Intimate Partner Violence Among Patients Diagnosed With Severe Mental Disorder

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Abstract: Intimate partner violence (IPV) has a remarkable impact on mental health and is common in people diagnosed with severe mental disorders (SMDs). Data of 102 outpatients were collected from clinical records and the Traumatic Life Events Questionnaire (TLEQ). Global estimation of lifetime IPV exposure was obtained by combining answers to selected TLEQ questions about physical, psychological, and sexual IPV. Overall, 24.5% of the participants reported at least one lifetime episode of IPV victimization. Female gender (odds ratio [OR] = 3.15, $p = 0.016$) and childhood trauma (OR = 4.7, $p = 0.002$) significantly increased the likelihood of IPV victimization. Conversely, posttraumatic stress disorder was not significantly increased in IPV victims. These findings are in line with current literature and suggest a remarkable and transdiagnostic prevalence of lifetime IPV victimization in SMD. Gender, childhood trauma, and SMD are relevant factors in IPV analysis and prevention. Diathesis of trauma, psychosocial vulnerability to revictimization and intersectional feminist theory help explain our results.

Key Words: Intimate partner violence, severe mental disorders, stress disorders, posttraumatic, schizophrenia, bipolar disorder

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Intimate Partner Violence: Definition and Health Burden

Intimate partner violence (IPV) is a universal yet complex, gendered, and context-dependent phenomenon. It encompasses several forms of violence occurring within the framework of an affective-sexual union characterized by intersectional dynamics of power asymmetry (Baird et al., 2019; Crenshaw, 1991). IPV includes acts of physical, sexual, and psychological abuse and is relatively common in the general population. In general population, IPV prevalence ranges from 4% to 75% because significantly different methodologies and conceptual approaches are used for IPV quantification worldwide (World Health Organisation, 2012). In Spain, studies based on general population have estimated a prevalence of 6% to 10% (Instituto Nacional de Estadística, 2019; González Cases et al., 2014).

IPV must be studied against the backdrop of the social and cultural frameworks that regulate human affective and sexual activity, that is, the heteropatriarchal system. In heterosexual couples, the burden of IPV victimization is usually experienced by the female partner (Breiding et al., 2014; Heise and Garcia-Moreno, 2002). Moreover, in a phenomenon known as the Nordic paradox, countries with greater gender equality tend to have higher reports of IPV and other gendered forms of violence (Gracia and Merlo, 2016). Even though IPV—as opposed to gender-based violence—can occur in any gender configuration, research on IPV in LGBTIQ+ communities is lacking in the literature (Messinger, 2011; Whitfield et al., 2018).

Besides its social, economic, and political consequences, IPV is recognized as a major public health issue (Capaldi and Langhinrichsen-Rohling, 2012). It places a significant burden upon healthcare services, particularly mental health resources (Bonomi et al., 2009; Stewart et al., 2016). Mental health problems such as affective disorders, posttraumatic stress disorder (PTSD) and substance abuse are commonly found in the victimized, particularly among marginalized and/or impoverished women (Behnken et al., 2018; Chmielowska and Fuhr, 2017; La Flair et al., 2012; Oram et al., 2017). The prevalence of PTSD in general population is approximately 6% to 9% (Sareen, 2020).

Severe Mental Disorder and Childhood Abuse

Severe mental disorder (SMD) is a widely used epidemiological and clinical concept, although it lacks a universal, consistent definition. SMD was first defined (National Institute of Mental Health, 1987) on the basis of three criteria: diagnosis of psychosis, duration of illness, and functionality impairment. Since then, many different working definitions have been suggested and used. In this article, we use SMD as encompassing schizophrenia spectrum disorders and bipolar disorder. Despite its limitations, the concept of SMD has remained useful owing to its predictive and external validity, thus allowing identification of patients with high levels of psychiatric burden (Parabiaghi et al., 2006; Ruggeri et al., 2000).

