during COVID-19 pandemic. It was found that COVID-19-related stressors were associated with IPV victimization. However, the study does not find any association between poor physical, mental health and COVID-19 related stressors. This contrary finding could be attributed to the assessment of IPV during the pandemic which comes with its stress already. Similarly, Akhtar and Kroener-Herwig (2019)

study also showed that socio-demographical characteristics of the participants had no predictive influence on well-being.

Several studies have looked at IPV among married women in Nigeria (Adebowale & James, 2020; Mapayi et al., 2013). Nevertheless, only a few studies considered IPV among married individuals, and it was done in the context of the COVID-19 pandemic in southern part of the country (Ojeahere et al., 2022; Oloniniyi et al., 2022), to the best of researcher's knowledge no study has been done on IPV in Maiduguri, North-Eastern Nigeria.

The concept of IPV and its health implications has been widely researched in developed countries (Gresham et al., 2021; Potter et al., 2021). Yet this phenomenon has not been given adequate attention in Nigeria, and the few available studies only looked at the prevalence and risk factors (Mapayi et al., 2013; Ojeahere et al., 2022; Oloniniyi et al., 2022). Hence, the predictive influence of IPV on mental well-being has not been given adequate attention in Maiduguri, North-Eastern Nigeria.

Aims

The aim of the study is to examine IPV as a predictor of mental well-being among married individuals in Maiduguri, North-Eastern Nigeria.

Based on the aim stated above, the specific objectives are:

i) to explore the extent to which age, gender, educational level and marriage duration predict mental well-being.
ii) to examine the level at which age, gender, educational level, marriage duration and humiliation predict mental well-being.
iii) to determine the extent to which age, gender, educational level, marriage duration, humiliation and afraid predict mental well-being.
iv) to examine the extent to which age, gender, educational level, marriage duration, humiliation, afraid and rape predict mental well-being.
v) to explore the extent to which age, gender, educational level, marriage duration, humiliation, afraid, rape and kick predict mental well-being.

Hypotheses

The main hypothesis stated that intimate partner violence (humiliation, afraid, rape and kick), age, gender, educational level, and marriage duration will jointly and independently predict

mental well-being among married individuals. Arising from the main hypothesis are the sub-hypotheses stated as follows:

1. Age, gender, educational level, and marriage duration will jointly and independently predict mental well-being among married individuals
2. Age, gender, educational level, marriage duration and humiliation will jointly and independently predict mental well-being among married individuals
3. Age, gender, educational level, marriage duration, humiliation and afraid will jointly and independently predict mental well-being among married individuals
4. Age, gender, educational level, marriage duration, humiliation, afraid and rape will jointly and independently predict mental well-being among married individuals
5. Age, gender, educational level, marriage duration, humiliation, afraid, rape and kick will jointly and independently predict mental well-being among married individuals

Method

Design and settings

A cross-sectional survey design was adopted in this study. The design is appropriate because the objective of the study is predictive and data was collected at a specific point in time. Of 27 local government areas in Borno State Nigeria, the three selected local government areas were considered safest considering the ongoing insurgency, and they are Maiduguri Metropolitan Council (MMC), Konduga and Jere Local Governments.

Participants

A total number of 686 married individuals residing within Maiduguri Metropolitan Council (MMC), Konduga and Jere Local Governments, Maiduguri, Borno State, Nigeria were recruited to participate in the study. The Mean (x) age of the participants is 37.2, and the Standard Deviation (SD) is 8.5. On gender, the total number of males was 289 (42%), and females was 397 (58%). On marriage duration, participants that are less than one year were 50 (7.3%), 1-3 years were 174 (26%), 4-6 years were 170 (25%), above 6 years were 292 (43%); on educational level, primary school and below 27 (4%), Senior Secondary Certificate Education 105 (15%), Bachelor's Degree 229 (34%), Master Degree 15 (2%), and Doctorate Degree 4 (0.6%).

