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Why Place and Space Matter for Intimate Partner Violence Survivors' Mental Wellbeing and Communities in Northeastern Uganda

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Abstract

The context of place matters for mental health. Employing a feminist framework, this study used key informant interviews and focus group discussions in May of 2012 with 77 conflict-affected adults, children, and adolescents in Northeastern Uganda to understand the relation of place and the symbolic space of family to IPV survivors' mental wellbeing to shape intervention possibilities. Using Grounded Theory methods, narratives identified numerous negative mental health experiences, such as having a disturbed mind, associated with inhabiting a violent domestic space. Place-associated qualities interacted with the symbolic space of the family to impede women's ability to enhance the safety of their domestic space, discourage separation, and encourage reunification in the case of separation, all of which related to negative mental health experiences. Interventions should not assume that IPV survivors' exposure to violence has terminated and look beyond mental health as an individual outcome.

Keywords

intimate partner violence; Uganda; armed conflict; mental health; psychosocial intervention

Introduction

Women's risk of intimate partner violence (IPV), i.e., behaviors between partners that cause psychological, physical, or sexual harm (World Health Organization 2016), increases due to contextual factors, such as displacement or ongoing armed conflict, the separation of families, dependence on others for goods and services, and breakdowns in the rule of law and social networks (Kelly et al. 2018). IPV is associated with multiple health consequences, including injury, chronic pain, gastrointestinal, and sexually-transmitted diseases, such as

premature mortality due to HIV, and homicide (Stöckl et al. 2013). Among women in developing countries, IPV is the fifth leading cause of years lived with a disability (Institute for Health Metrics and Evaluation 2018).

A lifetime history of IPV is associated with specific mental ill health consequences. A systematic review indicated that women with depressive disorders, anxiety disorders and post-traumatic stress disorder (PTSD) were more likely to report a history of IPV than those without mental disorders (Trevillion et al. 2012; Devries et al. 2013). The relationship between IPV and mental disorders may be compounded in conflict settings, where rates of depressive and anxiety disorders are elevated and access to care may be limited (World Health Organization 2013).

Literature on IPV and women's mental health from Africa remains sparse, however. Most studies have come from clinical samples and primarily focused on depression. For example, studies on pre- and post-partum populations indicated an association between IPV exposure during pregnancy and depressive symptoms during pregnancy and post-partum (Tsai et al. 2016). With notable exceptions (Hansrod, Spies, and Seedat 2015), very few studies exist on PTSD or other anxiety disorders and IPV among women in Africa or on the relation between different forms of IPV and various mental health problems. In one of the very few studies from Uganda, a study from a conflict-affected region revealed that exposure to war torture was a risk factor for IPV victimization, and IPV victimization was associated with problem alcohol drinking, attempted suicide, and major depressive disorder (Kinyanda et al. 2016). In another study from rural Uganda, IPV co-occurred with depression and alcohol use—the combination of which put women at increased risk of HIV (Kiene et al. 2017).

The present study examined the outcomes of IPV in a rural community that has experienced armed conflict and is located in Northeastern Uganda. Uganda, one of the poorest countries in the world (United Nations Development Programme 2015) is a country in Eastern, sub-Saharan Africa with a population of 33.8 million persons (Central Intelligence Agency 2018). More than 80% of Ugandans live in rural areas (Speizer 2010). For over twenty years, conflict between guerrilla rebels of the Lord's Resistance Army (LRA) and the government of Uganda has plagued the northern part of the country, displacing over two million people, forcing an estimated 85% of internally displaced people to live in government-created camps called protectorate villages, which have been characterized by over-crowding, poverty, health and mental health risks, and IPV (World Health Organization 2005). The community under study has been affected by armed conflict inflicted by the LRA, but also by an ethnic group called the Karamajong through cattle rustling raids (armed raids that loot livestock).