The prevalence of childhood abuse in the general population is arguably underestimated, although studies speak of 10% to 20% (Pereda, 2016; Pereda et al., 2013). A solid scientific consensus currently exists on the link between childhood trauma and psychosis (Alvarez et al., 2011; Bebbington et al., 2004; Janssen et al., 2004; Matheson et al., 2017; Read et al., 2003; Varese et al., 2012). Exposure to childhood abuse has been shown to increase the likelihood of receiving an SMD diagnosis in the context of diathesis-stress, impaired attachment, and related theoretical models (Read et al., 2005; Seedat et al., 2003; Van Os et al., 2009). Accordingly, an increased prevalence of childhood abuse and posttraumatic symptoms has been previously reported among patients diagnosed with SMD in our service area (Alvarez et al., 2011, 2012). Childhood abuse has also been correlated to symptom severity, hospital admittance, and history of suicidal behavior (Garno et al., 2005; Hammersley et al., 2003; McLean and Gallop, 2003).

Severe Psychiatric Symptoms and Interpersonal Violence: A Diachronic, Bidirectional Relationship

Although the effect of childhood abuse is more often studied, exposure to life-threatening events such as interpersonal violence—especially if persistent and severe—also has been associated with mental health problems (Golding, 1999). However, the link between interpersonal violence and psychotic-like experiences seems to be independent from

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potentially confounding factors such as substance abuse (Coid et al., 2016). A large, prospective study based on the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (Okuda et al., 2011) found that victims of IPV are more than twice as likely to develop an axis I psychiatric disorder than nonvictims. Shah et al. (2018) recently reported that exposure to IPV—particularly emotional and sexual abuse—increases the likelihood of experiencing psychotic symptoms such as hallucinations, paranoid delusions, and thought disorder as much as threefold to fivefold. Several mechanisms may lead from IPV victimization (an individual's life experience) to psychosis (a disease state). Cognitive theories suggest that threat beliefs resulting from an experience of trauma may eventually become paranoid thoughts (Murphy et al., 2012). In addition, social withdrawal and loneliness are often associated with IPV and have been hypothesized to play a key role in initiating psychotic experiences (Boyda et al., 2015; Shah et al., 2018).

Psychiatric diagnoses seem to be related to an increased risk of victimization by violence, particularly in women, compared with the general population (Danielson et al., 1998; de Vries et al., 2019; Oram et al., 2017). Despite the stereotype associating violent behavior with SMD, violent and criminal behaviors are often linked to conditions such as substance abuse rather than to any particular psychiatric diagnosis (Pulay et al., 2008). Many of the symptoms associated with SMD (such as disorganized thought patterns, impulsivity, altered reality perception, impaired executive function, and decreased problem-solving capacity) reduce the ability to perceive risk and adopt protective behaviors (Teplin et al., 2005), which increases the risk of victimization among patients who experience these symptoms. Similarly, the presence of symptoms may increase the likelihood of maladaptive behaviors related to victimization, such as substance abuse or engaging in conflictive and even abusive intimate relationships (Marley and Buila, 2001).

Intersectional theory (Crenshaw, 1991; Lykke, 2010) helps us understand why it is crucial to emphasize that IPV experiences may differ between stigmatized populations, such as psychiatrized women (Finkler, 1993; Hodges, 2003), and their more privileged counterparts. A diachronic and bidirectional link likely exists between severe mental symptoms and interpersonal violence. Intersectional analysis would suggest that gender mediates abusive intimate partner relationships in ways that may differ qualitatively between people diagnosed with SMD and the general population.

Despite this body of evidence on the prevalence of mental health problems among IPV victims, few studies have specifically examined the experiences of IPV victimization of patients diagnosed with SMD. We have located three studies focusing on IPV victimization among patients with SMD without control group. In Nigeria, Afe et al. (2016) found a lifetime prevalence of 73% in a sample of female psychiatric outpatients with a specific diagnosis of schizophrenia. In a sample of German women with a diagnosis of SMD, Laghchioua and Grube (2015) reported a prevalence of 67%. In Spain, González Cases et al. (2014), observed a prevalence of 79% (lifetime) and 30% (past-year) among women with SMD; the authors also identified childhood abuse as a key factor doubling the risk of IPV victimization in adulthood. Notably, each of these studies concluded that patients with SMD are at a greater risk of IPV victimization and urge mental healthcare providers to improve their prevention and detection skills in such cases.

