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# Gender-Based and Domestic Violence as a Determinant of Mental Health in Kenya: A Quantitative Integrative Review with Implications for Culturally Responsive Clinical Practice

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***Abstract*: Gender-based violence (GBV) and domestic violence (DV) constitute pervasive public health and human rights concerns in Kenya, with substantial yet often under-recognized implications for mental health. This quantitative integrative review synthesizes empirical evidence examining GBV/DV as determinants of psychological distress and translates these findings into culturally responsive clinical practice recommendations. Guided by ecological, feminist, and trauma-informed frameworks, the review contextualizes mental health outcomes within intersecting relational, community, and structural dynamics. A systematic search of peer-reviewed literature (2010–2025) identified thirteen quantitative studies conducted across diverse Kenyan settings, including urban informal settlements, rural counties, and refugee contexts. Findings indicate consistently high prevalence of violence, with lifetime intimate partner violence affecting approximately 41–52% of women. Strong statistical associations were observed between GBV/DV exposure and adverse mental health outcomes, including elevated odds of PTSD, depression, anxiety, and increased risk of substance use and suicidality. Evidence further highlights systemic under-detection of violence within healthcare settings, contributing to fragmented care and misinterpretation of trauma-related symptoms. Structural factors, including gender inequality, economic dependence, stigma, and limited access to coordinated services, were identified as key determinants shaping both exposure to violence and mental health outcomes. The review underscores the need for integrated, trauma-informed, and culturally responsive clinical approaches in Kenya, with implications outlined across assessment, formulation, intervention, and clinician supervision.**

***Keywords*: Anxiety, clinical psychology, culturally responsive practice, depression, domestic violence, ecological framework, feminist theory, gender-based violence, intimate partner violence, Kenya, mental health, post-traumatic stress disorder, trauma-informed care.**

## 1. Introduction

Gender-based and domestic violence (GBV/DV) remain significant public health and human rights concerns in Kenya, with far-reaching consequences that extend beyond immediate physical harm to include profound psychological distress. National and regional data consistently indicate high prevalence rates of violence, particularly among women and adolescent girls, yet the mental health dimensions of these experiences remain under-recognized within both research and clinical practice [1].

Survivors frequently experience a range of adverse mental health outcomes, including depressive symptoms, anxiety, trauma-related distress, and functional impairment. However, these outcomes are often addressed in isolation from the contexts in which the violence occurs, resulting in fragmented care and missed opportunities for early identification and intervention. This gap reflects a broader disconnect between the recognition of GBV/DV as a societal issue and the integration of its mental health implications into routine clinical and community-based service [2], [3].

In the Kenyan context, the relationship between GBV/DV and mental health is shaped by complex and intersecting structural, cultural, and systemic factors. Gender inequality, economic dependence, stigma surrounding disclosure, and limited access to coordinated support services constrain survivors' ability to seek help and achieve safety, thereby prolonging psychological distress [4]. At the same time, mental health systems often operate with limited resources and may lack standardized approaches for identifying and responding to violence-related trauma. As a result, survivors may present with psychological symptoms that are decontextualized or misinterpreted within clinical settings [5]-[7].

Against this backdrop, there is a critical need to synthesize existing quantitative evidence on the mental health outcomes associated with GBV/DV in Kenya and to translate this evidence into culturally responsive and trauma-informed clinical practice. This paper therefore undertakes a quantitative integrative review to examine patterns of psychological distress among survivors and to propose contextually grounded implications for assessment, formulation, and intervention within Kenyan mental health services. With lifetime IPV prevalence at 41–52% and past-year emotional IPV at 38–40%, these exposures contribute to elevated rates of depression (9–52%), PTSD (12–56%), anxiety (10–18%), substance use, and

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suicidality [8], [9]. Amid structural factors like poverty, patriarchal norms, and weak legal enforcement, mental health repercussions are often under-detected or misattributed to somatic complaints in Kenyan contexts [10], [11].

## 2. Conceptual Framework

Gender-based and domestic violence are not only individual experiences but are deeply embedded within broader social, cultural, and structural systems that shape both exposure to violence and its psychological consequences [12]. Understanding their mental health consequences in the Kenyan context requires a framework that moves beyond individual pathology to consider external influences such as gender relations, power, and systemic inequities. This paper employs an integrative conceptual framework drawing on ecological, feminist, and trauma-informed models to guide the interpretation of quantitative findings.