Sample size and technique

The sample was derived using a Cochran statistical formula ($n = Z^2pq/d^2$) for an unknown population size (Cochran, 1963). Where *n* = the desired sample size; *Z* = the standard normal deviation, set at 1.96, which corresponds to 95% confidence level, *p* = the prevalence of IPV, *q* = 1-*p* (1-p), and *d* = degree of accuracy desired (set at 0.05). A prevalence of 36.7% was set as obtained from a study conducted in Ile-Ife, South-Western Nigeria (Mapayi et al., 2011). A sample size of 354 was arrived at, but this figure was doubled to factor in missing and incomplete questionnaires and for generalisation purposes. Out of the 709 questionnaires that was distributed, a total of 686 questionnaires was retrieved, coded and analysed. Due to the security situation in the state, a purposive sampling technique was employed because the study is meant for married individuals that have stayed together with their partners for at least one year; are above 18 years of age; are psychologically stable; and in case of separation, the duration of separation must be less than a year.

Measures

Data were collected with the use of a designed questionnaire by the researchers to gather information on socio-demographic variables such as age, gender, levels of education, occupational type, and marital status; while General Health Questionnaire (GHQ-28), and Humiliation, Afraid, Rape and Kick scale (HARK-4) were adopted.

Mental well-being

General Health Questionnaire-*28* (Goldberg & Hiller, 1979) is a self-administered instrument designed to measure mental well-being of the participants. It has four subscales: somatic symptoms (subscale A1-A7), anxiety and insomnia (subscale B1-B7), social dysfunction (subscale C1-C7), and severe depression (subscale D1-D7). The scale is scored as follows, “not at all” and “no more than usual” were scored 0, and scores of “rather more than usual” and “much more than usual” were scored 1. Overall scores above 4, and 2 in any of the subscales indicated the presence of distress. The GHQ questionnaire has been used and validated in over 38 countries including Nigeria (Armiya’u, et al., 2013; Obi-Nwusu, & Joe-Akunne, 2013). A test-retest reliability coefficient (r = .68) was established (Obi-Nwusu, & Joe-Akunne, 2013). For this study, the 28 items inputted yielded a Cronbach’s Alpha (.88), and scale mean of (3.8).

Intimate Partner Violence (IPV)

Humiliation, Afraid, Rape and Kick scale (HARK-4) was developed to assess IPV by Sohal et al. (2007). The acronym HARK denotes four short questions which represent different components of IPV, adapted from Abuse Assessment Screening (AAS). One point is awarded to every yes answered, while no point was awarded for every no response; the response of "no" to all of the HARK questions suggests that IPV is probably not present; whereas answering "yes" to three or four HARK questions produce a specificity of 100%, which indicates that IPV is present, while response "yes" to one or two of the HARK questions is less specific. According to the authors, a HARK cut-off score of ≥1 indicates current experiences of IPV, the sensitivity of the optimal HARK cut-off score of ≥1 was 81% (95% C.I. 69% to 90%), specificity 95% (95% C.I. 91% to 98%), and positive predictive value 83% (95% C.I. 70% to 91%); but this index study considered a cut-off score ≥2, which implies a HARK score of 2, 3 or 4), an indication of current IPV in the last one year. HARK was tested against the 30-item Composite Abuse Scale, the concurrent validity was high. For this study, the 4 items inputted yielded a Cronbach's Alpha .65, and a scale mean of .57; on the dimensions of the HARK, humiliation, afraid, rape and kick had means of .22, .18, .08 and .08 respectively. The scale was previously used in Nigeria where a Cronbach's alpha of .73 was established (Oloniniyi et al., 2022).

Ethical Consideration

Ethical clearance was obtained from the institutional review board of the Federal Neuropsychiatric Hospital, Maiduguri (FNPH/042022/REC114). The research procedure and ethics such as informed consent, privacy, confidentiality, respect, safety, and right to withdraw at any stage conformed to the recommendations of the Helsinki Declaration for research on human subjects.

