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Intimate Partner Violence: Individual and societal consequences

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ABSTRACT

This policy brief, the second in a three-part series on Intimate Partner Violence (IPV), reviews the individual and societal consequences of IPV and the barriers victims face in exiting abusive relationships. It covers acute and chronic physical health effects, mental health consequences, impacts on employment and earnings, and effects on children exposed to violence, drawing on international evidence and Belgian survey data. The brief shows that IPV substantially raises the risk of injury, chronic disease, depression, and PTSD; reduces victims' labour market participation, earnings, and workplace performance; and produces lasting developmental and behavioural harm in exposed children. It highlights that not all victims of IPV are equally exposed with IPV-related physical and mental health consequences disproportionately severe among socioeconomically disadvantaged groups. It concludes that financial dependence, emotional entrapment, and the presence of children combine to keep victims in abusive relationships, and that sustainable exit typically requires coordinated psychological, social, and material support, underscoring the case for integrated legal aid, health, and social services.

KEY ELEMENTS

- Physical health: IPV victims are four times less likely to report being in good health and more than twice as likely to report pain, sedative use, or prescribed antidepressants than non-victims; international evidence shows that ongoing physical abuse raises annual healthcare costs by up to 42%.
- Mental health: Exposure to IPV is associated with a 63% increased risk of major depressive disorder, and Belgian primary-care data found up to 60% of patients renewing sleep-disorder prescriptions were IPV victims.
- Employment and earnings: In a Belgian workplace survey, 40% of IPV victims reported absenteeism and over 70% said it affected their productivity; international evidence shows that entering an abusive relationship cuts women's employment by 4% and earnings by 6% within the first year.
- Consequences on children: Exposure to IPV multiplies risk of conduct disorder by a factor of 2, with effect of peers in class, and is also associated with more than twofold increase in early pregnancy and mental health deterioration. Effects vary strongly between children with between 30% and 60% of exposed children show no measurable harm.
- Exit paths: In a survey of Belgian workers, 55% of IPV victims had disclosed the violence to someone at work, yet 12.6% faced a negative reaction.

INTRODUCTION

This policy brief is the second in a series of three briefs dedicated to Intimate Partner Violence. The first piece (*here*) focuses on the factors of victimisation and perpetration and on the prevalence rates, with a focus on Belgium. The present piece presents a literature review of individual and societal consequences of IPV as well as the ensuing challenges associated with exiting violent households. The last piece (*here*) focuses on the institutional and societal responses to IPV. This series of policy brief is part of a broader research project covering the costs and benefits of legal aid for IPV victims.

In this Policy brief we present the individual consequences of intimate partner violence for the victims and their societal ripple effects (see Figure 1 below for an overview). We start with physical and mental health issues, aiming at covering both acute and chronic, long-term, consequences. The health status of IPV survivors is a major public health concern, with Intimate Partner Violence accounting for larger loss in disability-adjusted life years in women of reproductive ages than risk factors such as smoking (Spencer et al., 2023).

We then present the other consequences identified in the literature, namely the victim's ability to take part in the labour market and earn income, as well as the consequences endured by the children exposed to violence. The effects on both involvement in the labour market and the development of children are strongly determined by the mental health status of the victim, most often the women/mother.