### *A. Ecological Framework*

At its core, the ecological framework situates a person's experiences within nested layers of influence, including individual, relational, community, and structural domains. At the individual level, exposure to violence is associated with a range of psychological outcomes, including anxiety, depressive symptoms, trauma-related distress, and somatic complaints [4]. However, these outcomes cannot be fully understood without considering relational dynamics, particularly within intimate partnerships and family systems where patterns of control, dependency, and repeated exposure to harm may occur [13], [14].

At the community level, social norms surrounding gender roles, stigma associated with disclosure, and limited access to supportive resources shape both the experience of violence and help-seeking behaviour. At the structural level, broader forces such as gender inequality, economic precarity, and gaps in legal and health systems contribute to both the occurrence and persistence of violence [15], as well as the availability and accessibility of mental health care [16]. The ecological perspective is particularly useful in explaining how risk accumulates across contexts and over time. For instance, individual psychological distress may be worsened by relational instability, which in turn is reinforced by community-level stigma and structural barriers to leaving abusive environments [17]. This cumulative layering of risk helps explain why mental health outcomes among survivors are often chronic rather than episodic, and underscores the importance of integrated, multi-sectoral responses that address both immediate psychological needs and broader determinants of wellbeing [18].

### *B. Feminist and Gender-Power Lens*

Adopting a feminist and gender-power lens is essential in framing GBV/DV, as this form of violence is often an expression of unequal power relations rather than an incident of interpersonal conflict [19]. Feminist perspectives highlight how gendered expectations and power inequalities can shape vulnerability to violence and constrain survivors' options for safety, thereby influencing psychological outcomes [20]. In the Kenyan context, where social and economic structures may reinforce gendered dependency, experiences of violence are often intertwined with barriers to leaving abusive environments, thereby prolonging exposure to stress and compounding mental health difficulties [21].

A feminist lens also draws attention to how social expectations around endurance, family cohesion, and respectability may shape both the experience and reporting of violence. Survivors may internalize responsibility for maintaining relationships in order to avoid familial disruption and social stigma, which can contribute to delayed help-seeking and the normalization of abuse [22]. These dynamics are embedded within broader systems that privilege male authority and constrain women's autonomy in both private and public spheres. As such, psychological distress must be understood not only as a response to discrete events of violence but also as a response to sustained conditions of constrained agency [23].

### *C. Trauma-Informed Perspective*

A trauma-informed perspective deepens this framework by emphasizing both the psychological and physiological impacts of chronic and repeated exposure to violence. Trauma-informed approaches recognize that symptoms such as hypervigilance, emotional dysregulation, withdrawal, and somatic distress may represent adaptive responses to ongoing threat rather than mental health disorders [24]. In contexts where violence is ongoing or unresolved, conventional diagnostic frameworks may inadequately capture the complexity of survivors' experiences, leading to risks of misdiagnosis or fragmented care [25]. This perspective emphasizes the importance of safety, trust, and empowerment in both the interpretation of findings and the design of clinical responses, and shifts the focus from symptom reduction alone to a broader consideration of safety, agency, and context [26], [27].

## 3. Methods

This integrative review quantitatively synthesized evidence on GBV and DV as determinants of mental health outcomes among Kenyan populations, with implications for culturally responsive clinical practice. The review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for scoping and integrative approaches, emphasizing quantitative data extraction from empirical studies [28]. Searches were systematically conducted across PubMed, PMC (PubMed Central), Google Scholar, and Kenyan institutional repositories, using keywords including "gender-based violence Kenya," "domestic violence mental health Kenya," "GBV PTSD depression Kenya," and "intimate partner violence prevalence Kenya" [29], [30].

Studies were included if they were quantitative in design (cross-sectional surveys, cohort studies, or longitudinal assessments), published between 2010 and 2025, and reported prevalence rates of GBV/DV exposure alongside statistical associations with mental health outcomes such as depression, PTSD, anxiety, substance use, or suicidality in Kenyan adult or adolescent samples [10], [31]. Exclusion criteria eliminated qualitative-only studies, non-Kenyan contexts, intervention

trials without baseline quantitative data, and works lacking validated mental health measures (e.g., PHQ-9, GAD-7, PCL-5). Key variables extracted included GBV/DV exposure types (physical, sexual, emotional IPV or non-partner violence) as independent variables and mental health outcomes as dependents, with effect sizes such as odds ratios (ORs), correlations, or regression coefficients where available. Data extraction and quality appraisal used Joanna Briggs Institute (JBI) critical appraisal tools, ensuring methodological rigor [32].

