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Research Article

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Prevalence of Intimate Partner Violence and Associated Factors

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ABSTRACT

Introduction: The aim of the present cross-sectional study was to investigate the prevalence of intimate partner physical violence among depressive Turkish women, as well as the association of intimate partner physical violence with attachment patterns, childhood traumas, and socio-demographic factors.

Methods: The study included 100 women diagnosed with depressive disorder and 30 healthy women. The Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders-IV axis I disorders, Hamilton Depression Rating Scale, Hamilton Anxiety Rating Scale, Adult Attachment Style Questionnaire (AASQ), and Childhood Trauma Questionnaire (CTQ) were used for clinical assessment.

Results: It was found that 64% of the women diagnosed with depression were suffering from intimate partner physical violence. In these women, the severity of depression and anxiety symptoms was higher, suicidal ideation and suicide attempts were more common, and the diagnosis of double depression was more prevalent. These women also achieved higher scores in the avoidant and ambivalent subscales of AASQ and higher total scores and higher scores in the physical abuse subscale of CTQ. The partner's and the woman's experiences of physical violence in their families during their childhood predicted intimate partner physical violence for women suffering from depression.

Conclusion: The investigation of domestic violence contributes to the treatment of depression and also to the recognition and prevention of domestic violence that has profound effects on successive generations.

Keywords: Intimate partner violence, depression, attachment style, childhood trauma

INTRODUCTION

According to the results of a survey conducted by the World Health Organization (WHO) using face-to-face interviews on 24,000 women in 10 countries, all types of violence against women were found to be substantially prevalent (physical violence, 13–61%; emotional violence, 20–75%; and sexual violence 6–59%) (1). The prevalence of physical domestic violence was reported to be 39% in a study conducted on more than 12,000 women in Turkey (2). Another national study found that one in three women is subjected to violence from their partners (3). Apart from population-based studies, the studies conducted on patients presenting to health care providers indicate high rates of domestic violence (4,5). Early and arranged marriage, inadequate social support, total economic dependence, living in a large family, low educational level, alcohol abuse/addiction by the male partner, and exposure to violence during childhood were found to be associated with violence (2,4,5,6).

Apart from the above-mentioned social factors, attachment patterns and childhood traumas were also found to be associated with domestic violence (7,8). The attachment theory defines the function of relationship between a baby and his/her caregiver(s) and how this relationship would predict future psychological development of the baby (9). According to attachment theory, there are three types of attachment in adults: secure attachment, anxious-resistant insecure attachment, and anxious-avoidant insecure attachment (9,10). Individuals interiorize their relations with people with whom they develop attachment, and they develop cognitive and internal working models and learn how to regulate their behaviors in a close relationship. Being exposed to or witnessing violence shapes cognitive models and affects relations during adulthood (8,11,12). Individuals with an insecure attachment pattern are more likely to engage in or maintain abusive relationships (7,8).

Another risk factor for intimate partner violence is neglect and abuse experienced during childhood. The findings of studies support a relationship between the history of abuse during childhood and sustaining intimate partner violence during adulthood (8).

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All types of abuse and trauma experienced during childhood pose a risk for all forms of psychopathology. Studies found that childhood traumas are risk factors for early-onset depression and persistent symptoms (6,11).

The rate of depression is higher in women sustaining violence (6,13,14). The risk of depression in women exposed to domestic violence is 4–5-fold higher compared with women who do not have a history of trauma (14). The prevalence of lifetime intimate partner violence reaches 60% in patients diagnosed with depression (6). It must be taken into consideration that intimate partner violence is an important risk factor for depression, but it can also affect the course of depressive disorder. Domestic violence against women is a public health concern with increasing importance. Raising awareness and information levels among mental health care providers will also raise public awareness about domestic violence. There are a limited number of studies conducted on this subject in Turkey. The aim of the present study was to evaluate the prevalence of domestic violence against women with depression, which is one of the most common patient groups encountered in daily practice, and to investigate the relationship between domestic violence and attachment patterns, childhood traumas, and socio-demographic variables.