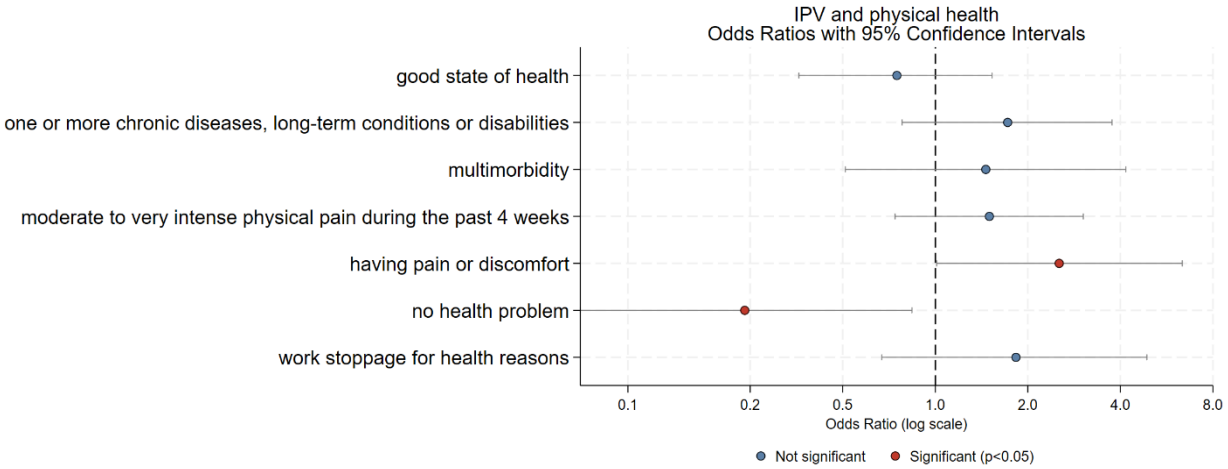
PHYSICAL HEALTH – ACUTE AND CHRONIC CONSEQUENCES

Intimate partner violence (IPV) produces **immediate and severe acute health consequences**, foremost among them physical injuries. These include bruises, fractures, skin lacerations, burns (including fire or acid burns), traumatic brain injuries, gunshot wounds, and, in the most extreme cases, death (based on a review of 52 studies by Stubbs & Szoeke (2022)). In a survey of the Belgian population, it was estimated that 15% of women and 1% of men victims of IPV are physically harmed (Pieters et al., 2010). During pregnancy, IPV is associated with a substantially increased risk of miscarriage (estimated increase of 35%) and abortion (Spencer et al., 2023, based on literature review of 57 studies). In addition, studies reviewed by these authors have pointed out increased maternal hypertension, gestational diabetes, maternal hemorrhage, as well as heightened risks of HIV infection. Acute trauma can lead to adverse birth outcomes such as premature delivery and low birth weight.

Beyond injuries and pregnancy-related complications, IPV, including non-physical violence, translates into **measurable deterioration in overall health status and increased healthcare utilization**. In Spain, a recent survey found that abused women exhibited a two- to threefold higher risk of reporting bad or very bad health and, as a consequence, a 2.7 percentage point higher probability of hospitalization, a 7 percentage point increase in emergency care use, and an 8 percentage point increase in sedative consumption (Alonso-Borrego & Carrasco, 2023). In Belgium, a survey in 2014 (Drieskens & Demarest, 2015) identified that IPV victims were four times less likely to declare being in good health than non IPV victims, were more than two times more likely to declare suffering from pain or discomfort and to have sedatives, sleeping pills or antidepressant prescribed. Likelihood of

psychotropic prescription was more than three times more likely. Key results of this survey are presented in Figure 1 below.

Figure 1. IPV and odds of physical health issues in Belgium. Based on survey data from Drieskens & Demarest (2015).



This health deterioration leads to **substantially higher healthcare consumption** by IPV victims. In a reference study in the field, Bonomi et al. (2009) find that annual healthcare costs are 42% higher for women experiencing ongoing physical abuse, 24% higher for recent abuse, and 19% higher for remote abuse, while even (recent) nonphysical abuse is associated with costs 33% higher than for non-abused women. Notably, these studies do not allow us to conclude on the causal effect of IPV independently from confounding factors such as poverty. Particularly, a study on Finish data (Hisasue et al., 2024) estimates that while the healthcare needs are on average much higher among IPV victims, the difference between victims and non-victims halves when confounding factors (gender, age, education, occupation, and mental-health- and pregnancy-related diagnoses) are accounted for, highlighting once again the socioeconomic gradient in both health and domestic violence victimization.

IPV generates **substantial long-term physical health consequences that persist well after the violence has ceased**. Some chronic conditions stem directly from physical or sexual trauma, including traumatic brain injury, burns, lasting bodily pain from fractures, and gynaecological complications, with certain injuries producing enduring and potentially irreversible impairments (Barboza-Salerno et al., 2025; Kwako et al., 2011).