Statistical Analysis

Moderated hierarchical regression analysis was used to test the stated hypothesis. With these statistics, the researchers were able to test how IPV and its dimensions predict mental well-being by controlling for the effect of some socio-demographic variables.

Results

A prevalence rate of 18% was recorded for IPV among married individuals in Maiduguri, North-Eastern Nigeria. In terms of gender; out of 686 participants, 110 experienced IPV in their marriages. More females 79 (13%) experienced IPV than their males 31(5%) counterparts.

Table 1.

Hierarchical regression showing predictions on mental well-being, p < .01, N = 686

Variables	*B*	*T*	*p*	*R*	R^2	ΔR^2	*df*	*F*	ΔF
Step 1				.24	.06	-	4, 681	10.22**	-
Age	-.14	-3.01	< .01						
Gender	.01	.28	> .05						
Educational level	.13	3.28	< .01						
Marriage duration	-.12	-2.56	< .05						
Step 2				.30	.09	.03	5, 680	13.52**	25.28**
Age	-.15	-3.35	< .01						
Gender	.00	.11	> .05						
Educational level	.11	3.00	< .01						
Marriage duration	-.13	-2.81	< .01						
Humiliation	-.19	-5.03	< .01						
Step 3				.33	.11	.02	6, 679	13.42**	11.83**
Age	-.15	-3.23	< .01						
Gender	.02	.39	> .05						
Educational level	.11	2.93	< .01						
Marriage duration	-.13	-2.86	< .01						
Humiliation	-.12	-2.83	< .01						
Afraid	-.14	-3.44	< .01						
Step 4				.33	.11	.00	7, 678	11.66**	1.12
Age	.15	3.29	< .01						
Gender	-.02	-.48	> .05						
Educational level	-.11	-2.81	< .01						
Marriage duration	.13	2.82	< .01						
Humiliation	.11	2.70	< .01						
Afraid	.13	3.17	< .01						
Rape	.04	1.06	> .05						
Step 5				.33	.11	.00	8, 677	10.36**	1.21
Age	.15	3.29	< .01						
Gender	-.02	-.51	> .05						
Educational level	-.10	-2.77	< .01						
Marriage duration	.13	2.83	< .01						
Humiliation	.10	2.34	< .05						
Afraid	.13	3.02	< .01						
Rape	.04	.91	> .05						
Kick	.04	1.10	> .05						

Hierarchical regression analysis

Table 1 shows a 5-step hierarchical regression analysis. The socio-demographic variables were entered in the first step of the model, while from steps 2 to 5, the components of intimate partner violence were added.

The first step of the regression which stated that age, gender, educational level and marriage duration will jointly and independently predict mental well-being among married individuals was partially supported. Regression analysis showed that mental well-being was predicted by age (β = -.14; t = -3.01; p < .01). This implies that mental well-being decreases as an individual gets older. Gender did not significantly predict mental well-being (β = .01; t = .28; p > .05). It was also noted that mental well-being increases with significant increase in educational level (β= .13; t = 3.28; p < .01). The prediction of mental well-being by marriage duration was such that mental health decreases with significant increase in marriage duration (β = -.12; t = -2.56; p < .01). Jointly, the socio-demographic variables contributed a significant variance of 6% to the variance in mental well-being [R = .24; R^2 = .06; F(4, 681) = 10.22; p < .01].

The second step of the regression which stated that age, gender, educational level, marriage duration and humiliation will jointly and independently predict mental well-being among married individuals was accepted. In step two of the model, humiliation as a dimension of IPV was added and the result revealed that mental well-being increases with a significant decrease in humiliation, while the socio-demographics were kept under control (β = -.19; t = -5.03; p < .01). This was with a significant variance of 3% contributed to the observed changes in mental well-being (ΔR^2 = .03; ΔF = 13.52; p < .01), while all the variables in step 2 led to a significant 9% variance in mental well-being [R = .30; R^2= .09; F(5, 680)= 13.52; p < .01].