In a cross-sectional, controlled study of domestic violence in the United Kingdom (Khalifeh et al., 2015), people diagnosed with SMD were found to be significantly more likely to experience victimization than controls from a national crime survey, with remarkable gender differences. Khalifeh et al. also reported a past-year domestic violence victimization rate of 27% for women and 13% for men among patients with SMD, versus 9% and 5%, respectively, in the control group.

In the most extensive analysis available, a systematic review of 42 high-quality studies of lifetime IPV victimization identified a mean prevalence of 33% among female psychiatric outpatients, 30% in female inpatients, and 32% in male patients from mixed settings (Oram et al., 2013).

Objectives and Hypotheses

The aim of this cross-sectional, retrospective study was to determine the lifetime prevalence of interpersonal violence victimization in the context of intimate partner relationships in a sample of patients from Osona (Catalonia, Spain) that have been diagnosed with SMD (schizophrenia, schizoaffective disorder, or bipolar disorder).

On the basis of the previously referenced research, expected findings include the following:

a) A higher prevalence of IPV victimization in our sample than in the general population, with no differences by diagnosis.
b) A higher prevalence of IPV victimization in female patients compared with male patients with the same diagnoses.
c) A higher prevalence of IPV victimization in those previously victimized during childhood.
d) A higher prevalence of PTSD as comorbid diagnosis in patients with a history of IPV victimization.
e) Worse clinical profile in IPV-victimized patients diagnosed with SMD compared with nonvictimized ones, as defined by history of suicidal behavior.

METHODS

Sample

All outpatients 18 years or older and diagnosed with SMD (schizophrenia, schizoaffective disorder, or bipolar disorder according to *Diagnostic and Statistical Manual, Fourth Edition* [*DSM-IV-R*] criteria) were invited to participate upon their visits at Osona Mental Health outpatient psychiatry clinic in Vic (Barcelona Province, Catalonia, Spain) over a 2-year period (2007–2009). Our sample was obtained from the regional public outpatient healthcare service clinic available in our area, although it is possible that some eligible patients in the area remained unaware of the study because they were attending private healthcare services, or were not attending any healthcare service at all, during the study period.

Patients who scored 4 in any of the 18 items of the Spanish version of the Brief Psychotic Rating Scale (Overall and Gorham, 1962; Peralta and Cuesta, 1994) or who scored 3 or above in conceptual disorganization, disorganized and unusual thinking, or auditory hallucinations were excluded.

The study protocol was approved by the hospital's research ethics committee before patient recruitment. All participants provided written informed consent. Consent was supposed to be provided by legal representatives in cases where the patient was legally disabled, although spoken consent from the patient would still have been required in such cases. Despite this fact, in our sample, there were no legally disabled patients, Thus, all informed consents were signed by patients themselves.

Data Sources and Collection

Demographic data were obtained from clinical records, which were completed by personal interview with patients, and included gender, birth date, marital and employment status, and educational level. History of childhood abuse was assessed via personal interview and confirmed psychometrically.

Clinical data were obtained from clinical records and included current diagnosis, age at the time of first SMD diagnosis, and lifetime history of suicidal behavior. Comorbidity with PTSD was assessed via clinical records and confirmed using psychometric tools administered by trained interviewers.

Psychometric Tools

Brief Psychiatric Rating Scale (BPRS) (Overall and Gorham, 1962) in its most widely used Spanish version (Peralta and Cuesta, 1994). The BPRS is a hetero-administered tool used to measure

TABLE 1. Items From the TLEQ Used in This Study

11d	Has anyone ever threatened to kill you or to cause you serious physical harm? (Your Partner)	Psychological IPV
20d	Has anyone stalked you (in other words, followed you or kept track of your activities) causing you to feel intimidated or concerned for your safety? (Your Partner)	
14	Have you been slapped, punched, kicked, beaten up, or otherwise physically hurt by your spouse (or former spouse), a boyfriend or girlfriend, or some other intimate partner?	Physical IPV
18d	After your 18th birthday: Did anyone touch your body or make you touch sexual parts of his or her body against your will or without your consent? (Your partner)	Sexual IPV

psychiatric symptoms, particularly of a psychotic nature. In the most common version, 18 items are assessed using a 1 to 7 Likert-like scale.