In addition, **IPV operates as a form of chronic stress**, contributing to endocrine and immune-inflammatory dysregulation (Davis, 2025; Yim & Kofman, 2019), which in turn has lasting health consequences. Evidence from New Zealand (Fanslow et al., 2025), Australia (Loxton et al., 2017) and Canada (Wathen et al., 2025) converge to show worse general health, chronic pain and increased hospitalization among women with history of IPV, consistent with chronic stress pathway and even years after violence ceased. Importantly, even non-physical forms of IPV are associated with sustained health impacts and long-term healthcare costs (Metheny et al., 2024).

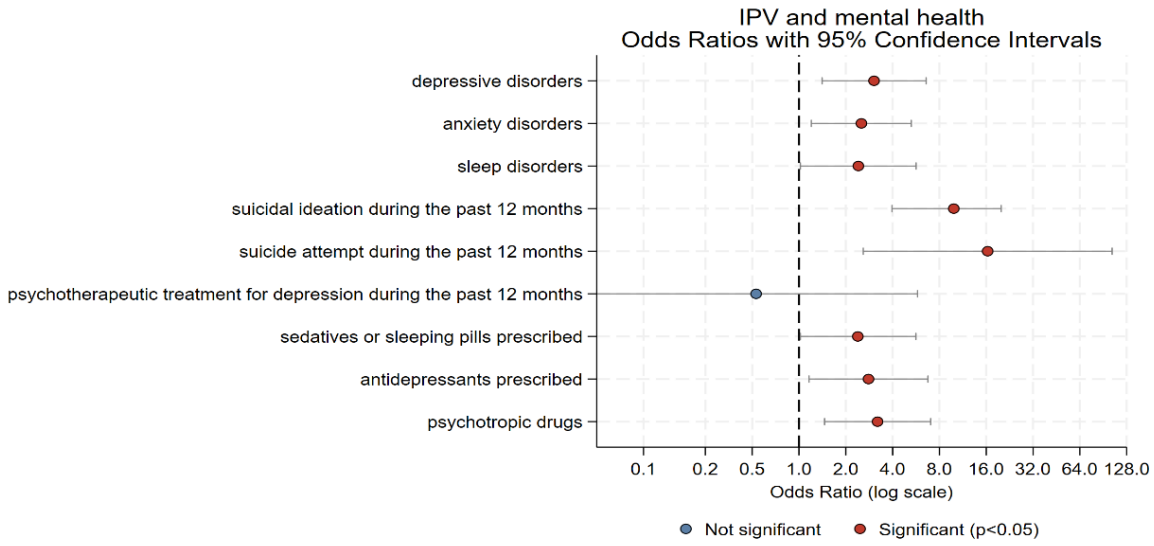
In Belgium, the latest data available on health and IPV is the health survey of 2013 which largely confirmed that IPV victims were less likely to be in good health or to declare having no health problem. They were on the opposite significantly more likely to declare suffering from pain or discomfort. IPV victims are also more likely to suffer from chronic diseases, from multiple diseases, from moderate to

very intense pain in the last four weeks and to be absent from work for health reasons although for these categories the difference in off ratio was not statistically significant at the chosen threshold (see Figure 1 above).

MENTAL HEALTH

IPV is consistently associated with **severe and persistent mental health consequences**. Robust evidence indicates a 63% increased risk of major depressive disorder among exposed women based on 16 observations across 12 studies in nine settings, accounting for effect size and significance across studies (Spencer et al., 2023). IPV is also strongly linked to depression, suicide attempts, post-traumatic stress disorder (PTSD), severe anxiety, insomnia, substance use, and self-harm (Devries et al., 2013; Wathen et al., 2025), as well as postpartum depression (Spencer et al., 2023). In Belgium, a 2013 survey (Drieskens & Demarest, 2015) largely confirmed these findings: IPV victimisation is associated with significantly higher risk of depressive, anxiety and sleep disorders as well as a much higher risk of suicidal thoughts and suicide attempts (see Figure 2 below). In a small-scale study among patients of a primary care centre in Brussels, it was evidenced that up to 60% of patients coming to renew prescription drugs for sleep disturbance were victims of IPV (Madelpuech et al., 2024).

Figure 2. IPV and odds of mental health issues in Belgium. Based on survey data from Drieskens & Demarest (2015).