An estimated 68% of ever-married women in Uganda have experienced at least one kind of violence by an intimate partner, ranking the country on the higher end of regional and global prevalence rates (Devries et al. 2013). Using a systematic random sample across four camps in northern Uganda (Stark et al. 2010), researchers found that 51.7% of women reported having experienced physical IPV in the last year. Perpetuating violence against women in Uganda reflects widespread social norms. Studies have found that 73% to 90% of women and 57% to 70% of men in Uganda believe IPV is justified, with one of the most frequent

reasons for physical IPV was a woman neglecting the household chores (Koenig et al. 2003; Speizer 2010).

Given the high prevalence rates in conjunction with the range of accompanying negative mental health experiences of IPV survivors, the development and facilitation of contextually grounded psychosocial interventions for IPV in Uganda are needed and timely. The *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings* (World Health Organization 2010) recommends first addressing psychosocial stressors, including exposure to IPV, and implementing psychosocial interventions for depression prior to prescription of anti-depressant medications. However, a gap remains between practice recommendations and knowledge of the relation of sociocultural factors to women's mental wellbeing and their options for seeking help. Literature on sustainability and implementation of evidence-based interventions has recognized the importance of accounting for socio-political context and fitting the intervention to the population and context (Shelton, Cooper, and Stirman 2018) Yet, outside of research conducted on family- or couple-based interventions, literature on implementation and sustainability has been less explicit in addressing the role of the symbolic space of family (Marsiglia and Booth 2015).

Uganda's status as a low-income country with a mostly rural population, widespread beliefs about the acceptance of battering, and heightened insecurity in rural areas, warrants better understanding of the factors associated with place that are related to IPV survivors' wellbeing, communities, and IPV intervention possibilities. Feminist geographers understand place as fluid and as encompassing both material and sociocultural practices in the community that produce and maintain boundaries through rules that are formulated and governed by inequitable power relations (McDowell 1999; Macintyre, Ellaway, and Cummins 2002). The site of IPV, the family and home, is likewise a geographical construct, a spatial microcosm of the larger social order of place. The family unit as a symbolic spatial practice (Luzia 2013) is dependent on context and the home. As more than a mere physical structure, the family is "...the site of lived relationships, especially those of kinship and sexuality, and is a key link in the relationship between material culture and sociality" (McDowell 1999, 92).

The examination of both place (material and sociocultural practices) and the symbolic space of family allows for a better understanding of how these sociocultural constructs at the family and community levels intersect to relate to women's wellbeing. We used qualitative interviews and focus group discussions with community members in a conflict-affected community in Northeastern Uganda to understand the relation of place and the symbolic space of family with the processes of IPV and the mental health experiences of IPV survivors. The research questions were twofold: 1) What are the perceived psychological outcomes of IPV among community members? And 2) In which ways does place interact with the symbolic space of family to relate to the mental health experiences of IPV survivors, communities, and IPV psychosocial intervention possibilities?

Methods

Approach

The study of IPV outcomes and whether space and place inform psychosocial intervention possibilities for IPV was part of a larger project that examined the intersection of experiencing ongoing conflict and the broader construct of partner or non-partner perpetrated gender-based violence (GBV) using a socioecological framework. (See (Mootz, Stabb, and Mollen 2017b) for a full description of methods.) Our community-partnered approach, the community defined as a collection of several villages that are geographically proximal and that share a school and health centre, was informed by principles of Community Based Participatory Research (Minkler and Wallerstein 2008), which we selected to address power inequities and encourage participation, an approach compatible with transnational feminist methods (Mohanty 1988; Patton 2015). Our feminist community-partnered approach consisted of: forming collaborative partnerships with local organizations; using qualitative methods to give priority to participants' perspectives; observing and coding inequitable power structures reflective of a patriarchal society; and disseminating our findings at the community level (Mootz, Stabb, and Mollen 2017a; Mootz et al. 2019). We recognized that women's experiences vary across and within national contexts and aimed to elucidate local experiences, as is reflected in the focused study of space and place (Mootz, Stabb, and Mollen 2017a). Thus, we collaborated with a community volunteer group and Transcultural Psychosocial Organization Uganda (TPO Uganda), a local NGO. Our local partners had previously worked together on GBV projects. We jointly designed the study and created the interview guides.