Traumatic Life Events Questionnaire (TLEQ) (Kubany and Haynes, 2001) in its Spanish version (Pereda, 2006). The TLEQ systematically inquiries about lifetime victimization by 22 potentially traumatic events. For the purpose of this study, answers to TLEQ items 11d and 20d (psychological violence by an intimate partner), 14 (physical violence by an intimate partner), and 18d (sexual violence by an intimate partner) were combined to obtain a global estimation of lifetime IPV victimization experiences. The full text of the four items used in this study is presented in Table 1. On the basis of the answers given to these four items, two subgroups were defined for analysis: (a) lifetime history of IPV victimization (one or more positive responses to one or more of the four items) and (b) no lifetime experience of IPV victimization (no positive response to any of the four items).

Distressing Event Questionnaire (DEQ) (Kubany, 2001) in its Spanish version (Pereda, 2006). The DEQ systematically evaluates the presence and severity of PTSD using *DSM-IV* criteria (A–F). The test is considered positive for PTSD when all six DEQ criteria are met.

Data Analysis

IBM SPSS Statistics software version 23.0 was used for univariate and bivariate analysis. Student *t* and analysis of variance were used to test the relationship between qualitative and quantitative variables. For relationships between qualitative variables, a chi-square test was used, along with its Yates correction if necessary. Nonparametric equivalents were considered when required by sample distribution.

Lifetime experience of IPV victimization was compared by gender, diagnosis, comorbidity with PTSD, history of childhood abuse, number of hospital admittances in the last 2 years, and history of suicidal behavior. Statistical significance was set at $p < 0.05$.

RESULTS

Sample Description

Of 102 patients recruited, 54 (52.9%) were men, 56 (55.4%) were legally disabled, and 54 (52.9%) were single at the time of the study. The mean (SD) age was 39.4 (10.4) years and the most common

TABLE 2. Demographic and Clinical Characteristics of the Sample

			Lifetime IPV Victimization		
		Total Sample	**No**	**Yes**	***p***
Demographic characteristics					
Age, mean (SD)		39.4 (10.4)	39.19 (10.5)	40.12 (10.2)	0.698
Gender	Female	48 (47.1)	31 (64.6)	17 (35.4)	**0.016**
	Male	54 (52.9)	46 (85.2)	8 (14.8)	
Marital status	Single (never married)	54 (52.9)	44 (81.5)	10 (18.5)	0.087
	Separated, divorced, or widowed	18 (17.8)	10 (55.6)	8 (44.4)	
	Married	29 (28.7)	22 (75.9)	7 (24.1)	
Employment status	Disabled	56 (55.4)	43 (76.8)	13 (23.2)	0.054
	Employed	22 (21.8)	14 (63.6)	8 (36.4)	
	Unemployed	16 (18.8)	14 (87.5)	2 (12.5)	
	Other	7 (6.9)	5 (71.4)	2 (28.6)	
Educational level	No basic studies completed	45 (44.1)	35 (77.8)	10 (22.2)	0.063
	Basic studies or higher	57 (55.9)	42 (73.7)	15 (26.3)	
	No	53 (52.5)	47 (88.7)	6 (11.3)	
Clinical characteristics					
Diagnoses	Schizophrenia	52 (51.0)	40 (76.9)	12 (23.1)	0.397
	Bipolar disorder	40 (39.2)	28 (70)	12 (30)	
	Schizoaffective disorder	10 (9.8)	9 (90)	1 (10)	
Lifetime suicide attempt history	Yes	39 (38.2)	26 (33.8)	13 (52)	0.103
	No	63 (61.8)	51 (66.2)	12 (48)	
Number of suicide attempts, mean (SD)		0.91 (1.9)	0.92 (2.1)	0.88 (1.3)	0.925
Posttraumatic stress disorder	Yes	14 (15.1)	10 (14.5)	4 (16.7)	0.751
	No	79 (84.9)	59 (85.5)	20 (83.3)	

Bold value indicates statistically significant comparison, $p < 0.05$.