## 4. Results: Quantitative Findings

Thirteen studies met inclusion criteria, encompassing cross-sectional (ι = 9), cohort (ι = 3), and survey-based (ι = 1) designs, primarily from urban slums, refugee camps, and rural counties including Kisumu and Nairobi, with sample sizes ranging from 200 to over 2,000 participants, predominantly female (70–95%) [10], [29], [31]. Prevalence of GBV/DV in Kenyan samples was consistently high: lifetime physical or sexual IPV affected 41–52% of women, past-year emotional IPV reached 38–40% among youth, and refugee settings reported 45–50% past-year IPV/NPV exposure [8], [9]. Mental health outcomes frequently assessed included depression (prevalence 9–52%, measured via PHQ-9 or HSCL-25), PTSD (12–56%, via PCL-5 or HTQ), anxiety (10–18%, via GAD-7), substance use (15–25%), and suicidality (ideation 20–30%) [33], [9].

Statistical associations demonstrated robust links between GBV/DV and adverse mental health. Conflict-related GBV significantly increased PTSD risk (OR = 6.83, 95% CI [4.21, 9.44]), depression (OR = 2.26, 95% CI [0.51, 4.02]), and anxiety (OR = 3.48, 95% CI [1.85, 5.10]) in refugee camps [10]. Emotional IPV more than doubled odds of poor mental health treatment adherence (OR > 2.0) and depression (β = 1.68, 95% CI [0.25, 3.11]) among Nairobi youth, while physical/sexual IPV correlated with substance use (r = .35–.48) and suicidality (OR = 2.5–4.1) [9], [11]. Cohort data from Kisumu pregnant women showed baseline GBV linked to antepartum depression (effect size d = 0.50), attenuated post-psychosocial intervention [29]. The table below summarizes key study findings.

## 5. Interpretation of Quantitative Findings

### *A. Patterns of Mental Health Outcomes*

The reviewed studies consistently indicate elevated levels of depressive symptoms, anxiety, and trauma-related distress among individuals exposed to GBV/DV in Kenya. While these findings align with global literature, their persistence across diverse Kenyan samples underscores the significant psychological burden associated with such violence within this context. Notably, the co-occurrence of multiple forms of distress suggests that survivors rarely present with discrete, isolated conditions; rather, their experiences reflect complex and overlapping symptoms shaped by prolonged exposure to stress and harm [34], [35].

The manifestation of psychological distress often extends beyond conventional diagnostic categories. Several studies highlight the presence of somatic complaints, emotional withdrawal, and functional impairment that may not always be readily recognized as trauma-related within clinical settings [36]. Interpreted through ecological and trauma-informed frameworks, these patterns can be understood as contextually embedded responses to chronic stress, where psychological distress is intertwined with relational instability and ongoing threat [37]. This has implications for clinical assessment, as reliance on narrowly defined diagnostic criteria may result in under-recognition of violence-related mental health needs.

### *B. Under-detection and Fragmented Care*

A key pattern emerging from the literature is the under-detection of GBV/DV within health and mental health services. Survivors frequently present with psychological or physical symptoms without explicit disclosure of violence, yet routine screening for such experiences remains inconsistent across service settings. As a result, care pathways are often fragmented, with mental health concerns treated in isolation from the underlying context of abuse [38].

This fragmentation reflects broader systemic gaps, including limited integration between GBV services, primary healthcare, and mental health systems. From a trauma-informed perspective, such patterns risk perpetuating cycles of care that fail to address safety and context, thereby limiting the effectiveness of interventions [39]. These findings highlight a critical clinical gap: the need for more systematic, context-sensitive approaches to identifying and responding to violence within routine care.

### *C. Structural Drivers of Psychological Distress*

The relationship between GBV/DV and mental health outcomes cannot be understood independently of the structural conditions that shape survivors' experiences. Across studies, factors such as economic dependence, limited access to legal protection, and fear of social stigma emerge as significant barriers to seeking help or exiting abusive environments [40], [39]. These constraints contribute not only to continued exposure to violence but also to the intensification and prolongation of psychological distress. The ecological and feminist lenses underscore how structural inequalities,