Procedures

Focus group discussions (FGDs)—To incorporate a wide variety of perspectives, we included participants across the lifespan (Kieffer et al. 2005). Using snowball and purposive sampling, nonprobability sampling strategies frequently used in qualitative studies (Patton 2015), participants were selected by our local community partners to represent the diversity of the community—from varied neighborhoods and villages. Potential participants were invited to tell friends and neighbors about the study. When possible, we aimed to recruit 8–10 members per FGD. Inclusion criteria were age and gender (i.e., girls and boys ages 9–12 years; adolescent girls and boys ages 13–17 years; adult men and women ages 18–55 years; and elders over age 55 years), profession (described below), and willingness to participate in the focus group. Exclusion criteria included psychotic, developmentally delayed, or inebriated people. Interested participants spoke with the community volunteer group members who recruited until groups were full. All participants who indicated interest were eligible. Given limited guidance in the literature for ideal number of FGDs (Carlsen and Glenton 2011), we collaborated with our local partners to determine the number of FGDs that would constitute representativeness of the community (i.e., one group representing each age and gender category)—a strategy that resulted in data saturation (Corbin and Strauss 2008).

Following recommendations from our local partners who are unaffiliated with a university, ethical approval was sought by an Institutional Review Board (IRB) from an academic

institution in the U.S. After obtaining consent from adults and caretakers and assent from children and adolescents, the first author with assistance of an Ateso/English bilingual translator collected demographic information and conducted nine FGDs that lasted for 30 to 100 minutes each ($Mean = 60.3$ minutes; $SD = 24.7$ minutes) with a gender-combined elder group (over 55 years) and a group for each of the following: adult women (ages 18–55 years), adult men (ages 18–55 years), adolescent girls (ages 13–17 years), adolescent boys (ages 13–17 years), younger girls (ages 9–12 years), younger boys (ages 9–12 years), an Anti-Stock Theft Unit (ASTU; a specialized sector of the police force to protect against livestock looting) group, and a gender-combined group of police (see Table 1). Parents did not participate in children and adolescent groups. All FGDs were audio recorded. Participants were compensated 3,000 UGX (1.50 USD) and were provided referrals to local organizations in the event that they experienced distress.

Individual interviews—Following obtaining written informed consent, the first author conducted audio-taped individual interviews ($n = 6$), lasting 30 to 60 minutes ($Mean = 40.29$ minutes; $SD = 11.43$ minutes), with adult key informants who were identified by our local partners for their work with GBV in fields of law enforcement, health, education, development, and political leadership. Key informants preferred that the interviews were conducted in English and were compensated 3,000 UGX for their participation.

Interview guides—The interview guides were forward- and back-translated and consisted of open-ended questions (Krueger 1998), such as “How does GBV impact persons involved,” and “What challenges does the community face in the prevention of and response to GBV?” Although respondents divulged personal experiences, questions inquired about general observations due to the focus group format. Individual interviews used a similar guide with additional questions asking about each key informant’s role in responding to GBV.

Data analysis—Data analysis commenced during data collection. Following each FGD and individual interview, the first author and translator debriefed by completing a contact summary form, noting newly introduced topics, main themes, and interpersonal processes, among others. The first author used the Grounded Theory method (Corbin and Strauss 2008). She first examined the discussions line by line to determine where an idea began and ended and then assigned a unique code to capture the idea’s meaning (open coding). She then organized these codes according to clusters of related meanings (axial coding). Finally, she organized the axial codes into overall themes (selective coding). This process generated 91 open codes and 16 axial codes, informing the broader analytic themes, for which the translator provided feedback as an additional source of analyst triangulation (Patton 2015). (See (Mootz, Stabb, and Mollen 2017a) for a detailed discussion of data analysis procedures.) To conduct within- and between-group analyses, the first author created tables and conceptual diagrams for each focus group discussion and individual interview. After completing the grounded theory method, the first author assigned conceptual codes to correspond to the four levels of the socioecological framework (individual, relational, community, and societal; authors blinded). For this paper, we examined material and sociocultural *community* and *societal* variables for an understanding of place and *relational*

variables to understand the symbolic space of family and women's mental health (*individual*).