In addition, the authors show that **mental health service utilisation remains high even years after the violence has ceased**. This long-term trend has been refined by Patton et al. (2022) who showed that depressive and post-traumatic symptoms may decline in the months following abuse ending but tend to plateau after approximately nine months, indicating incomplete recovery. In study on New Zealand data, Mellar et al. (2024) explore how IPV, and in particular the economic aspects of violence, increase the risk of poor mental health through financial insecurity resulting from the violence. Notably, the type of violence (physical or non-physical) does not appear to matter, with all victims suffering from similar increase in their chances of facing mental health issues, as evidenced by Bonomi et al. (2009)

The **effects of IPV on mental health are worsened by the relational nature of IPV**. Violence perpetrated by a trusted partner constitutes a form of betrayal trauma, involving a violation of basic

trust that intensifies psychological harm (Andersson et al., 2020; Barboza-Salerno et al., 2025). **Other compounding factors are socioeconomic disadvantage, migrant status, discrimination, and substance use**, all which exacerbate mental health burdens and reduce help-seeking behaviour (Stockman et al., 2015; Wathen et al., 2025).

Poor mental health constitutes a risk factor to become a victim of IPV (*see dedicated policy brief here*), and hence **reverse causality** must be treated with caution in all epidemiological studies (Devries et al., 2013). Research in psychiatry has evidenced that women exposed to IPV have roughly double the baseline prevalence of mental illness (50% vs. 25%). The same study evidenced as well that exposure to IPV was associated with a threefold increase in severe mental illness among those without prior mental illness (Chandan et al., 2020).

IPV-related mental health issues constitute in itself **a significant loss of quality of life for the victims** (European Institute for Gender Equality, 2021). In addition, IPV-related psychological stress contributes to broader neuroendocrine dysregulation and physical health consequences (Yim & Kofman, 2019). By fuelling negative personal feelings and negative perspectives towards themselves (Bryngeirsdottir & Halldorsdottir, 2022), it contributes to lower employment rate and earning from the labour market (Cordier et al., 2024). Good mental health of the mother has also been identified as a key resilience factors for children exposed to violence between their parents (Bogat et al., 2023; Racicot et al., 2010; Renner et al., 2020). Finally, deteriorating mental health contributes to entrapping victims in abusive relationships, reducing perceived exit options and reinforcing dependency (Dziewa & Glowacz, 2022). At the same time, a smaller body of literature documents that **under some conditions, survivors may experience post-traumatic growth** with mental health improving as a result of overcoming victimisation (Bryngeirsdottir & Halldorsdottir, 2022; Cobb et al., 2006), underscoring heterogeneity in long-term psychological trajectories.

Not all victims of IPV are equally exposed. IPV-related physical and mental health consequences are disproportionately severe among socioeconomically disadvantaged groups, including poverty-stricken households, migrants and other victims marginalized based on ethnicity or class (Rhee & Silver, 2025; Stockman et al., 2015; Wathen et al., 2025). In addition to the financial barrier to healthcare, these groups tend to refrain from seeking help (non-take-up) due to minimization of symptoms and fear of the consequences of disclosure (Costa et al., 2019; Orpinas et al., 2025).

