

# The Psychological Trifecta of Intimate Partner Violence (IPV): Women's First Account Experiences in Arkansas

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## Abstract

Arkansas faces a significant challenge with domestic violence and intimate partner violence (IPV), consistently ranking among the top states for domestic violence homicides. In 2022 alone, 23 women, 15 men, and 7 children have lost their lives due to domestic violence incidents. This qualitative study examined the lived experiences of intimate partner violence (IPV) survivors in Arkansas, with a focus on the intersection of IPV, mental health, and substance use. Using a phenomenological design, researchers conducted in-depth, semi-structured interviews with 20 participants to explore how survivors provided their experiences as they navigate the effects of IPV. The findings indicate that IPV had significant psychological consequences, with many participants describing symptoms consistent with anxiety, depression, and post-traumatic stress disorder (PTSD) trends supported by existing research. In addition, several participants reported using alcohol or drugs as a coping strategy to manage emotional pain, reinforcing previous findings on the cyclical relationship between IPV and substance use. These results highlight the pressing need for integrated, trauma-informed services that address the dual burden of mental health and substance use among IPV survivors, particularly in rural and underserved communities. There is a dire need for coordinated, evidence-based programming that supports survivors by fostering emotional resilience, improving coping strategies, and nurturing an environment of healing and empowerment.

**Keywords:** Domestic Violence, Intimate Partner Violence (IPV), Mental Health, Substance Abuse.

## Introduction

Intimate Partner Violence (IPV) is a pervasive public health issue affecting millions of women worldwide. The Centers for Disease Control and Prevention (2024) defines IPV as any physical or sexual violence, stalking, and/or psychological aggression by a current or former dating partner or spouse. A staggering, fifty-nine million women in the United States have reported some form of IPV in their lifetime. The prevalence of IPV in Arkansas is alarmingly high. Approximately 40.8% of women and 34.8% of men in the state have experienced physical or sexual violence or stalking by an intimate partner in their lifetime.

Additionally, 18.6% of Arkansas women have reported being victims of stalking. The impact of domestic violence extends beyond immediate physical harm. In 2022, there were 5,606 hospitalizations of women in Arkansas due to domestic violence [1].

Despite these alarming numbers, support infrastructure remains insufficient and fewer than half of Arkansas's counties have domestic violence shelters, which leads to a scarcity of available beds and critical resources for victims. These statistics underscore the urgent need for comprehensive, trauma-informed programs that support both survivors and the professionals who assist them. Women who experience IPV are at heightened risk for a range of challenges including homelessness, mental health issues, including depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders. Understanding the mental health consequences of IPV is critical for developing effective interventions and support mechanisms [2].

## Literature Review

**Prevalence of Mental Health Issues Among IPV survivor's**  
Women who experience IPV are disproportionately affected

by mental health challenges. Studies indicate that up to 60% of women survivor's report symptoms of depression, and as many as 80% report significant anxiety. PTSD is particularly common, with prevalence rates ranging from 30% to 60% in various studies. These mental health outcomes are often compounded by factors such as social isolation, economic dependency, and ongoing exposure to violence [3].

### **Depression and Anxiety**

Depression and anxiety are the most frequently reported mental health outcomes among IPV survivors. The chronic stress of living in a violent relationship can lead to feelings of hopelessness, worthlessness, and pervasive fear. According to Cavanaugh et al. (2012), women exposed to IPV are nearly twice as likely to develop major depressive disorder compared to women without such experiences. Depression in IPV survivors is often characterized by low self-esteem, difficulty concentrating, sleep disturbances, and a persistent sense of sadness or emptiness [4].

Anxiety disorders, including generalized anxiety disorder and panic disorder, are also highly prevalent among IPV survivors. Constant exposure to threats of harm and unpredictable abusive behavior creates a heightened state of alertness, which can manifest as excessive worry, irritability, and physical symptoms like increased heart rate and sweating. Research by Campbell (2004) highlights that the pervasive fear and psychological trauma of IPV can leave survivors in a chronic state of hypervigilance, further exacerbating their anxiety. These conditions often coexist, compounding the survivor's challenges in navigating daily life and seeking help [5].