METHODS

The study was conducted on consecutive women who presented to the outpatient psychiatry clinic at İzmir Atatürk Training and Research Hospital between November 1, 2010 and December 1, 2010 and who were diagnosed with depressive disorder. The study inclusion criteria were age between 18 and 60 years, voluntary participation, being literate, and having been diagnosed with major depressive disorder, dysthymic disorder, or depressive disorder not defined otherwise during an interview based on Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV axis I disorders (SCID-I). The exclusion criteria included the presence of cognitive impairment that would prevent a participant from understanding study questions, psychotic disorder, bipolar disorder, mental retardation, or dementia, and the presence of an organic brain disease (epilepsy, stroke, etc.). The control group included patients matched for age, educational level, and socio-economic status with the study group who did not have any psychiatric disorder during SCID-I and who provided consent for participation in this study (15).

Assessments

The women were assessed with a face-to-face interview. Approval was obtained from the ethics committee of the hospital. The study participants provided written informed consent for the study.

Assessment Tools

Semi-structured questionnaire: A 97-item questionnaire prepared for the study was used during the face-to-face interviews to obtain socio-demographic data and features related to violence. Detailed information was obtained about physical violence. Age at the first exposure to physical violence, duration, last exposure to physical violence, frequency of violence, exposure to physical violence during pregnancy, witnessing violence by children, causes of violence, woman's reaction, violence against children by the female or male partner, and physical violence experienced or witnessed by the male partner during childhood were questioned. The same questions were asked to the women in the control group.

SCID-I: This was developed by First et al. (15) and adapted to Turkish (16).

The Hamilton Rating Scale for Depression (HRSD): This scale measures the level of depression and the severity of depressive symptoms. The validity and reliability of the Turkish version of the scale was evaluated (17,18).

The Hamilton Anxiety Rating Scale (HAM-A): This scale was developed by Hamilton to evaluate anxiety level, symptom distribution, and changes in the symptom severity, and the Turkish version of the scale was evaluated for its validity and reliability (19,20).

The Adult Attachment Style Questionnaire (AASQ): The first section developed by Hazan and Shaver (10) consists of three different statements including definitions with reference to the quality of the relationship with parents as well as overall behavioral qualities. The second section developed by Mikulincer et al. (21) consists of 15 items. Each item is scored from 1 to 7. Each pattern of attachment is represented with five items. The Turkish version of AASQ used in the present study was validated by Sabuncuoglu and Berkem (22) in 2006.

The Childhood Trauma Questionnaire (CTQ): This scale was developed by Bernstein et al. (11) to evaluate traumatic experiences sustained before the age of 18. The scale consists of 40 items. Higher scores achieved in this scale are associated with traumatic experiences during childhood. The Turkish version of this scale was validated by Aslan and Alpaslan (23) in 1999.

Statistical Analysis

The Student's t-test and χ^2 test with Yates correction were used in statistical analysis. A p-value of less than 0.05 was considered statistically significant. A logistic regression analysis was performed to determine variables predicting domestic physical violence. For analysis, the Statistical Package for the Social Sciences (SPSS Inc., Chicago, USA) version 13 was used.

RESULTS

The Prevalence of the Diagnoses and Comorbidities in the Patient Group

A total of 130 women were included in the study (100 women diagnosed with depressive disorder according to the diagnostic criteria of DSM-IV-Text Revision and 30 healthy women) (24). The distribution of the diagnoses is presented in Table 1. In the depression group, 24% of the women had a comorbid condition, and anxiety disorders accounted for majority (96%) of the comorbidities (seven had phobia, six had anxiety disorder, not otherwise specified, six had obsessive-compulsive disorder, two had panic disorder, two had agoraphobia, two had social phobia, and two had post-traumatic stress disorder).

