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BRIEF REPORT

Prevalence and Characteristics of Intimate Partner Violence Against Women with Severe Mental Illness: A Prevalence Study in Spain

Juan González Cases · Cristina Polo Usaola · Francisco González Aguado · Marisa López Gironés · Margarita Rullas Trincado · Alberto Fernández Liria

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Abstract This study examined the prevalence and characteristics of intimate partner violence (IPV) towards women with a severe mental illness (SMI). The sample consisted of 142 adult women with SMI treated in public mental health services in three districts of Madrid (Spain). The prevalence of IPV in the 12 months preceding the interview was 30.3 % and over the lifespan was 79.6 %. 32.7 % of women victims of violence do not qualify themselves as battered women. 48.5 % of battered women do not talk about their abusive situation with anyone or come to any resource or service. Women victims of abuse have low social support. Women who have suffered physical abuse in childhood are at 2.22 times higher risk of being victims of IPV in the past year. Mental health professionals identified 50 % of recent abuse cases. This research highlights the extent of IPV experienced by women with SMI.

Keywords Intimate partner violence · Mental illness · Prevalence · Abuse · Schizophrenia

J. González Cases · C. Polo Usaola · F. González Aguado · M. López Gironés · M. Rullas Trincado · A. Fernández Liria
Human Rights Section, Spanish Association of Neuropsychiatry, Madrid, Spain

J. González Cases (✉)
Psychosocial Rehabilitation Center, C/Pablo Coronel, 18, 28802 Alcalá de Henares, Madrid, Spain
e-mail: jgcases@grupoexter.com

C. Polo Usaola · M. López Gironés
Mental Health Center Hortaleza, University Hospital Ramón y Cajal, C/Mar Caspio, 8, 28033 Madrid, Spain

F. González Aguado
Mental Health Center, University Hospital Príncipe de Asturias, C/Alfonso de Alcalá s/n, 28802 Alcalá de Henares, Madrid, Spain

M. Rullas Trincado
Psychosocial Rehabilitation Center, C/Jardín n° 28 bajo, 28830 San Fernando de Henares, Madrid, Spain

A. Fernández Liria
University of Alcala, Carretera Alcalá-Meco s/n, 28805 Alcalá de Henares, Madrid, Spain

Introduction

Intimate partner violence (IPV) against women is a serious worldwide phenomenon, not only because of the extent of IPV but also because of the consequences that it has on a woman's physical and mental health. There are many studies published in various countries that refer to the extent of the problem. In a survey conducted by the World Health Organization on general populations in different countries and contexts, it was found that between 15 and 71 % of women had suffered physical and/or sexual aggression at some point in their lives at the hands of their intimate partner or ex-partner. In addition, the survey found that between 15 and 71 % of women had suffered abuse during the year preceding the survey (García-Moreno et al. 2005). Thus, it may be concluded that to a greater or lesser degree, IPV towards women is a phenomenon that is present in all countries, cultures and social strata without exception (World Health Organization 2002). Worldwide, almost one-third (30 %) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (World Health Organization 2013).

In Spain, general population surveys have indicated that the prevalence of partner-related violence during the

preceding year sits at 7–10 % (Ministerio de Sanidad, Servicios Sociales e Igualdad 2012; Instituto de la Mujer & Sigma Dos 2006; Lasheras et al. 2008). Within the context of studies carried out at a primary healthcare level, the prevalence detected is slightly higher, with the proportion of women who have been abused by their partners or ex-partner being 15 % in the preceding year and 30–50 % at some point during their lifetime (Plazaola et al. 2008b; Ruiz et al. 2010; Alhabib et al. 2010, González-Losada et al. 2012).

There is also ample literature regarding the consequences of violence for women who suffer from their partner's violence, from the most extreme cases, such as a woman's death from violence, to the physical or psychological aftermaths that women suffer as victims of violence within an intimate partner relationship (Campbell 2002; Ellsberg et al. 2008; World Health Organization 2013). The World Health Organization estimates that for 38 % of the homicides of women worldwide, the perpetrator is a partner or ex-partner (World Health Organization 2013).