Results

Participants' ($n = 77$) ages ranged from 9 to 80 years of age ($Mean = 30.04$ years), including 34 children (18 girls and 16 boys) and 43 adults (16 women and 27 men). Participants' ethnicities were Iteso (90.9%), Acholi (5.2%), Langi (2.6%), and Bantu (1.3%). Youth's education levels ranged from primary one to primary seven ($Mean = 4.5$ years; $SD = 1.80$ years). Most youth (64.7%) lived with a single or widowed mother. Adult education levels ranged from having no education to specialized training beyond a high school diploma ($Mean = 7.59$ years; $SD = 4.78$ years). The majority of adults (70.7%) were married; most identified as peasant farmers.

Violent family spaces and mental health

Fear and traumatization—With the exception of focus groups with older boys and men who did not mention psychological outcomes, all groups and most key informants described several mental health outcomes among women and children associated with inhabiting a violent family space (Table 2). Fearing the perpetrator was a frequent experience for both women and children. An ASTU official described, *"It can cause what we call phobia. ... And let me say when a man has gone on his way [left the house], on his way back, the woman will be really intimidated. What will the man come back and tell her; and what will happen next?"* A male key informant observed that children might be traumatized if their mother is killed by the father, ascribing the traumatization to not being supported when they are left with the father.

Other psychological experiences—Participants across all focus groups, except men and older boys, furthermore identified *stress*, *psychological torture*, *having a disturbed mind*, and *having lots of thoughts* as negative mental health experiences associated with IPV. One woman expressed, *"If somebody becomes so harsh to you it will now disturb your mind. You will start to think and become angry."* An adolescent girl said simply, *"There'll be a lot of thoughts, over-thinking."* Children often spoke of feeling *bad and experiencing bitterness*, and anger. One young girl explained, *"I feel a lot of bitterness inside when I see those people are fighting and killing themselves."*

Suicide—As opposed to adults who rarely mentioned suicide, children openly discussed suicidal ideation, attempts and completion, as they observed both occurring with mothers and as part of their own mental health experiences. A young boy shared, *"When dad goes to drink, some fathers or some dads allege that, 'When I leave this home, some man come.'"* And you find that that thing will anger the mom, and eventually she goes and commits suicide." One young girl stated, *"It [IPV] makes people kill themselves."*

Place and the fortification of family space boundaries

Despite survivors' negative mental health experiences associated with inhabiting a violent domestic space, most adult participants frequently referenced women remaining in the

family space and enduring (see Figure 1). An ASTU professional explained, “*There are times women end up just enduring such harassment. They [women] say, ‘Ok, if I report this man, he might chase me away [make her leave the home].’ You know, here, divorce- people fear divorce.*” Material and sociocultural factors associated with place strengthened the family space boundary for women and children by limiting their options to separate from the violent space.

Material drivers of place

A central material driver that fortified the family space boundary for women and children was poverty, exacerbated by living in a community that has experienced decades of armed conflict. All of the focus groups and key informants shared narratives that poverty weakened systems and people, especially women and children because of inequitable access to resources. Poverty limited the resources that women and children needed to leave, and second, poverty resulted in failed systems that would help create better outcomes for survivors—such as providing access to treatment or police and legal protection in the absence of bribes. One male key informant shared this:

A husband has beaten a woman and when you come, somebody is carrying her. Her arm is broken. She is bleeding, and you cannot start counseling that person when she’s in pain. So the immediate thing is to provide medical treatment for her. And when you take her back to the health center you’re told that, “We don’t have any drugs. We can’t give her support.” So the only answer is to take her to the clinic, and the clinic definitely needs money. And when you take her there, and if you ask the client, the client says, “I don’t have money,” so it now falls on you to go and talk to the office.