The third step of the regression which stated that age, gender, educational level, marriage duration, humiliation and afraid will jointly and independently predict mental well-being among married individuals was accepted. In the third step of the model, afraid as a component of IPV was added and it significantly predicted mental well-being in such a way that mental well-being decreases significantly with an increase in afraid, while the socio-demographics were kept under control (β = -.14; t = -3.44; p < .01). This was with a significant variance of 2% contributed to the observed changes in mental well-being (ΔR^2 = .02; ΔF = 1.83; p < .01), while all the variables in step 3 led to a significant 11% variance in mental well-being [R = .33; R^2 = .11; F(6, 679) = 13.42; p < .01]. This hypothesis was also partially supported.

The fourth step of the regression which stated that age, gender, educational level, marriage duration, humiliation, afraid and rape will jointly and independently predict mental well-being among married individuals was rejected. Adding rape to the model in step 4 indicated no

significant prediction, as the socio-demographics were kept under control (β = .04; t = 1.06; p > .05). All the variables in step 4 led to a significant 11% variance in mental well-being [R = .33; R^2 = .11; F(7, 678)= 11.66; p < .01]. However, rape alone had no contributions to the total variance observed in mental well-being (ΔR^2 = .00; ΔF =1.12; p > .05).

The fifth step of the regression which stated that intimate partner violence (humiliation, afraid, rape and kick), age, gender, education level, and marriage duration will jointly and independently predict mental well-being among married individuals. At this level, kick component of intimate partner violence was added in step 5 and the result show that it did not significantly predict mental well-being (β = .04; t = 1.10; p > .05). All the variables in step 5 still maintain a significant variance of 11% mental well-being [R = .33; R^2= .11; F(8, 677)= 10.36; p < .01]. However, kick alone had no contribution to the total variance observed in mental well-being (ΔR^2 = .00; ΔF =1.21; p > .05). Based on the outcome of the results, the formulated hypothesis was partially supported.

Discussion

A prevalence rate of 18% was recorded for IPV among married individuals in Maiduguri, North-Eastern Nigeria. The study was similar to a study conducted among Nigeria's households across the states in Nigeria during the COVID-19 lockdown, a prevalence rate between 7.2% to 13.5% was reported (Ojeahere et al., 2022). However, the prevalence rate was much lower to the rate recorded among adult women in South-Western Nigeria where 73.3% was recorded (Oluwole et al., 2020). The differences in the prevalence rate may be connected to the study's locations, the previous studies were conducted in South-Westen Nigeria, while the index study was conducted in North-Eastern Nigeria. Additionally, the rate of IPV might be relatively low among the study's population in Maiduguri, North-Eastern Nigeria, this might not be unconnected to the culture of not being open to discussing any infarction or maltreatment in one's marriage because of the societal attitude towards it, especially in this part of the country where women voice is rarely heard.

Intimate Partner Violence in marriages affects both males and females; however, women are the most vulnerable group. Thirteen percent of women were affected compared to five percent of men; this study aligned with previous studies conducted which reported that most victims of IPV were women (Sardinha et al., 2018; Huecker et al., 2022; Morgan & Thompson, 2021). This

study also aligned with a previous study conducted in Nigeria where IPV prevalence rate of 58% was found for women and 43% for men (Oloniniyi et al., 2022). Their vulnerability might be associated with their gender type and perceived culture and religious approval of male dominance with disregard for human rights in our society.