Table 1
Summary of key quantitative findings on GBV/DV and mental health in Kenya

| Study Context | GBV/DV Prevalence | Mental Health Outcomes | Key Associations |
|---|---|---|---|
| Refugee camps (Dadaab) [10] | Past-year IPV/NPV ~50% | PTSD >50%, depression/anxiety >50% | Conflict GBV: PTSD OR 6.83 (4.21–9.44) |
| Nairobi youth [11] | Emotional IPV 40%, physical 25% | Depression 50%+ | Emotional IPV: poor MH adherence OR >2.0 |
| Informal settlements [31] | GBV-linked presentations | PTSD 12%, depression 9%, anxiety 18% | Poverty-GBV interaction exacerbates outcomes |
| Kisumu pregnant women [29] | High baseline GBV | Antepartum depression (d = 0.50) | Psychosocial intervention lowers depression scores |

particularly those related to gender and economic power, shape both exposure to harm and the capacity to respond to it.

### *D. Clinical Blind Spots and Risks of Misinterpretation*

The findings point to several clinical blind spots that may limit effective care for survivors. One key concern is the potential for misdiagnosis or incomplete formulation when psychological symptoms are assessed without adequate exploration of underlying violence. For example, presentations of depression or anxiety may be treated symptomatically without recognition of ongoing abuse, leading to interventions that do not address the root cause of distress [41]. Additionally, there is a risk of over-medicalizing responses that are, in many cases, adaptive reactions to unsafe environments. Addressing these gaps requires a shift toward more integrated and context-sensitive clinical practices that incorporate broader psychosocial and structural considerations into case formulation [42].

## 6. Clinical Implications

GBV and DV, as defined by WHO (2021) and operationalized in Kenya's Sexual Offences Act (2006) and Protection Against Domestic Violence Act (2015), encompass physical, sexual, psychological, and economic violence perpetrated on the basis of gender or within intimate and familial relationships. Epidemiological data from the KDHS (2022) indicate that 34% of ever-married Kenyan women aged 15–49 have experienced physical partner violence, with 14% reporting sexual partner violence. Clinical implications are presented across four domains: assessment, formulation, intervention, and supervision.

### *A. Assessment*

Universal routine screening offered to all clients regardless of presenting complaint is recommended by WHO (2013) and the Kenya Ministry of Health GBV Clinical Care Guidelines (2014) [43]. Routine screening normalizes disclosure, reduces stigmatizing implications, and ensures equitable access to support. Barriers to spontaneous disclosure include fear of stigma, economic dependence on the perpetrator, and mistrust of formal institutions [44], [45].

Tool selection must balance psychometric validity with cultural and linguistic appropriateness. The Woman Abuse Screening Tool (WAST) offers a brief two-item triage suitable for busy primary care settings and should be administered in Kiswahili or the client's preferred language in a private setting. The Composite Abuse Scale (CAS) captures physical, sexual, psychological, and harassment dimensions and has been used in East African research contexts. The Revised Conflict Tactics Scale (CTS-2) has been validated in Kenya [46] and is appropriate in research-informed clinical settings. For mental health outcomes, the PHQ-9 (Kiswahili version, validated in Kenya) and the Harvard Trauma Questionnaire are recommended alongside GBV screening.

Risk assessment should use a validated tool such as the Danger Assessment [47], adapted for low-resource settings, to identify femicide risk indicators including escalation in violence severity, perpetrator threats to kill, presence of weapons, and economic coercion. Safety plans should address multiple contingencies and should always include information about the Kenya GBV Hotline (1195), Gender Violence Recovery Centers (GVRCs), FIDA Kenya, and the Centre for Rights Education and Awareness (CREAW).

### *B. Formulation*

Clinical formulation must contextualize symptoms within the structural determinants of the client's experience. Applying DSM-5 or ICD-11 diagnostic categories without this contextualization risks pathologizing adaptive responses to an abnormal situation [48]. A biopsychosocial-structural formulation framework is recommended, comprising biological factors (physical injury, neurobiological effects of chronic stress), psychological factors (trauma history, internalized shame and self-blame), social factors (support networks, economic resources, housing), structural factors (availability of legal protection, implementation of the Protection Against Domestic Violence Act, 2015), and cultural and meaning-making factors.

Two diagnostic risks warrant attention. First, Borderline Personality Disorder may be incorrectly applied to survivors whose presentations reflect complex responses to chronic relational trauma; ICD-11 Complex PTSD typically provides a more contextually accurate and less stigmatizing formulation. Second, somatization, a well-documented idiom of distress in Kenya, should be understood within its cultural context and not dismissed or over-medicalized.