The violent victimisation of people with mental illness has been the focus of several investigations, with the general conclusion that such individuals suffer violence to a greater extent than the general population (Gearon and Bellack 1999; Walsh et al. 2003; Hart et al. 2012; Bengtsson-Tops and Ehliasson 2012). The numerous studies and data regarding partner violence towards women contrast sharply with the lack of specific research concerning partner violence towards women who suffer severe mental illness (SMI). These circumstances are surprising because, at first glance, one would suppose that those women are twice as vulnerable to being victimised by their intimate partner or ex-partner—vulnerable because they are women and vulnerable because they suffer from SMI. The considerations shown below have been taken from the few studies published regarding violence and SMI within an intimate partner relationship (Post et al. 1980; Herman 1986; Bryer et al. 1987, 1997; Carlile 1991; Goodman et al. 1995; Lipschitz et al. 1996 ; Poirier 2000; Chandra et al. 2003; Grubaugh and Frueh 2006; McPherson et al. 2007; Friedman et al. 2011):

- Most of the studies were carried out in the United States (10 studies); two studies are from Canada, one from South Africa and another from India. No specific studies have been identified in Spain, Europe or in Spanish-speaking countries.
- There is no standardised method of data collection, appropriate tools or application context.
- None of the papers cover psychological abuse; the data collected refer only to sexual and/or physical violence.
- The prevalence of partner violence towards women with a SMI is considerably higher than that of women in the general population. Thus, for example, during a lifetime, approximately 50 % (a range of 16–80 %[1]) of women with SMI will experience physical violence, 30 % will experience sexual violence and between 32.3 and 68 %[2] will experience a combination of physical and/or sexual violence. As far as recent violence is concerned, i.e., violence suffered in the year preceding data collection, the prevalence of physical violence stands at approximately 25 % and the combination of physical and/or sexual violence at 19 %. No data have been found regarding sexual violence in the preceding year. In a recent systematic review, Oram et al. (2013) found that the median prevalence of lifetime partner violence was 30 % among female in-patients and 33 % among female out-patients.

The lack of research concerning IPV towards women with SMI in Spain and Europe has led to the design of this study. Thus, the objective of this research was to identify the prevalence and characteristics of IPV towards women with SMI. The following aspects were also analysed: the relationship between abuse and the sociodemographic and clinical characteristics of the sample, the existence of abuse during childhood, and the ability of mental health professionals who attend to the women to detect violence. Poor detection by professionals makes treatment more difficult, so it may prove worthwhile to implement IPV screening protocols to accompany existing services (Rodríguez et al. 1999; Chang et al. 2011). Recent research has found some variables that correlate with IPV, including low levels of social support, and physical and sexual abuse during childhood (Bengtsson-Tops and Tops 2007; Yoshihama and Horrocks 2010; Vives et al. 2010).

Methods

Design and Subjects

The study's design consisted of a cross-sectional survey. The inclusion criteria were: (1) women with an SMI diagnosis; (2) over 18 years of age; (3) with an intimate partner and/or ex-partner. SMI was defined as: a psychotic diagnosis (schizophrenia, bipolar disorder or other psychotic disorder) or a personality disorder that may lead to a disability; a long duration of the illness; and a severe recurrent disability resulting from mental illness. All eligible participants were receiving services at Public Health outpatients' mental health resources [as offered by the

[1] Prevalence is particularly high as the sample consisted of women classified as homeless (Goodman et al. 1995).

[2] Prevalence is particularly high as the sample consisted of women with a Latin origin (Friedman et al. 2011).

three Health Districts belonging to the Madrid Autonomous Community (Alcalá de Henares, San Fernando de Henares, and the Hortaleza district, which belongs to Madrid Capital City's Municipality)]. The cases were recruited from a locale-wide public mental health register in each of the three Health Districts.