The Comparison between the Patients with Depressive Disorder and the Control Group

The mean age was 39.1±10.2 years in the depression group and 41.9±11.3 years in the control group. Of the study subjects, 67% in the depression group and 66.7% in the control group were primary school graduates. Majority of the women in both groups were unoccupied (81.0% in the depression group and 70.0% in the control group). There was no significant difference between the two groups in terms of socio-demographic features with the exception of marital status. The rates of women living separately and rates of divorce were higher in the depression group than in the control group (Table 2). There was no significant difference between the groups in terms of socio-demographic features of the partners.

The prevalence of physical, emotional, economic, and sexual violence was significantly higher in the depression group than in the control group. In addition, the prevalence of children's exposure to physical intimate partner violence and the prevalence of physical violence by the father of the male partner against the mother were significantly higher in the depression group than in the control group (Table 2).

The patients in the depression group achieved significantly lower scores in the secure attachment subscale and significantly higher scores in the avoidant and ambivalent subscales of AASQ than in the control group. Similarly, the patients in the depression group achieved higher total scores and higher scores in emotional, physical, and sexual abuse subscales of CTQ (Table 3).

The Comparison between the Patients with Depressive Disorder who Sustained Domestic Violence and the Control Group

The comparison of the causes of violence between the subjects in the two groups who sustained domestic violence revealed that the women in the depression group were mostly exposed to domestic violence due to "sexual issues" (p=.03) and that the rates of "physical violence during pregnancy" (p=.001) and "economic violence" (p=.001) were higher in this group.

The Comparison between Depressive Patients who Sustained Physical Intimate Partner Violence and Patients who did not

The diagnosis of double depression (dysthymic disorder and major depressive disorder) was more prevalent among depressive women who were exposed to physical violence, and the diagnosis of "major depressive disorder, single episode" and other depressive disorders were more prevalent among depressive women who were not exposed to physical violence (p<.05). There was no significant difference between the groups in terms of comorbid conditions (p>.05). In the depression group, women who were exposed to physical violence achieved higher total scores in HRDS and HAM-A, higher scores in the depressed mood and somatic subscales of HAM-A and had higher rates of suicidal ideation and suicide attempt and achieved higher scores in the avoidant and ambivalent subscales of AASQ and higher total scores and higher scores in the physical abuse subscale of CTQ (Table 4).

The rate of women with economic independence was higher among depressive women who were exposed to domestic physical violence than in women who were not exposed to domestic violence. The prevalence of emotional, economic, and sexual abuse, physical violence against children by the female or male partner, and physical violence experienced or witnessed by male partner during childhood were more prevalent among women who experienced physical intimate partner violence (Table 4).

There was no significant difference between the women in the control group who did or who did not experience physical violence in terms of childhood traumas and attachment styles (p>.05).

The Variables predicting Domestic Violence in Women with Depressive Disorder

The physical violence experienced by the male partner during childhood, physical violence of the partner against his children, physical violence experienced by the woman during childhood, suicide attempts of the woman, total score in HRDS and HAM-A, scores in the avoidant and ambivalent subscales of AASQ, and total score in CTQ were included as variables

Table 1. The prevalence of the diagnoses and comorbidities in the patient group

Depression type	Number
Major depressive disorder, single episode	36
Major depressive disorder, recurrent	48
Dysthymic disorder+major depressive disorder	10
Not otherwise specified depressive disorder	5
Dysthymic disorder	1
Comorbidities	
Anxiety disorder	23
Somatoform disorder	1

Table 2. Significant variables associated with socio-demographic variables and violence between the patient and control groups

Variable		Patient group (n=100)		Control group (n=30)		Statistical significance	
		Number	%	Number	%	x^2	p
Separation/divorce	No	74	74	29	96.7	4.4	.001
	Yes	26	26	1	3.3		
Physical violence of partner	No	36	36	22	73.3	13.0	.001
	Yes	64	64	8	26.7		
Psychological violence of partner	No	27	27	20	66.7	15.7	.001
	Yes	73	73	10	33.3		
Economic violence of partner	No	49	49	27	90.0	16.0	.001
	Yes	51	51	3	10.0		
Sexual violence of partner	No	52	52	24	80.0	7.5	.001
	Yes	48	48	6	20.0		
Partner's physical violence against children	No	34	38.2	18	62.1	5.3	.03
	Yes	55	61.8	11	37.9		
Physical violence by the father of the male partner against the mother	No	25	28.9	16	66.7	11.3	.001
	Yes	59	71.1	8	33.3		