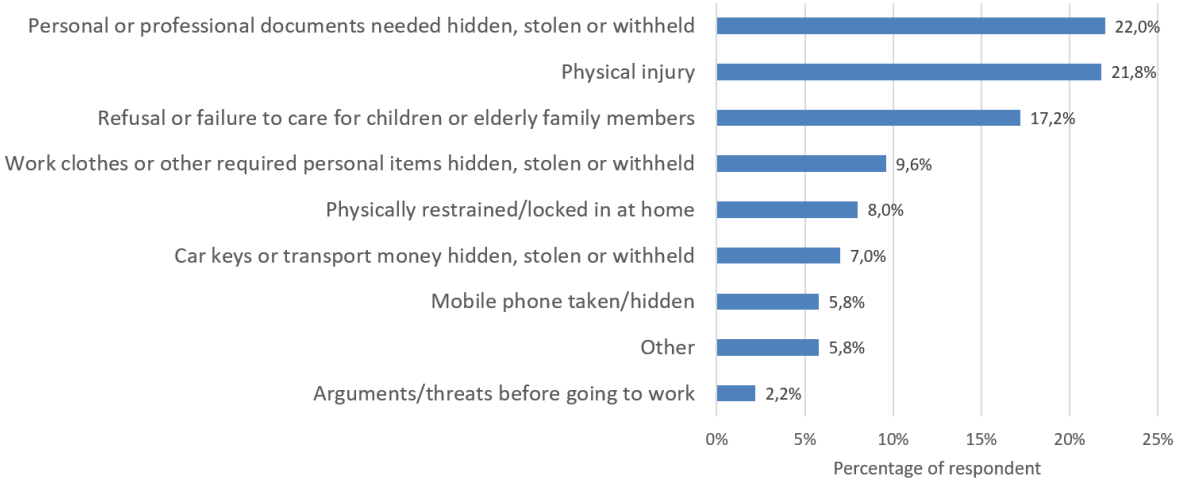
CONSEQUENCES ON EMPLOYMENT AND EARNINGS

IPV affects labour market outcomes through both direct economic control and indirect health-mediated pathways, with persistent consequences for employment stability and earnings.

Direct economic control operates through coercive behaviours that deliberately **undermine women's economic autonomy**. Researchers have evidenced that IPV perpetrators sabotage victims' career with the explicit objective of limiting their ability to exit the relationship (A. Adams et al., 2024). In practice, the control (also referred to as "sabotage" in the literature) can take various forms, examples listed by Anderberg & Rainer (2013) include keeping partners up at night before important interview, destroying homework assignment, turning off alarm clocks, damaging reputation at work, sabotaging child care arrangements, failing to show up for childcare or transportation. In a European level survey among employees led by One In Three (2019), IPV victims (16% of women and 4% of men surveyed) reported receiving abusive phone calls and text messages during work hours (87% of victims); bullying

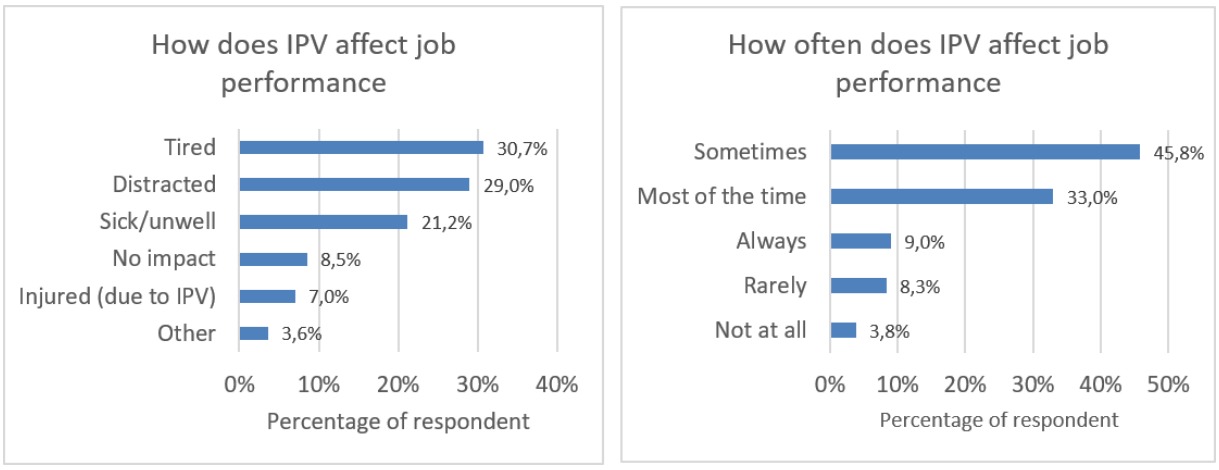
or harassment by the abuser in the workplace or nearby (57% of victims), or even their physical presence in the workplace (44% of victims); and the abuser contacting colleagues (37% of victims) or threatening to contact colleagues (33% of victims). Similar types of coercive control (confiscation of documents or money for transport, forced confinement at home, refusal to provide childcare) have been evidenced in a survey of Belgian workers (IEFH, 2020) as shown in Figure 3 below.

Figure 3. IPV-related causes of absenteeism at work, survey of Belgian workers. Translated from IEFH (2020).