The initial sample consisted of 395 women aged over 18 years. Of those, 76 refused to take part in the study; they did not want to sign the informed consent form or did not turn up for the interview (degree of acceptance 80.7 %). In addition, 10 women were unable to answer because of their positive symptomatology, 42 could not be contacted, 14 could not participate because of incompatible schedules or other objective reasons, and finally 111 were excluded because they did not have or had never had an intimate partner.

Measures

These instruments were used in this study: the *Intimate Partner Violence towards Women Questionnaire*, a tool translated into Spanish and validated in the Spanish population (Lasheras et al. 2008) that evaluates psychological and sexual violence using a section based on the *Enquête nationale sur les violences envers les femmes en France* (Enveff) (Jaspard and Équipe Enveff 2000) and physical violence with the section based on *Conflict Tactics Scales* (CTS-1) (Straus 1979); the *Social Support Questionnaire DUKE-UNC* (Broadhead et al. 1988; Bellón et al. 1996); and the *Global Assessment of Functioning (GAF)* (American Psychiatric Association 1994).

In addition, data were obtained regarding all partner violence suffered during their lifetime, information about the aggressor, the duration of the abuse, self-rating as a female victim of abuse, aggravation, response to abuse, physical and/or sexual abuse during childhood, socio-demographic and clinical data, psychiatric stability during the preceding 6 months, detection by professionals and reliability/coherence of the answers according to the interviewer.

The evaluation of partner violence involved two time periods: violence suffered during the 12 months preceding the interview and violence suffered from partners at any time in adulthood. The survey was conducted by trained professionals (a psychologist, psychiatrists, nurses and social workers) via personal interviews.

Statistical Data Analysis

Data were analysed using the statistical software package SPSS, version 18.0.0. The measurements used are the arithmetic mean and standard deviation for quantitative data. The qualitative data are shown in percentage form. Contingency tables were drawn for group comparison and statistical significance with standard residue, Pearson's Chi square test and t test for independent samples. Significance was found at $p < 0.05$ or $p < 0.01$.

The study protocol and informed consent were approved by the local Hospital Ethical Committee. All respondents gave their informed consent prior to their inclusion in this study.

Results

Description of the Sample

The final sample of this study involved 142 women, all with an intimate partner or ex-partner. The average age was 50.9 years (SD = 11.19), 41.5 % were married, 7.7 % were cohabiting and the remaining 45.8 % were divorced or separated. The most frequent diagnosis was schizophrenia (40.8 %), followed by personality disorder (21.8 %), bipolar disorder (20.4 %) and other psychotic disorders (14.8 %). They had been under psychiatric treatment an average of almost 14 years (166 months; SD = 113.5) and 76.5 % had been admitted to hospital for psychiatric treatment at least once in their life (an average of 5.41 admissions). In addition, 31.7 % of the women mentioned having experienced childhood physical abuse and 26.1 % experienced childhood sexual abuse.

Prevalence and Characteristics of IPV

The prevalence of IPV towards women with SMI in the 12 months preceding the interview was 30.3 and 79.6 % in the case of lifetime victimisation. All the women who had suffered violence during the preceding year had also been subject to previous abuse.

Half of the women did not tell anyone about their situation, nor did they access any resources or help services. Those who did seek help or talk about their situation did so mainly with mental health services or the police. It was observed that those women who rated themselves as abused had spoken about their violence situation more often than those who did not consider themselves as abused women.

Abuse and Social Support

As far as social support is concerned, it was observed that there was little support for women who had been victims of violence from their partners or ex-partners, with similar rates for women who experienced IPV in the preceding year ($p = 0.000$, independent samples t test) and for those who had experienced it during their lifetime ($p = 0.006$, independent samples t test). Thus, the Duke-UNC questionnaire average scores for women who suffered abuse in the

preceding year was 30.95 (SD = 10.12) compared with an average score of 38.89 (SD = 11.22) for women who were not victims ($p < 0.01$). In addition, it was observed that the difference was statistically significant ($p < 0.01$) in lifelong violence: 35.16 (SD = 11.59) for victims of abuse compared with 41.66 (SD = 9.47) for non-victims.