Table 3. To compare the scores of AASQ and CTQ between the patient and healthy control groups

	Patient group (n=100)		Control group (n=30)		Statistical significance	
	Mean	**SD**	**Mean**	**SD**	**t**	**p**
AASQ secure attachment score	23.6	6.8	28.5	5.2	3.7	.001
AASQ avoidant attachment score	20.6	7.9	11.7	4.9	7.4	.001
AASQ ambivalent attachment score	18.0	8.3	11.1	4.5	5.9	.001
CTQ total score	83.3	33.8	58.8	17.8	4.5	.001
CTQ emotional abuse score	43.9	18.9	31.7	12.9	3.4	.001
CTQ physical abuse score	33.3	15.5	22.2	6.6	5.4	.001
CTQ sexual abuse score	6.0	2.9	5.2	1.0	2.5	.01

SD: standard deviation; AASQ: Adult Attachment Style Questionnaire; CTQ: Childhood Trauma Questionnaire

in the logistic regression analysis to determine the predictors of domestic violence. The physical violence experienced by the male partner (p=.01, OR=7.3) and woman (p=.013, OR=7.8) during childhood predicted physical violence in depressive women.

DISCUSSION

In the present study, 64% of the women were found to have experienced physical intimate partner violence. Two studies conducted on psychiatric outpatients in different regions of Turkey exhibiting different cultural features reported prevalence rates of 57% and 62% for domestic violence (4,5). In the study by Scholle et al. (25), the prevalence of physical domestic violence was found to be 55.2% in 303 women who were diagnosed with depression. Another study reported a prevalence rate of domestic violence (emotional and/or physical and/or sexual) of up to 60% in women with depression (6). The exposure to domestic violence is one of the major risk factors for depression (26).

Studies in Turkey and other countries suggest that other forms of violence are also common in addition to physical violence. A study conducted by WHO reported prevalence rates of 6–59% and 20–75% for sexual and emotional violence, respectively (1). Field studies conducted in Turkey reported prevalence rates of 9–15%, 44%, and 36–40% for sexual, emotional, and economic violence, respectively (2,3). In the present study, the prevalence rates for various forms of violence were higher in the depression group than in the healthy controls. Three of four women with depression were found to have experienced emotional violence, and approximately one-half experienced economic and sexual violence. The fact that the present study was conducted on women with a psychiatric disorder may explain the higher prevalence rates for violence than those in field studies. A woman who has experienced physical violence is often found to have been exposed to other forms of violence, and therefore, patients should be questioned for other forms of violence when one form of violence is observed.

There is a relationship between insecure attachment style and major depressive disorder, postpartum depression, and many other psychiatric disorders (27). Secure attachment style can act as a protector against adverse life events and render an individual resistant to life stresses (28). In the present study, the scores of the patients in the secure attachment subscale were significantly lower and the scores in the avoidant and ambivalent attachment subscales were higher in the depression group than in the control group. Furthermore, depressive women who were exposed to physical violence achieved higher scores in the avoidant and ambivalent subscales than in women who were not exposed to physical violence. Studies support the role of individual and partner characteristics on marital adjustment and violence between intimate partners (7,8). In the present study, attachment styles were not evaluated in the partners of the women. Another risk factor for both intimate partner violence and developing psychopathological conditions during adulthood is the neglect and abuse experienced during childhood (29). Individuals with a history of abuse during childhood are known to be susceptible to be a victim of abuse during adulthood (30). In the present study, the prevalence of sexual, physical, and emotional abuse during childhood was higher in the depression group than in the control group. In addition, depressive women who were exposed to physical violence achieved higher total scores and higher scores in the physical abuse subscale of CTQ than in depressive women who were not exposed to physical violence. In the control group, there was no significant difference between the subjects who did or did not experience physical violence in terms of a history of trauma during childhood. It is important to investigate the history of psychological trauma during childhood and attachment styles in depressive women who are exposed to physical violence. In a therapeutic relationship, addressing the attachment style of the patient and past traumas may provide a significant contribution to the treatment process (29).