Another example referred to the need for community residents to provide refreshments for a jury to sit for a local court in judgment of an IPV case. A male key informant shared, “*That makes a person again to not bring a case because, ‘If I take a case, I don’t have money to give these people.’ Like especially women, they suffer silently.*” Men, boys, and key informants tended to place greater focus on material drivers than did women and girls.

Sociocultural drivers of place

In addition to poverty, both children and adults reported a challenge regarding reporting and gender inequitable justice practices with political leaders unfairly aligning with male perpetrators. One adolescent boy explained:

The LC 1 [Local Council Person] might be a friend to the dad, and when the mother goes to report [him], the dad will just go to the LC 1 and convince him to drop the case. And when they’ll [LC 1 and dad] meet at the drinking joint, and then they’ll have to drink together, and then they come back still to cause violence in the family.

Transgressing the family space boundary and mental health

Shaping violent family spaces

In spite of the fortified family space barriers, the psychological effects of experiencing or witnessing IPV seemed to motivate participants to shape their family space in various ways. All focus groups discussed some form of shaping family space, whether that was directly intervening with the perpetrator or separating from the space. Children, with the exception of adolescent girls, were more likely than adults to discuss attempting to transform the family space by responding and intervening to alleviate the violence against their mothers. In essence, their strategies took place within the familial space. Adolescent girls, on the other hand, discussed substituting another domestic arrangement through early marriage, in an effort to leave violent family spaces. However, this process often contributed to exposure to violence and negative mental health experiences in the new home. As one woman shared:

Early marriages and forced marriages and even early pregnancies also can cause violence because if like a child marries early, you find that when you reach the other home, you're subjected to a kind of heavy work and now that thing will torture you psychologically.

Transgressing the family space boundary

Key informants, professionals who managed IPV in the community, in particular described the stigmatization associated with separation. These narratives showed that women received strong messages not to separate from a violent domestic space, and if they elected to separate, sociocultural tethers reconnecting them to the violent domestic spaces emerged. A male key informant shared, "*And when the woman goes away, the neighbors will not give respect, 'Now who told her to go away?' They will even chase the children away.*" While not naming social stigmatization directly, narratives regarding the separation of families were unequivocally negative. Even when women IPV survivors required responder intervention, the counseling intervention targeted non-separation, giving advice about model behaviors and reinforcing the importance of remaining a family entity.

Reinforcing the family space boundary

Notwithstanding the reinforcement of the family spatial unit through responders' interventions, most focus group discussions presented observations of women who had separated from their husbands, often to live with members of their family of origin or another man, the latter sometimes referenced as a form of prostitution. Following separation, responder counselling consisted of mediating, usually financially, between two members of a couple where the perpetrator was asked to offer some small financial compensation to the victim for reunification, again propelling women back to the violent family space. As previous narratives allude, it was often economically impossible for a woman to maintain an independent space following IPV, given the social norms surrounding divorce in the country and lack of rights to land for women. Custom requires women's families to repay the bride price in the event of divorce or separation, and many women's families of origin either cannot or are not amenable to repay the bride price. An ASTU professional shared, "*Or her*

parents may end up telling her, ‘You go back, because [what] if the man comes to ask for the dowry.’”

As the primary caretakers of children, many women who separate from violent domestic spaces, but do not have the rights over their children, suffer. The women’s focus group (along with two key informants) framed women’s affective experiences as psychological torture and conceptualized children who were left behind with fathers as orphans. It was these psychological experiences that propelled women back to violence-afflicted domestic spaces, and in some cases, prevented women from leaving in the first place. Men, children, and adolescents did not reference women’s psychological experiences resulting from leaving children.