### **Post-Traumatic Stress Disorder (PTSD)**

PTSD is a hallmark consequence of IPV, characterized by intrusive memories, hypervigilance, and emotional numbness. IPV survivors often experience a form of complex PTSD due to prolonged exposure to trauma, which can impair their ability to form trusting relationships and navigate daily life. The severity of PTSD symptoms is often correlated with the frequency and intensity of the violence, as well as the presence of additional stressors, such as custody battles or financial instability [6].

### **Substance Use Disorders**

Substance use disorders frequently co-occur with mental health issues in IPV survivors. Many women turn to alcohol or drugs as a coping mechanism to numb the emotional pain or manage anxiety and fear. However, substance use can exacerbate mental health symptoms and increase vulnerability to further abuse, creating a vicious cycle that is difficult to break [7].

### **Intersectionality and Mental Health**

The mental health impacts of IPV are not experienced uniformly; factors such as race, socioeconomic status, sexual orientation, and immigration status play a significant role in shaping outcomes. For instance, African American women and immigrant women may face additional barriers to accessing mental health care due to systemic racism, language barriers, or cultural stigma around mental health. Intersectional approaches are essential for understanding and addressing the unique experiences of diverse populations [8].

### **Barriers to Mental Health Care**

Despite the high prevalence of mental health issues among IPV survivors, many women face significant barriers to accessing care. These barriers include fear of retaliation from the abuser, lack of financial resources, limited availability of trauma-informed services, and societal stigma around both IPV and mental health. Additionally, cultural norms and beliefs can discourage women from seeking professional help, further isolating them and exacerbating their mental health struggles [9,10].

### **Interventions and Support**

Effective interventions for addressing the mental health needs of IPV survivors include trauma-focused therapies, such as Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR). Group therapy and peer support programs have also proven beneficial by providing survivors with a sense of community and shared understanding. Community-based interventions, particularly those that integrate mental health care with other support services like housing and legal assistance, are particularly effective in addressing the multifaceted needs of IPV survivors [11].

The mental health consequences of IPV are profound and multifaceted, affecting survivors long after the violence ends. Addressing these issues requires a comprehensive, trauma-informed approach that considers the diverse needs and experiences of survivors. Future research should focus on developing and evaluating interventions that not only alleviate mental health symptoms but also empower women to rebuild their lives in the aftermath of IPV [12].

### **Methodology**

#### **Research Design**

This study employed a qualitative research design using in-depth, semi-structured interviews to explore the experiences of domestic violence survivors in Arkansas. The qualitative approach was chosen to provide a rich, nuanced understanding of participants lived experiences, focusing on themes of resilience, survival, support, barriers to accessing services, and the intersection of IPV with mental health concerns and substance use disorders [13].

#### **Participant Recruitment and Sampling**

This study is part of a larger research project examining the experiences of domestic violence survivors in Arkansas. From the broader sample, a subset of 20 participants was identified for this analysis based on self-reported mental health concerns, including depression, anxiety, PTSD, and substance use disorders [14]. Participants were recruited through domestic violence shelters, crisis intervention programs, mental health service providers, and community-based organizations. A purposive sampling strategy ensured diversity in racial and ethnic backgrounds, as well as variation in age. Inclusion criteria required participants to be adults (18 years and older) who self-identified as survivors of domestic violence and had reported at least one mental health concern or substance use disorder. Potential participants were provided with detailed information about the study, including confidentiality measures and voluntary participation [15, 16].

#### **Data Collection**

Data were collected through semi-structured interviews con-

ducted in person and via virtual platforms, depending on participant preference and accessibility. The interview guide included open-ended questions designed to elicit detailed narratives about participants' experiences with IPV, their mental health and substance use challenges, coping strategies, access to support services, and systemic barriers they encountered. Each interview lasted approximately 45 to 90 minutes and was audio-recorded with participants' consent. Verbatim transcriptions were generated using Rev.com and manually reviewed for accuracy [17].

### Data Analysis

Data were analyzed using Interpretative Phenomenological Analysis (IPA) to capture the complexity of survivors' experiences while identifying recurring themes. The analysis process involved multiple stages:

1. reading and re-reading transcripts for familiarization.
2. coding emergent themes.
3. clustering related themes, and
4. developing overarching thematic categories.

NVivo software was used to assist with coding and organization of qualitative data. Special attention was given to identifying themes related to mental health struggles, substance use, and the impact of these factors on survivors' recovery and access to resources [18].