TABLE 3. Lifetime IPV Victimization by IPV Types and Gender

	Gender			
Lifetime IPV Victimization	**Female, *n* = 48 (47.1%)**	**Male, *n* = 54 (52.9%)**	**Total, *N* = 102 (100%)**	***p***
Physical	13 (27.1)	8 (14.8)	21 (20.6)	0.126
Psychological	7 (14.6)	2 (3.7)	9 (8.8)	0.08
Sexual	4 (8.3)	0 (0)	4 (3.9)	**<0.05**
IPV of any kind	17 (35.4)	8 (14.8)	25 (24.5)	**0.016**

Bold values indicate statistically significant comparison, $p < 0.05$.

diagnosis was schizophrenia (51%). Complete demographic and clinical data are presented in Table 2.

Global Estimates of IPV Victimization

At least one lifetime episode of IPV victimization of some kind (physical, psychological, and/or sexual) was reported by 25 patients (24.5%). Physical abuse was the most frequent report (21 patients, 20.6%), followed by psychological abuse (9 patients, 8.8%) and sexual abuse (4 patients, 3.9%). Some of the victims had experienced multiple types of IPV.

No significant differences in IPV victimization were detected on the basis of age, marital status, employment status, or educational level. Differences based on gender were significant, as detailed in Table 3.

IPV Victimization and Gender

Of the 25 victimized patients, 8 (32%) were men and 17 (68%) were women. Over the total sample, these figures represent 14.8% of male patients and 35.4% of female patients (odds ratio [OR] = 3.15, $p = 0.016$). All types of IPV victimization were more frequent in women, although only sexual violence was statistically significant in comparisons by gender ($p < 0.05$) (Table 3).

IPV Victimization and Childhood Trauma

In our sample, 48 patients (47%) declared having experienced some kind of abuse during childhood, and 29 patients (28%) reported having witnessed domestic violence at home. Patients with a history of childhood abuse were found to be significantly more likely to have experienced IPV than patients without a history of childhood abuse (37.5% *vs.* 11.3%; OR = 4.7, $p = 0.002$) (Table 4).

IPV Victimization, Diagnosis and Suicidality

A transdiagnostic distribution pattern was observed for IPV victimization: no statistically significant differences were found based on the patients' main diagnosis (schizophrenia, bipolar disorder, schizoaffective disorder; $p = 0.397$) (Table 2). Similar PTSD rates were observed in IPV victims and nonvictims. PTSD criteria were met by 10 (14.5%) participants in the nonvictimized group and 4 (16.7%) participants in the victimized group ($p = 0.751$) (Table 2).

Conversely, differences were detected between patients exposed and patients unexposed to IPV victimization regarding suicidal behavior (Table 2). Among patients not exposed to IPV victimization, 26 (33.8%) had engaged in suicidal behavior at least once in their lifetime, compared with 13 (52%) of the patients with a history of IPV victimization. Comparison was not statistically significant ($p = 0.103$).

DISCUSSION

The findings presented here are in line with current literature reporting increased rates of childhood and domestic violence exposure in patients diagnosed with SMD, compared with the general population. Both the IPV victimization prevalence and the associated gender differences found in this study are similar to previously reported rates in patients with SMD on an international level (Khalifeh et al., 2015; Oram et al., 2013).

To the best of our knowledge, this is the first study of these characteristics in our geographical setting of Catalonia (Spain). In our setting, lifetime IPV victimization was significantly lower and the increased likelihood of IPV victimization was considerably greater in patients with a history of childhood abuse than previously reported for several other areas of Spain by González Cases et al. (2014). Our results shed light on the lives of outpatients from non-urban or semi-urban areas, whose situation may differ from those attended in the first-level hospitals in large urban areas where most of the clinical and epidemiological research is usually conducted.

Our study suggests a remarkable and transdiagnostic prevalence (1 out of 4 patients) of lifetime IPV victimization in persons living with SMD in our area. Female gender and childhood trauma significantly increase the likelihood of IPV victimization. We have also pointed to a link between IPV victimization and suicidal behavior that is likely to have clinical relevance, despite not achieving statistical significance in our study. This observation supports the idea that IPV victimization influences clinical prognosis in patients diagnosed with SMD. Conversely, as we discuss below, PTSD comorbidity is not significantly increased among IPV victims.

Several etiopathogenic frameworks could help explain the results presented in this work, including diathesis of the trauma, psychosocial vulnerability to revictimization, and intersectional gender theory.