Battering and Abuse in Childhood

When analysing the number and proportion of women that had suffered childhood abuse, distributed according to whether they were victims or not of abuse by their partners or ex-partners, only one statistically significant result was observed concerning childhood physical abuse and being a victim of partner violence during the preceding year ($\chi^2 = 4.449$; $p = 0.035$): 44.1 % of women who suffered abuse in the preceding year were also victims of physical childhood abuse. The risk of being a victim of abuse from their partner in the preceding year was 2.22 times higher for women who suffered childhood physical abuse. While the data show a tendency for a relationship between a history of childhood sexual abuse and being or previously being a victim of partner abuse, the results were not significant.

Socio-demographic and Clinical Characteristics

No significant differences were found between cases of abuse and the following socio-demographic variables: age, country of origin, level of education, years of cohabitation with the partner, income or current occupation. However, there were more abuse cases in the preceding year among married women who currently live with their partner, have children, and have no professional qualifications. It was also found that there were more cases of lifelong abuse in divorced women who are living without a partner, have children, and have no professional qualifications.

From the various clinical variables studied (diagnosis, duration of illness, age at onset of disorder, psychiatric hospital admissions during the preceding year and throughout life), it was observed that those women who were victims of violence in the preceding year presented a higher incidence of a diagnosed personality disorder ($p < 0.05$); 39.5 % of the women who suffered abuse during the preceding year were diagnosed with a personality disorder. It was also found that women who were abused throughout their lifetime had a higher number of hospital admissions for psychiatric reasons in the preceding year [average of 0.45 admissions for women who suffered abuse (SD = 0.93) compared with 0.14 (SD = 0.58) for women who had not suffered abuse]. This also held true for the entire history of hospital admissions [average of 4.60 admissions for abused women (SD = 5.95) compared with 2.14 (SD = 4.26) for women who had not suffered abuse].

It was also found that 37.2 % of women who suffered abuse were psychiatrically stable in the preceding 6 months. Psychiatric instability was determined by the opinions of professionals treating the women. It was found that there was a significant relationship between psychiatric instability in the 6 months preceding the interview and a higher proportion of victims of partner or ex-partner violence ($\chi^2 = 5.087$; $p = 0.024$).

Discussion

This is the first study on a Spanish population to determine the prevalence of violence (current and lifelong) against women with SMI, at the hands of intimate partners or ex-partners. Furthermore, this work helps to address the lack of research regarding this phenomenon worldwide.

Almost one in every three women with SMI (30.3 %) suffered or had recently suffered abuse from their partner or ex-partner. An earlier macro-survey carried out by telephone on 2,136 women of the general population in Madrid, using the same tools as this study, found that the prevalence of abuse in women with SMI is three times higher than the prevalence detected in women of the general population (10.1 %) (Lasheras et al. 2008).

Four out of five women (79.6 %) with SMI have suffered abuse from their partner or ex-partner at some point in their life. It should be taken into account that the estimated lifelong prevalence is 30 % for women in the general population (Ruiz et al. 2010). Thus, it can be concluded that the prevalence levels in the sample of women with SMI is 2.6 times higher than that of the general population.

The most frequent form of abuse was psychological (29.6 %: during preceding year; 66.9 %: lifelong), followed by physical (8.5 %: during preceding year; 48.6 %: lifelong) and then sexual (4.2 %: during preceding year; 33.1 %: lifelong). In all three types of violence the aggressor is usually an ex-partner in the case of lifelong abuse and the current partner during the year preceding the survey. These findings are similar for the general population (Instituto de la Mujer & Sigma Dos 2006; Ruiz et al. 2006; Lasheras et al. 2008).