The prevalence of children's exposure to physical intimate partner violence and the prevalence of physical violence by the father of the male partner against the mother were significantly higher in the depression group than in the control group. The present study found that the male partners of depressive women who experienced physical violence engaged in acts of physical violence against children and have also been a victim of domestic violence during childhood. Another important point is that physical violence experienced by the male partner and the woman during childhood predicted physical domestic violence. The violence being exposed or witnessed by an individual increases the risk of future exposure to or engaging in acts of violence (8,11). Holt (31) made a reference to the social learning theory and emphasized that children are more likely to imitate behavior of being rewarded than that of being punished. Individuals who witnessed domestic violence during childhood and those who grew up in a family environment and who considered domestic violence as if it were an ordinary event would become the perpetrator of violence against their partners during adulthood. This is referred to as intergenerational cycle of violence (32). Lewendosky et al. (33) dealt with the relationship between attachment theory, traumatic experiences during childhood and domestic violence.

In romantic relationships, each partner is the figure of attachment for the other partner. The internal attachment models created during childhood are reflected in the romantic relationships during adulthood. Exposure to domestic violence increases the risk of developing psy-

Table 4. The comparison between depressive patients who sustained physical intimate partner violence and patients who did not

Variable		Not Sustained Physical Violence (s=36)		Sustained Physical Violence (s=64)		Statistical significance	
		Number	**%**	**Number**	**%**	**x^2**	**p**
Economic independence of woman	No	33	91.7	46	71.9	5.4	0.02
	Yes	3	8.3	18	28.1		
Physical violence of partner	No	22	61.1	5	7.8	33.2	.001
	Yes	14	38.9	59	92.2		
Economic violence of partner	No	27	75.0	22	34.4	15.2	.001
	Yes	9	25.0	42	65.6		
Sexual violence of partner	No	27	75.0	25	39.1	11.9	.001
	Yes	9	25.0	39	60.9		
Partner's physical violence against children	No	20	65.4	14	24.1	13.9	.001
	Yes	11	35.5	44	75.9		
Physical violence experienced by the male partner during childhood	No	12	44.4	6	12.0	10.3	.001
	Yes	15	55.6	44	88.0		
Physical violence experienced by the woman during childhood	No	19	52.8	13	20.3	11.2	.002
	Yes	17	47.2	51	79.7		
Suicidal ideation	No	24	66.7	21	32.8	10.7	.001
	Yes	12	33.3	43	67.2		
Suicide attempt	No	30	83.3	35	54.7	8.9	.001
	Yes	6	16.7	29	45.3		
		Mean	**SD**	**Mean**	**SD**	**t**	**p**
HRSD total score		10.7	5.8	15.2	7.1	3.3	.001
HAM-A total score		8.8	5.8	12.6	5.5	3.3	.001
HAM-A psychical subscale score		4.3	2.6	5.7	2.2	2.9	.001
HAM-A somatic subscale score		4.5	3.6	6.8	3.8	3.0	.001
AASQ avoidant attachment score		17.7	7.6	22.2	7.8	2.8	.006
AASQ ambivalent attachment score		14.0	6.7	20.3	8.3	3.9	.001
CTQ total score		73.0	27.1	89.1	36.0	2.5	.01
CTQ physical abuse score		27.9	13.0	36.3	16.1	2.8	.001

SD: standard deviation; HRSD: Hamilton Rating Scale for Depression; HAM-A: Hamilton Anxiety Rating Scale; AASQ: Adult Attachment Style Questionnaire; CTQ: Childhood Trauma Questionnaire

chopathological conditions and unfavorably affects the internal working models of a mother against herself and her children. This harms both the mother and her children and results in intergenerational transmission of violence. Consequently, domestic violence is associated with traumatic childhood experiences and attachment styles. Domestic violence can result in insecure attachment and vice versa. This vicious cycle indicates the importance of preventing violence from the standpoint of preventive psychiatry.