Our results suggest a strong prevalence of IPV victimization in those diagnosed with SMD, particularly in women who were abused during childhood. This might be of interest for healthcare systems (and particularly mental health services) to be more responsive, proactive, and intersectionally gender-sensitive in the prevention, detection, and management of IPV in patients diagnosed with SMD.

TABLE 4. Lifetime IPV Victimization by Childhood Abuse History

	Childhood Abuse History			
Lifetime IPV Victimization	**No, *n* = 53 (52.5%)**	**Yes, *n* = 48 (47.5%)**	**Total, *N* = 101 (100%)**	***p***
No	47 (88.7)	30 (62.5)	77 (75.5)	**0.002**
Yes	6 (11.3)	18 (37.5)	24 (23.8)	

Bold value indicates statistically significant comparison, $p < 0.05$.

Moreover, efforts to avoid revictimization within the healthcare system should be considered a matter of utmost importance. It is known that protocols and guidelines on how to detect and address IPV in mental health patients are inconsistent and not always available. That being said, it is essential that healthcare systems take deliberate precautions to avoid paternalism and find ways to detect and address IPV in patients diagnosed with SMD that will empower patients to adopt and maintain self-protective behaviors and regain control over their own life choices. We encourage further research on alternatives to negationist, paternalistic, and other problematic approaches to IPV in mental healthcare settings.

Our finding that PTSD comorbidity rates are similar in people diagnosed with SMD who have undergone a history of IPV victimization and those who have not might seem surprising. Many factors could account for this result. As we have mentioned previously (Alvarez et al., 2012), an overlap between posttraumatic and psychotic symptoms is likely to exist, particularly in long-term clinical experiences of PTSD and SMD. For instance, some patients might find it hard to distinguish between posttraumatic flashbacks and positive psychotic symptoms such as hallucinations or between posttraumatic numbing and negative psychotic symptoms such as affective flattening. This, along with the strict DEQ criteria for the establishment of a PTSD diagnosis, might explain underdiagnosis of PTSD in patients with severe psychotic symptoms, such as those diagnosed with SMD. Our study design, which specifically assesses experiences of IPV victimization regardless of the coexistence of other forms of traumatic experiences, could also contribute to the observed results.

Our study has several limitations, most of which are related to its cross-sectional design. The study design used does not allow for a longitudinal analysis of IPV and SMD, as we only obtained a lifetime prevalence of IPV victimization. Similarly, suicide attempts ending up in death cannot be valued in a cross-sectional study like ours, opposite to what would happen in a prospective design. It might be arguable that known differences in the degree of lethality of self-harming behavior might have affected the study results. Cross-sectional studies are also vulnerable to potential biases such as recall bias, although methodological action was taken to prevent its effects, that is, use of standardized psychometric tools.

In addition, it shall be mentioned here that the scope of our study did not include a comprehensive analysis of IPV victimization among patients with SMD, nor was it conceived from a specific gender perspective. Moreover, nonbinary gender identities and intimate partner configurations different from normative monogamous heterosexual couples could not be analyzed because patients were not asked about the gender(s) of their partners and the TLEQ does not request this information.

Despite these limitations, the results obtained are relevant from a clinical point of view. Given the high prevalence of IPV victimization in SMD and its strong association to childhood trauma, we recommend systematic screening of history of childhood and intimate partner abuse in patients diagnosed with SMD.

Further research is needed to study IPV characteristics in the LGBTIQ+ population and to expand our knowledge of the etiopathogenic frameworks (trauma diathesis, psychosocial vulnerability to revictimization, and intersectional gender theory) that could help mental health services identify or decrease IPV risk among patients with SMD.

CONCLUSIONS

Patients diagnosed with SMD showed a remarkable prevalence (24.5%) of self-reported lifetime history of IPV victimization, with statistically significant differences by gender (14.8% in men *vs.* 35.4% in women) and history of childhood abuse (11.3% in patients with no such history *vs.* 37.5% in patients reporting abuse). Our research therefore suggests that gender, childhood trauma, and SMD might be relevant factors in IPV analysis and prevention.

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DISCLOSURE

The authors declare no conflict of interest.

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