### Ethical Considerations

Ethical approval was obtained from the Institutional Review Board (IRB) at the University of Arkansas at Little Rock prior to data collection. To ensure confidentiality, participants were assigned pseudonyms, and any identifying details were removed from transcripts. Informed consent was obtained from all participants, with clear explanations of the study's purpose, potential risks, and the voluntary nature of participation. Due to the sensitive nature of the study, participants were provided with referrals to local mental health, substance use, and domestic violence support services as needed [19].

### Trustworthiness and Rigor

To enhance the trustworthiness of the study, multiple strategies were employed, including member checking, peer debriefing, and maintaining an audit trail. Member checking involved sharing preliminary findings with select participants to validate interpretations. Peer debriefing was conducted with colleagues experienced in qualitative research, mental health, substance use, and domestic violence studies to ensure credibility. Reflexive journaling was also utilized to acknowledge potential researcher bias and maintain transparency in the analytical process [20].

### Results

The findings from this study reveal the profound impact of intimate partner violence (IPV) on twenty survivors' mental health, with participants reporting significant struggles related to depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders. These mental health concerns emerged as both immediate and long-term consequences of IPV, shaping survivors' daily lives, coping mechanisms, and help-seeking behaviors [21].

Participants described overwhelming emotional distress, persistent fear, and intrusive memories, contributing to chronic anxiety and depressive symptoms. Many also reported experiencing

hypervigilance, flashbacks, and emotional numbness, indicative of PTSD. In addition, several survivors turned to alcohol and drug use as a means of coping, which, for some, evolved into substance dependence over time [22].

The results are organized into three key themes:

1. The emotional response of IPV: Depression and Anxiety.
2. Trauma and PTSD Symptoms.
3. Coping Through Substance Use. Each theme captures the complex and deeply personal experiences of survivors as they navigated the psychological aftermath of abuse.

Several participants described experiencing feelings of depression, often linked to the challenges and emotional distress associated with their experiences of intimate partner violence.

One participant shared "Some days, I can't get out of bed. The weight of everything just sits on me, like I'm drowning in my own mind and I feel stuck and hopeless." Another participant reported "I lost myself in that relationship. When I finally got out, I didn't even know who I was anymore. I didn't have the energy to figure it out and I felt numb."

Several participants discussed the reality of them surviving however, one participant shared "I should be happy that I survived, right? But sometimes, I just feel empty and feel like I'm broken in ways that can't be fixed. Never." Others discussed the emptiness they felt from the isolation and years of abuse. One participant shared "Some days, I feel like I'm just existing. I don't feel happy, I don't feel sad, I just feel... nothing at all." Finally, one participant shared "I can't cry anymore. I used to cry all the time when I was with him, but now, it's like I ran out of tears and I'm numb."

Participants frequently expressed feelings of anxiety, describing persistent worry, fear, and emotional distress stemming from their experiences of intimate partner violence. As one of the participants shared, "I panic when I see someone who looks like him. My heart races, my hands shake, and I can't breathe. I know it's not him, but my body doesn't." Another participant shared

"Even now, when my phone rings, I flinch. I'm afraid it's him, even though I changed my number years ago." She also said "I can't go to certain places anymore. Grocery stores, restaurants or any place we used to go there together, and just stepping inside makes me feel like I can't breathe. I'm scared all over again."

Finally, a participants reported "If someone raises their voice, I shut down. I know they're not him, but my body doesn't know the difference." "I always sit with my back against the wall out of fear. I need to see the exits for protection. I need to know how I can leave if something goes wrong and I'm always on edge."

Many participants described experiencing symptoms of post-traumatic stress disorder (PTSD), including hypervigilance, intrusive thoughts, and emotional distress, as a result of their experiences with intimate partner violence. One participant shared "I still sleep with some type of light on. I don't know why since it's been years since I left, but in the dark, I can still feel him there and that makes me afraid." Another participant shared "I have nightmares almost every night, still. I wake up sweating,

gasping for air. Sometimes, I feel like I'll never be safe again. Oh what a horrible way to live" Also, one participant said, "I hear a door slam, and suddenly, I'm right back in that moment recalling when he came home angry, when I knew I was about to get beat." Finally, one participant shared "I keep replaying it in my head, over and over. What I could have done differently. How I should have seen the signs. It never stops. Never."