Dynamic interaction between symbolic space, mental health, and place

Remaining in the violent family space and experiencing IPV and leaving the family space connected with multiple other adverse outcomes, highlighting the cyclical interaction between violent domestic spaces, mental health, and place. Other outcomes included poor family relations, poverty, youth not being supported, mothers leaving children, children dropping out of school, all of the aforementioned psychological experiences, and physical effects, including the spread of HIV. An elder described, “*One is either beaten or because of separation and reunification, HIV is brought in and people die.*”

Most participants mentioned poverty. IPV splintered the cooperative family unit into individuals who functioned separately, evidenced by lack of communication and unshared decision-making. Separation of women from the violent family space also denoted increased poverty. A male key informant offered that “*if you have three cookers, [and] you remove one cooker away, two cannot do anything.*” In this rural region of Uganda, residents arrange three stones together in a triangular shape to provide a foundation on which a saucepan can rest over a fire. With one of the stones removed, the remaining two become ineffective. The woman’s absence meant a decline of the household because her contributions in the forms of cooking, cleaning, caring for the children, and performing agricultural duties no longer subsisted to support the household.

Discussion

To our knowledge, this is the first community-informed assessment that captures a wide range of developmental perspectives of IPV mental health consequences in Northeastern Uganda and how those consequences relate to interactions between space and place. The mental health outcomes of IPV dynamically interconnected with symbolic space and place, demonstrating the complexity of IPV in the community and in the domestic sphere. Noticeable material limitations impeded women’s ability to enhance the safety of and receive support within their family space, discouraged separation through social reinforcement of the domestic boundary, and encouraged reunification in the case of separation. Our findings demonstrated that space and place are interwoven, presenting implications for practice.

Participants in the present study identified women and children as experiencing negative mental health experiences associated with IPV. Although research on mental health outcomes in Uganda is limited, depression is the number one cause of years lived with a disability for women in Uganda, ranking above the impact of HIV and Malaria (Institute for Health Metrics and Evaluation 2018). Thus, in conjunction with structural level interventions, solutions for best practice IPV psychosocial interventions for low-resource settings are needed. Dissemination and implementation models that address infrastructural limitations inherent in low-income settings may provide promising strategies to guide IPV prevention and response efforts: community networks, providing support locally by using a task-shifting framework may assist in overcoming practical barriers (Mendenhall et al. 2014). These networks of community members, trained in delivery of intervention in a culturally relevant manner (e.g., working with couples to reduce violence in family spaces rather than encouraging women to separate) can provide immediate assistance in acute situations as well as an ongoing source for support. Specialized GBV working groups in Rwanda identified that effective community mobilization required an understanding of the symbolic context of IPV, including constructs associated with space and place (Jenevieve Mannell and Dadswell 2017).

Given our findings that elements associated with place limited women's options to leave or alter a violent family space, it appears unrealistic to provide psychosocial interventions designed with assumptions based on different constructions of space and place. Assumptions of many Western interventions, for instance, are that exposure to traumatic interpersonal violence is time-limited, historical, and occurs in a geographically contained place that is somewhere outside of the family space. The current gold standard for trauma-focused treatment is exposure-based treatment, such as prolonged exposure (Foa, Hembree, and Rothbaum 2007) and trauma-focused cognitive behavioural therapy (Ehlers and Clark 2000), both of which assume the trauma has ended and clients are in safe spaces. Clinical trials testing evidence-based treatments often exclude women experiencing IPV because the treatments focus on healing from past traumas (Warshaw, Sullivan, and Rivera 2013). Neither assumption is valid in communities such as that in the present study where women's actions and agency are constrained by their environment (J Mannell, Jackson, and Umutoni 2016). Clinical trials testing treatments adapted for IPV survivors have included only women who have separated from abusive partners (Warshaw, Sullivan, and Rivera 2013).