Indirect pathways arise from the deterioration in mental and physical health associated with IPV. In a Belgian population survey (Pieters et al., 2010), 20% of women experiencing very severe violence reported being unable to work as a result of their injuries. In a more recent survey among a sample of Belgian workers, among IPV victims who reported absence to work due to the violence, 40% indicate that is was consecutive of physical or mental health issues, including intense emotional fatigue (IEFH, 2020) and lower perceived self-esteem (ACTIV, 2021). The mediating impact of mental health on employment outcome has been confirmed in two distinct literature reviews (MacGregor et al., 2021; Showalter, 2016), highlighting the effect on employment, tenure and performance at work.

Figure 4. Impact of IPV on performance at work, survey of Belgian workers. Translated from IEFH (2020).



Through both direct control and because of deteriorated health, IPV causes victims to be more often absent (**absenteeism**) and have lower productivity when at work (**presenteeism**). A survey of

employees in mid-size organizations in the US confirmed that lifetime IPV victims miss more hours due to absenteeism, while current victims are more likely to experience presenteeism (Reeves et al., 2025). Belgian survey evidence documents deliberate sabotage affecting attendance and performance, with 40% of IPV victims reporting absenteeism and more than 70% declaring it affected their productivity sometimes or most of the time (see Figure 4 above (IEFH, 2020)). In a survey at the European level, nearly one quarter of victims reported taking time off as a direct consequence of domestic violence (One In Three, 2019).

IPV is associated with **reduced wages** and diminished access to employment-related benefits. Victims report lower salaries on average (Cordier et al., 2024; Reeves et al., 2025), and longitudinal administrative data from Finland show that upon entering an abusive cohabiting relationship, women's employment falls by 4% and earnings by 6% in the first year, interrupting prior growth trajectories (A. Adams et al., 2024). Evidence also surfaced that victims have lower access to job benefits such as paid leave and retirement plans, with effects persisting for at least three years after violence ends (A. E. Adams et al., 2012).

Beyond immediate earnings losses, IPV generates **sustained labour market instability and economic hardship**. Women in abusive relationships exhibit overall greater job instability (A. E. Adams et al., 2012; Showalter, 2016) and lower employment rates (A. Adams et al., 2024). In a survey of Belgian employees, 7.2% of victims reported having lost their job as a direct consequence of IPV (IEFH, 2020). This weakened labour market attachment translates into heightened material hardship, including difficulties affording housing, food, and basic bills (A. E. Adams et al., 2012), as well as debt accumulation (Sanders, 2015). Conversely, stable employment appears to buffer some of the adverse economic effects of IPV, partially mitigating its longer-term financial consequences (A. E. Adams et al., 2012).

At the **macroeconomic level**, these individual disruptions aggregate into substantial losses in economic output (Ciaschini & Chelli, 2021; European Institute for Gender Equality, 2021; Mañas-Alcón et al., 2025; Nectoux et al., 2010; Peterson et al., 2018; Zhang et al., 2009). Moreover, because health follows a strong socioeconomic gradient, IPV-induced income losses further exacerbate adverse health outcomes and consequences on children.