Furthermore, mental well-being had a significant relationship with IPV; as IPV increases, mental well-being decreases. Considering the dimensions of IPV on mental well-being; humiliation, afraid, rape and kicking had a significant negative relationship with mental well-being. This means that mental well-being increases with a decrease in IPV experience in marriage. This finding aligned with van Gelder et al. (2020) study where they concluded that constant exposure to IPV affects mental well-being. On the same note, this study also received support from the findings of Oloniniyi et al. (2022) in which IPV predicted mental well-being. IPV was linked with various psychological problems such as anxiety and depressive symptoms, and women in toxic relationships are more likely to report being depressed than anxious (Mapayi et al., 2013).

Among the social demographical variables, age and marriage duration had a significant negative relationship with mental well-being, this implies that mental well-being decreases with the older an individual becomes. Only educational level had a positive relationship with mental well-being, this implies that the higher the educational attainment of an individual the higher the mental well-being.

The assertion that IPV (Humiliation, afraid, rape and kick), age, gender, levels of education, occupational type, and marital status will jointly and independently predict mental well-being among married individuals was partially supported. Participants' socio-demographic variables such as age, educational level, and marriage duration predicted mental well-being with a variance of six percent changes that were observed in mental well-being. This finding is contrary to Akhtar and Kroener-Herwig's (2019) finding which reported that the socio-demographic characteristics of the participants had no predictive influence on well-being.

Similarly, two of the dimensions of HARK (humiliation and afraid) as a measure of IPV predicted mental well-being, and jointly contributed five percent variance observed in mental well-being. This finding was partially supported by Weaver et al. (2021) who found emotional abuse and sexual coercion as predictors of post-traumatic stress disorders and depressive symptoms among female victims of IPV. All the predictors (age, educational level, marriage duration,

humiliation and afraid) jointly contributed 11% to the variance observed in mental well-being. Furthermore, Audet et al. (2022) found that depressive and anxiety symptoms directly and indirectly linked with different dimensions of IPV such as emotional abuse and coercive control which could be considered a form of humiliation. Audet et al finding laid more credence to our study where the dimensions of IPV such as humiliation and afraid was reported to predict mental well-being among married individuals.

Being male or female does not predict mental well-being, likewise experience of rape and kick in marriage. The experience of rape and physical assault in marriage has become a norm in most marriages in Africa, an attitude that needs to be changed. Most married individuals, especially women might not see rape and minor physical assault in the context of marriage in Africa as a serious problem; hence, it does not predict mental well-being. These are some of the justifications for the variation of results compared to the previous study (Weaver et al., 2021).

Conclusion

In conclusion, an IPV prevalence rate of 18% was established, and more women experienced IPV in Maiduguri, North-Eastern Nigeria. Also, mental well-being and IPV significantly correlated in such a way that as IPV increases, mental well-being decreases. The dimensions of IPV, humiliation and afraid had a negative relationship with mental well-being, and the increase in humiliation and afraid decreases mental well-being.

Participants' age and marriage duration had a significant negative relationship with mental well-being, which implies that mental well-being decreases with the older an individual becomes; while educational level had a positive relationship with mental well-being, which implies that the higher the educational attainment of individuals the higher the mental well-being. Also, the dimensions of IPV (humiliation and afraid), age, and educational level jointly and independently predict mental well-being among married individuals in Maiduguri, North-Eastern Nigeria.

It is therefore recommended, that communication skills among married individuals should be strengthened. Also, programs that focus on prevention and response to gender-based violence and strengthening of human rights should be championed by governmental and non-governmental organisations, as failure to tackle this menace through relevant channels might have negative consequences on the mental well-being of married individuals. Also, future

studies should explore the experiences and coping mechanisms of women in IPV, and the effective strategies to increase mental wellbeing.

Limitations

The current study is not without limitations. The study population was mainly from Maiduguri Metropolitan Council (MMC), Konduga and Jere Local Governments, Maiduguri area of Borno State, Nigeria; hence cannot represent the opinion of all married individuals in North-Eastern Nigeria. Therefore, further study should be conducted in other North-Eastern states for wider representatives of the population.

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Competing Interests

The authors have declared that no competing interests exist.

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