Adaptation of interventions for trauma generally (Murray et al. 2014) for IPV-affected women specifically in the African context (Swart 2012) exist. However, randomized controlled trials (RCTs) examining the outcomes of such trials have been few, and are mostly available in a Western context (Graham-Bermann and Miller-Graff 2015). While remarkable RCTs in conflict-affected settings in Africa have transpired (Bass et al. 2013), these settings pose complexities for conducting RCTs to prevent IPV and potentially limit generalizability to other contexts. Examinations of the outcomes of such adapted treatments are clearly needed.

Some limitations of the study should be considered. First, having a cultural outsider facilitate the interviews and focus group discussions with the assistance of translator could have affected the processes in ways for which we were unaware. Moreover, the interviewer

was female, and the translator was male. Thus, every interview and FGD consisted of some type of cross-gender interviewing, which could have impeded discussions about IPV. Despite efforts to triangulate analysts, the coding and emergent themes were not reviewed by an independent researcher, potentially introducing observer bias. Second, social acceptability bias could have affected conversation in the FGDs, especially because the content reflects sensitive issues. Finally, this project was community-based and the sample was comprised mostly of people who identified as Iteso due to geographical location. The non-representative sample reduces the transferability to other populations. However, the results may have applicability for other people and ethnic groups in low-income, rural, and conflict-affected settings in Uganda and sub-Saharan who have similar constructions of space and place

Conclusion

Women and children experienced a range of negative mental health experiences associated with IPV. Symbolic space and place shaped IPV survivors' mental health experiences and psychosocial response possibilities by limiting women's ability to alter, leave, or remain separated from a violent domestic space. The contextual elements of space and place can provide insight for adaptation of interventions to make them applicable, useful, and sustainable for the prevention and response of violence in the home.

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Figure 1.
Interaction of Place with Symbolic Space for IPV Survivors in Northeastern Uganda

Table 1

Focus Group Discussion and Individual Interview Sample Description

Sample	<i>n</i>	Age Range	Age <i>M</i> (<i>SD</i>)
Focus Group Discussions	71	9–80	30.04 (20.13)
Elders	9	55–80	70.67 (8.35)
Adult Women	8	30–43	36.75 (5.18)
Adult Men	8	30–48	38.63 (5.71)
Teenaged Girls	10	13–15	14.50 (0.71)
Teenaged Boys	7	13–17	14.86 (1.46)
Younger Girls	8	9–12	10.25 (0.89)
Younger Boys	9	9–12	10.56 (1.01)
Anti-Stock Theft Unit	9	25–48	43.26 (8.90)
Police	3	29–54	39.67 (12.90)
Individual Interviews	6	25–54	44.00 (13.24)

NOTE: This table adapted from (authors blinded) (Date), p. XX.

Table 2

Frequency of Discussion of Intimate Partner Violence Outcomes in Northeastern Uganda

Intimate Partner Violence Outcomes	Focus Groups									Individual Interviews
	Boys 9–12	Girls 9–12	Boys 13–17	Girls 13–17	Women	Men	Elders	Police	ASTU	Key Informants
Physical Effects (injury/disability, illness, witchcraft, sex work, death) 47 *	2	5	2	5	--	6	5	6	5	11
Family Fragmenting (separation from family, mother leaves children, widowed, social stigmatization) 44 *	2	2	--	5	5	3	4	2	1	20
Negative Outcomes for Youth (youth not supported/abandoned, early marriage for girls, drop out of school, children have no future, youth learn violence) 35 *	1	--	6	--	--	3	7	1	4	13
Psychological Effects (fear, stress, psychological torture, having a disturbed mind, having lots of thoughts, feeling bad, experiencing bitterness, anger, children traumatized, suicide) 34 *	7	7	--	3	4	--	1	2	3	7
Poverty (low family development, famine) 21 *	2	--	2	--	--	1	5	2	4	5
Poor Family Relations (lack of shared decisions, children do not respect parents, mixed understanding, family division) 15 *	--	1	5	--	--	2	2	--	2	3
Participants Attempt Intervention (youth intervene) 8 *	3	4	1	--	--	--	--	--	--	--

NOTE: ASTU = Anti-Stock Theft Unit

* = frequency discussed