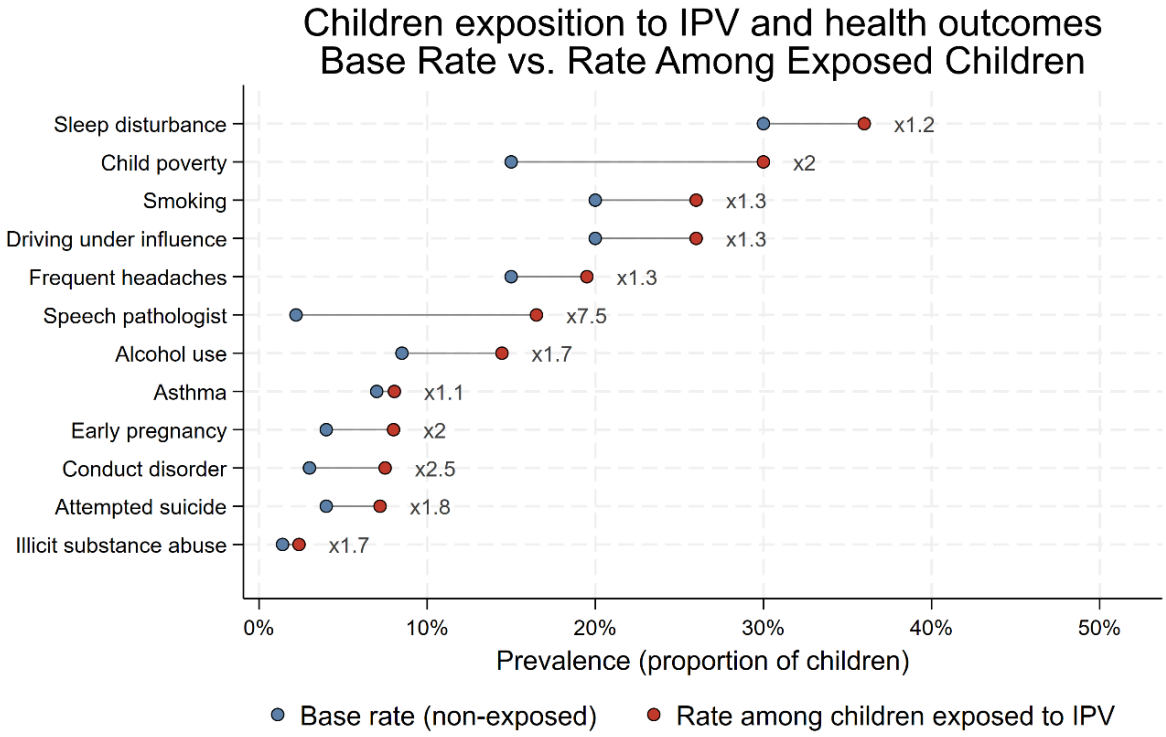
CONSEQUENCES ON CHILDREN

Exposure of children to IPV has **immediate behavioural and emotional consequences that often persist into adulthood.** Children exposed to IPV face elevated risks of neurological disorders, physical health problems, mental health difficulties, substance use, conduct disorders, delinquency, crime, victimization, and poorer academic and employment outcomes, with reinforcing effects across domains (Andresen & Linning, 2014; Artz et al., 2014; Savard & Zaouche-Gaudron, 2011) and including involvement in peer, dating, and partner violence (Oram et al., 2022; Wood & Sommers, 2011). Exposure to IPV is as detrimental to children's development as direct abuse, whether experienced through witnessing violence, its aftermath, or through impaired parenting practices linked to parental stress (Déroff & Potin, 2013; Meijer et al., 2019). Effects begin in utero through maternal stress

dysregulation (Bogat et al., 2023; Bréhat & Thévenot, 2019; Offermans, 2017), and follow a dose–response pattern[1] (Wood & Sommers, 2011).

The harms experienced by exposed children translate into **substantial societal consequences** across health, justice and education systems (Artz et al., 2014; Cavalin et al., 2015), with impact on children ranging from sleep disturbances, asthma, substance abuse, early pregnancy, attempted suicide, conduct disorders, and poverty (see Figure 5 (Andresen & Linning, 2014)). Beyond the consequences for the children directly exposed to IPV, other studies have highlighted how behavioural disruptions in the classroom further extend the social impact to peers. Carrell & Hoekstra (2010) empirically demonstrate that exposed children's misbehaviour in class leads to a significant decrease in the reading and math scores of their peers. They also find that the effect stops when the violence stops, confirming the dose-response hypothesis.

Figure 5. IPV exposition and odds of health issues, based on literature review by Andresen & Lining (2014).



Children's outcomes are shaped by **contextual and relational factors**. Between 30% and 60% of children do not appear to suffer consequences of exposition to IPV (Racicot et al., 2010). Maternal mental health plays a central mediating role, and parenting skills can moderate children's resilience (Bogat et al., 2023; Racicot et al., 2010; Renner et al., 2020). Consequences on children have been shown to vary based on the intensity of violence and decrease when violence stops. However, violence frequently persists after separation, particularly through visitation arrangements with the perpetrator parent, with high-conflict disputes continuing years after divorce and sometimes exposing children to renewed harm and instrumentalization of children as leverage in custody disputes (Durfee, 2021; Flory