### *C. Intervention*

Trauma-informed care (TIC) is an organizational and clinical orientation requiring attention to physical safety of clinical spaces, minimization of unnecessary narrative repetition, provision of genuine choice at every stage, and a non-judgmental relational stance. Re-traumatization through poor clinical practice is a documented harm that TIC training is designed to prevent.

Several evidence-based modalities have demonstrated efficacy for GBV-associated mental health difficulties in East African contexts. Cognitive Processing Therapy (CPT) has been validated in the Democratic Republic of Congo and Rwanda [49] and is suitable for delivery by trained lay counsellors under supervision. Narrative Exposure Therapy (NET) has shown efficacy for complex and repeated trauma in Sub-Saharan Africa. WHO's Problem Management Plus (PM+), a five-session transdiagnostic intervention validated in Kenya [50], available in Kiswahili and deliverable by trained non-specialists, is particularly appropriate for primary care and community settings. Peer support groups facilitated by trained community health workers and economic empowerment interventions combined with psychosocial support have also demonstrated reductions in DV and improvements in mental health outcomes.

### *D. Supervision and Clinician Wellbeing*

Clinicians working with GBV and DV survivors face documented risks of vicarious traumatization and secondary

traumatic stress (STS), particularly acute in Kenya's under-resourced mental health system (estimated at 1.6 psychiatrists per 100,000 population) [51]. Regular structured supervision is both a clinical standard and an ethical obligation: it supports decision-making in complex cases, provides reflective space for processing trauma content, and identifies emerging burnout or STS. Where specialist supervisors are unavailable, peer supervision with structured protocols and remote supervision via secure telehealth represent evidence-informed alternatives.

## 7. Equity Impact and Ethical Considerations

### *A. Beneficiaries*

The primary intended beneficiaries of this review are Kenyan women and girls exposed to or at risk of GBV/DV who may access better-informed mental health services; practitioners in primary care and community settings with limited specialist GBV training; policy actors designing GBV response systems at national and county levels; and training institutions developing a culturally competent mental health workforce. The paper also contributes to epistemic equity in African mental health literature by centering Kenya-specific data and experience.

### *B. Potential Dangers*

Three categories of potential harm require acknowledgment. First, primary studies informing this review were conducted with human participants; studies that failed to implement adequate safety protocols may themselves have caused harm. This review underscores the importance of evaluating the ethical quality of included primary studies as part of integrative review methodology.

Second, there is a significant risk in African GBV literature of cultural stigmatization, positioning particular communities or countries as inherently patriarchal or violent, reinforcing colonial discourses. This paper explicitly refuses that framing: documented patterns of GBV are understood as consequences of structural inequalities, not as cultural inevitabilities. Third, clinical recommendations may be implemented by practitioners who lack adequate training or supervision; poorly executed trauma-focused interventions can cause clinical deterioration, making all recommendations contingent on appropriate training and supervision infrastructure.

### *C. Disclosure Risks and Mitigation*

Disclosure of GBV is a double-edged process: it can activate support and protection but may also precipitate retaliation, social stigma, family breakdown, economic destitution, or femicide. In Kenya, formal legal protections are inconsistently enforced; research documents that survivors reporting to police frequently encounter disbelief [52]. At the clinical level, mitigation requires full informed consent about confidentiality limits before any disclosure; safety assessment before any referral to law enforcement; client-directed choice at all stages; minimal, safely stored clinical documentation; and ensuring survivors leave each encounter with at least one referral option regardless of their decision to use it.

## 8. Conclusion

This quantitative integrative review synthesized evidence on GBV/DV as determinants of mental health outcomes in Kenya, demonstrating consistently high prevalence of violence and robust associations with depression, PTSD, anxiety, substance use, and suicidality. The reviewed evidence highlights the complex and contextually embedded nature of these mental health outcomes. The persistence of psychological distress, coupled with patterns of under-detection and fragmented care, underscores the limitations of approaches that isolate mental health from its social and structural context.

Interpreted through an integrative ecological, feminist, and trauma-informed framework, these findings point to the need for mental health practices that are not only evidence-based but also culturally responsive, trauma-informed, and attuned to issues of power and inequality. By bridging quantitative evidence with clinical application, this paper contributes to the advancement of contextually grounded, equitable mental health care for survivors of GBV/DV in Kenya, and advocates for integrated, multi-sectoral responses that address both immediate psychological needs and the broader structural determinants of wellbeing.

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