In depressive women who were exposed to domestic violence, severity of depression and anxiety symptoms were higher, scores in the depressed mood and somatic subscales of HAM-A were higher, suicidal ideation and suicide attempts were more common, and the diagnosis of double depression was more prevalent than in women who were not exposed to domestic violence. As suggested in relevant studies, domestic violence plays a role in chronic state and severity of depression (25). Dienemann et al. (6) found that the severity of abuse correlated with the severity of depression. Field studies conducted in Turkey found that the rate of suicidal ideation was 3-fold higher and that the rate of suicide attempts was 4-fold higher in women who were exposed to physical or sexual violence than in those who were not (2). It is important to investigate the presence of domestic violence in women with severe and chronic depression in whom depressive symptoms are accompanied by somatic symptoms and in women having suicidal ideation/attempted suicide.

Poverty and lack of economic independence are suggested to be factors increasing the risk of being exposed to violence (2,14). In the present study, domestic violence was more prevalent among women who have achieved economic independence. In the study by Altınay and Arat (3), women having a higher income than their male partner were found to have a doubled risk of physical violence. The present study did not evaluate the incomes of women and their male partners, and therefore, it cannot be suggested whether the observed difference was caused by the difference between the incomes of the partners. One plausible explanation is that the economic independence of a woman may disturb the balance of power based on the gender stereotypes in the community and thereby increase the risk of violence.

Field studies conducted in Turkey found that approximately one-half of women do not reveal that they are victims of domestic or sexual violence (2,3). Akyüz et al. (4) highlighted that 98% of the patients presenting to an outpatient psychiatry clinic do not mention their experiences of violence unless asked by the physician or provide only limited information or prefer to keep it confidential. In the present study, 25% of the patients who were exposed to physical intimate partner violence in both groups talked about their experiences for the first time in this study, and almost all patients (93%) responded that they never faced any question before about their experiences of domestic violence. The attitude of health care professionals ignoring and neglecting the presence of violence is another contributor for the perception as if it were an ordinary life event (34). Factors related to children and social and economic concerns are the most commonly reported reasons for enduring violence in depressive women who are the victims of intimate partner violence. Economic concerns, embarrassment, fears of an increase in abuse, perception of violence as it were an ordinary life event, social gender inequality, and justification of violence in relation to biases are among social factors keeping violence under the seal of secrecy. Institutional and legal resources are important to help female victims of violence to effectively cope with the challenges they face. However, many female victims of violence in Turkey are devoid of individual and institutional support (3).

The relatively small sample size was the main limitation of this cross-sectional study. As a summary, two-thirds of depressive women are being exposed to domestic violence. These women have higher rates of childhood trauma and mostly exhibit insecure attachment style. They have a more severe depression-anxiety level and a higher risk of developing chronic depression and committing suicide. The physical violence experienced by the male partner and the woman during childhood predicts domestic violence during adulthood. Physical violence is often accompanied by emotional, economic, and sexual violence. Treating violence as a common and "ordinary" stressor and leaving the issue unspoken even in a professional relationship will increase the feelings of hopelessness and desperation in women as victims of domestic violence. Psychiatric care personnel should keep in mind the possibility of domestic violence in women diagnosed with depressive disorder. The investigation of domestic violence contributes to the treatment of depression, but it is also important for the recognition and prevention of domestic violence transmitted through generations. Long-term observational studies are warranted to gain an insight on how domestic violence affects the development and course of depression.

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