Several participants shared their experiences with substance use, including alcohol and marijuana, describing it as a coping mechanism to manage the emotional distress and trauma associated with intimate partner violence. One participant shared "At first, I just needed something to take the edge off, you know. The fear, the constant stress of walking on eggshells. A glass of wine turned into a bottle, and before I knew it, I was drinking just to make it through the day." Another participant had similar reactions and reported "At first, I only drank when he abused me. It helped take away the pain, making things easier to block out. But eventually, I was drinking even when he wasn't around, just to feel numb and make the pain go away. Another participant shared experience related to drugs and shared "He used to bring me drugs, as some type of reward. He wanted me hooked so I wouldn't leave. And for a long time, it worked. I didn't even recognize myself anymore." Another participant said "He controlled everything, even my addiction. He'd give me drugs when I did what he wanted and take them away when I didn't. I wasn't just trapped in the relationship and somehow, I felt trapped in my own body." Finally, one participant shared "I didn't want to use, but after years of being told I was worthless, it felt like the only thing that could quiet my thoughts."

The findings reveal that many participants experienced significant mental health challenges, including anxiety, depression, and PTSD, as a result of intimate partner violence. Additionally, some women turned to substance use, such as alcohol and marijuana, as a coping mechanism to manage their emotional distress [23].

### Limitations

While this study provides valuable insights into the experiences of IPV survivors in Arkansas, certain limitations should be noted. The use of purposive and snowball sampling may limit generalizability, as participants who are connected to support networks may have different experiences from those who remain isolated. Additionally, self-reporting of traumatic experiences, mental health concerns, and substance use histories may be subject to recall bias or underreporting. Despite these limitations, the study offers critical perspectives that contribute to the understanding of IPV experiences across diverse populations, particularly in relation to mental health and substance use challenges.

### Discussion

This study explored the intersection of IPV and mental health and substance abuse. The findings reveal that the impact of trauma from IPV has on survivors, leaving many in a constant state of fear, leading them to utilize substances to cope, in hopes of numbing, so that they can stop negative memories from replaying. These findings align with previous studies that discuss the significant increase in mental health related experiences and substance abuse among those who have experienced IPV. Survivors of IPV often find themselves in a constant state of vul-

nerability when they are left to navigate their own mental health and substance use without proper support. Arkansas domestic violence shelters recently faced severe federal cuts to funding, limiting support of staff and resources. This leaves those who desire to leave their violent relationships in an even more vulnerable position. It is important to find additional funding sources to sustain current programs, and to build in more support services in systems that already exist to provide the appropriate level of care required to assist survivors in obtaining not only physical safety, but emotional and psychological safety as well. This includes access to trauma informed therapist who are willing to look at the whole person and utilize an integrative approach. In order for people to live well and not be in a constant state of survival it is important that additional services and resources are made available to them, especially those living in rural areas where resources are often limited.

### Implications

This study highlights the need for ongoing research to explore the needs of IPV survivors who experience mental health and substance abuse challenges. While the literature is consistent about the intersection of IPV and mental health and substance abuse, there is not sufficient literature about the best practices to address these challenges, especially in rural areas. Additional evaluation of the effectiveness of integrated, trauma-informed, survivor centered programs in rural areas are needed. While the state of Arkansas has systems of support in place, it is important to know how often those resources are accessed and if survivors of IPV are aware that these resources exist, being that many of the resources require you to file a police report to have access. It is important to provide additional avenues of access. In addition to this, IPV shelters should consider the structure of shelters and rules related to substance use and alcohol, considering that survivors' often report hypervigilance, reactivity to noise, and use of substances to cope. In order to implement changes, more policies that direct funding to IPV shelters is needed.

### Conclusion

The statistics on the prevalence of IPV in Arkansas is staggering. However, statistics do not adequately represent the gravity of IPV on people's lives. The courage these participants demonstrated in their openness and willingness to share their experiences is very much appreciated. In their stories the psychological trifecta of experiencing IPV is revealed. It is imperative to digest this information in a manner that emphasizes the effects of IPV and refrain from pathologizing those with lived IPV experiences. The psychological consequences of experiencing IPV disrupt one's sense of identity, as well as how one can function in a community. For advocates, policymakers, clinicians, and any other people who want to be involved in the efforts to eradicate IPV and its life course effects, considerations must extend beyond physical safety, beyond physical housing, and beyond financial support. Policies, services, and funding must include mechanisms for addressing mental health, trauma, and new ways of coping that are not reliant on substances and delivered with compassion, empathy, non-judgmental nurturance, and cultural humility.

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