[1] In the medical literature, dose-response indicates that the frequency of the violence has an impact on the severity of the consequences.

et al., 2001; Heron et al., 2022; Khaw et al., 2021; Laing, 2017; Racicot et al., 2010). While mental health services have the potential to mitigate harm, they may remain underutilized or, in some cases, experienced as re-traumatizing (Oram et al., 2022). Finally, children exposed to IPV are at higher risk of being the direct victim of abuse by their parents, of being victim of maltreatment in shelter residence (Artz et al., 2014), and of living in poverty, possibly as a result of IPV. In Belgium for instance, 26.8% of children living in single-parent households are at risk of poverty, compared to 9% in two-adult households (Wertz et al., 2025).

EXIT PATHS: WHY DON'T THEY JUST LEAVE?

Despite the severe harm associated with intimate partner violence, victims often remain in abusive relationships for extended periods due to interacting financial, emotional, and social constraints. **Financial dependence** plays a central role: IPV is more prevalent among individuals experiencing economic hardship, and violence itself further undermines victims' financial autonomy and material resources, limiting their ability to exit (A. Adams et al., 2024; A. E. Adams et al., 2012; Barbier et al., 2022; Reichel, 2017; Sanz-Barbero et al., 2018). Policies developed in response include providing material assistance such as shelters or financial aid (Eggers Del Campo & Steinert, 2022; Farmer & Tiefenthaler, 1997; Rosenberg & Grab, 2015).

Emotional dynamics further entraps victims through **cycles** of tension, violence, and reconciliation that sustain hope for change, while abuse often leads to social isolation, learned helplessness, and difficulties recognising or disclosing victimisation (Déroff, 2016; Dziewa & Glowacz, 2022; Fuentes & Bai, 2025; Heron et al., 2022; Rhee & Silver, 2025). **Social support is therefore critical but unevenly available**, as isolation can be a deliberate strategy from the perpetrator and victims frequently encounter blame or stigma when disclosing abuse (Ferrari et al., 2018; IEFH, 2020; Meyer, 2016). For instance, in a survey of Belgian workers, 55% of IPV victims declared having discussed it with someone at work and while 28.5% declared having received an empathic reaction, possibly with relevant information (10%), 12.6% of those who declared being victim of IPV reported negative reaction upon disclosure of the violence to their employer, including discriminations or negative reviews (IEFH, 2020).

The **presence of children** further complicates exit: although concern for their safety may motivate separation, children also increase emotional, legal, and financial barriers to leaving and are associated with higher IPV persistence (Déroff, 2016; Heron et al., 2022; Meyer, 2016; Offermans, 2017). Consequently, sustainable exit generally requires a combination of psychological resilience, social support, and material resources, with institutional interventions becoming essential when private or social resources are lacking (Déroff, 2016).

CONCLUSIONS AND PUBLIC POLICY IMPLICATIONS

The policy brief examines the consequences of intimate partner violence (IPV) in Belgium as part of a research project evaluating the benefits of providing legal aid services integrated with psychological and social support to IPV victims.

The brief highlights the extensive individual and societal consequences of IPV. Victims face acute and chronic, physical and mental, health effects including injuries, severe depression, post-traumatic stress disorder and inflammatory diseases which lead to increased healthcare use and reduced quality of life. IPV also undermines economic stability through lower access to employment, absenteeism, and reduced earnings, while children exposed to violence experience developmental, behavioural, and long-term socioeconomic harms.

Two important blind spots in the literature remain to be explored. First, there is limited evidence on the evolution of health and healthcare use after violence ceases depending on case handling (in terms of legal assistance, psychological support and social work). While the literature based on longitudinal surveys highlights long-term effect of IPV, they do not point to factors of the scale of healthcare use. Second, while the literature points to socioeconomic status as a key compounding factors of the consequences of violence on victims, most quantitative estimates provide average effects across all IPV victims and do not account for heterogeneity. It has indeed been largely demonstrated that health and IPV victimisation both follow a strong socioeconomic gradient.

The public cost of IPV is hence particularly high in terms of healthcare provision, replacement income and lost labour income. Still, quantitative evidence of such public cost is scarce and is limited by the gaps regarding long term effect and heterogeneity among victims.

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