There was a high prevalence of extremely serious situations where women suffered all three types of violence: physical, sexual and psychological. One quarter (24.7 %) of the women who suffered abuse through their lifetime, and one tenth (9.3 %) in the preceding year, had been subjected to very serious abuse. This average is two times higher than that of the general population (18 %) (Ruiz et al. 2006; Plazaola et al. 2008a).

It was also found that a high percentage of women (41.9 %) who were, in technical terms, victims of abuse in

the preceding year did not consider themselves as abused. However, it seems that those women do in fact consider themselves as abused at a higher rate than women in the general population, as only one-third of the latter evaluate themselves as abused women (Instituto de la Mujer & Sigma Dos, 2006; Lasheras et al. 2008; Ministerio de Sanidad, Servicios Sociales e Igualdad 2012).

Our data indicate that between 50 % (during preceding year) and 62.5 % (lifelong) of the women who suffered abuse among those in our sample were detected by mental health service professionals (psychiatrist or clinical psychologist). Certain types of abuse are detected more easily than others (psychological and physical being easier than sexual). This percentage of detection is somewhat higher than that reported by other health professionals, which stands between 5 and 15 % (Vives et al. 2005). Considering that the abusive situation perpetrated by partners on women with SMI is a "hidden" reality, one clinical implication would be "to bring to light" this phenomenon and increase awareness among the professionals who attend to this group of women.

In the general population, lower levels of social support are associated with higher rates of IPV (Plazaola et al. 2008a). The same relation was found in this research with women with SMI. There appear to be lower levels of social support for women who are victims of abuse compared with those who are not. There are no data to determine if poor social support causes a higher vulnerability to abuse and/or a lesser capability to cope with abusive situations, or if low social support occurs because of the abuse or a combination of these factors. In clinical practice, a paradox is frequently observed where the partner that inflicts the abuse is the only care resource that a woman with SMI has; therefore, she faces very complicated circumstances to cope with the abusive situation.

In relation to the clinical characteristics, there were significantly more cases of lifelong partner violence for women with higher psychiatric hospital admissions during their lifetime or in the 12 months preceding the interview. Hospital admission could then be considered as a protective element against aggression for women who suffer abuse when they are psychiatrically unstable. Regarding recent violence, there were more abuse cases among women who were psychiatrically unstable in the six months preceding the interview.

The sample is considered representative of the situation of women with SMI and the abuse suffered at the hands of their partners. Nevertheless, certain limitations in the present study need to be discussed. Although the acceptance rate is in line with other similar studies, a sizable percentage (20.3 %) of women did not wish to take part in the study. Furthermore, the sample was extracted from just three districts within the Madrid Autonomous Community and all the participants attend and are in contact with public services. Therefore, there is no representation of women who use private services nor of women with SMI who do not receive professional attention.

Another limitation worth mentioning is that although the tools used are widely applied and recognised in other research projects, there is yet no international consensus regarding which tool should be applied to measure partner abuse.

Some implications for clinical practice: it would be advisable to improve the way abuse cases are detected within the Mental Health Services by implementing a detection protocol that deals directly with the women regarding intimate relationships and possible abuse. The protocol should be applied at the time of first contact as well as subsequently at determined intervals.

In the clinical management of abuse situations and SMI in women at risk or who do suffer abuse, the following points should be considered: the problem should be tackled as soon as signs of abuse are detected; social networks should be developed to support women with SMI; social skills should be coached so that the woman sees herself as more socially adept in a relationship; women should be encouraged to become self-sufficient and economically independent; psychiatric stability should be promoted; and abuse situations should be handled in conjunction with other resources and community agents.

In summary, this investigation highlights the magnitude of the violence suffered by women with SMI at the hands of their partner or ex-partner. This multi-layer discrimination (being a woman, disabled, mentally ill, and abused) makes this group particularly vulnerable. Mental health service professionals, together with all the other applicable resources (Social Services, support services for battered women, justice system, etc.), should be aware of this situation and take the necessary steps to address these issues now.

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