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RESEARCH ARTICLE

Psychological symptoms and intensity of partner violence: A study of women attending an anti-violence center in Italy

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ABSTRACT

Intimate partner violence (IPV) can seriously affect the health of victims. Our aims were to analyze the impact of IPV intensity on psychological symptoms in a sample of 151 victimized women (21–74 years old). We collected data through anonymous-auto-administrated questionnaires from a sample of women attending five Anti-violence centers in Italy, and assessed exposure to psychological, physical, sexual, verbal, and stalking partner violence in the last year. We used multiple logistic regression analysis to examine the probability of reporting psychological symptoms associated with IPV. After controlling for the potential confounders, the increase in the intensity of violence was associated with an increase in reported nightmares, panic attacks, and auditory hallucinations, with a dose–response effect. We think that understanding the impact of IPV on women's mental health is necessary to improve their psychological well-being, support their path to liberation, and prevent chronic and more serious suffering.

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Violence against women is a human rights issue and a global public health issue (WHO, 2013a). Many scholars have examined the consequences of violence, particularly from a partner or ex-partner, on women's psychological health; few, however, have considered certain types of violence, such as stalking, or some particularly disturbing symptoms, such as auditory hallucinations. Moreover, according to the WHO (2013b), health and social workers do not always fully recognize and understand the impact of violence on victims' health. The purpose of our research was to analyze the relationships between intensity of violence of the partner or ex-partner and some psychological symptoms in a sample of women victims of severe violence, who have turned to an Anti-violence center in Italy, and to bring some elements of reflection on the relationships between violence and health. We found strong associations between violence intensity and

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nightmares, panic attacks, and auditory hallucinations; in contrast, we found no association with depressive symptoms. This is a surprising result, which may pave the way for a better understanding of the relationships between violence and health in women who seek health or judicial services after experiencing severe partner' violence.

We carried out the study in Italy; however, our results seem to be in line with what has been found by other scholars in other countries and we think they may be useful not only to those who do research but also to those who work in health services alongside women victims of violence.

Background

Intimate partner violence (IPV) against women is widespread. Globally, the lifetime prevalence of physical or sexual IPV varies from 15% to 71% (Garcia-Moreno et al., 2006). In Europe, one in five women has experienced IPV, and 4% experienced it in the last 12 months (European Agency for Fundamental Rights, 2014). Other researchers in Europe found higher frequencies: among women in Finland, the prevalence of exposure to violence in close relationships during the past year was 7.6% (Hisasue et al., 2020).

Partner violence has a deleterious impact on victims' mental health: exposure to physical, sexual or psychological violence increases the likelihood of various mental health problems; the intensity of violence is often associated with the severity of symptoms (Dillon et al., 2013; WHO, 2013a). Depression is one of the more common consequences: in one of the first meta-analyses, Golding (1999) found a 48% weighted prevalence of depression among abused women. Other researchers confirmed the association between IPV and depression (Beydoun et al., 2012; Lövestad et al., 2017) and between IPV and post-traumatic stress disorder (PTSD) (Blasco-Ros et al., 2010; Chandra et al., 2009). In a large sample of women in the United Kingdom, women exposed to partner violence were three times more likely to have a serious mental illness than women not exposed (Chandan et al., 2020).

However, some symptoms or some types of violence are less studied. Hearing voices is a relatively common type of hallucination (Vellante et al., 2012) and is usually distressing for people who experience it (Romme & Escher, 2000). Yet, few scholars have explored the impact of IPV on this symptom. Shevlin et al. (2013) found an association between physical and psychological IPV and psychotic-like experiences, but sexual violence or stalking was not considered. Stalking is a frequent type of IPV. In Europe, for instance, 9% of women had been stalked by their previous partner (European Agency for Fundamental Rights, 2014), but few researchers

have analyzed the links between stalking and women' psychological symptoms (Basile et al., 2004; Mechanic et al., 2008). Stalking often continues after the woman has left the violent partner (Kelly et al., 2014; Pomicino et al., 2019), which may explain in part the lingering mental health problems in women well after the ending of the relationship (Estefan et al., 2016; Ford-Gilboe et al., 2009).

In addition, researchers have rarely taken all socio-demographic variables into account (Devries et al., 2013); for example, although post-separation violence is frequent (Pomicino et al., 2019), they rarely included in the analysis the status of the couple (cohabiting/non-cohabiting).

We can understand the links between IPV and mental health by considering what are the very characteristics of this violence. Physical or sexual aggression or violent scenes can be traumatic; psychological abuse, including denigration and humiliating situations as well as partners' manipulative or controlling behaviors can adversely affect women's self-esteem, feelings of control, and sense of reality. Isolation, a sense of entrapment, and fear of the perpetrator can contribute to women's feelings that they are "losing their mind" (Herman, 1992; Stark, 2007). These situations can lead to more specific emotional states, which can be interpreted as symptoms of mental illness (WHO, 2013a). Women interviewed in qualitative studies say that because their perceptions of reality are constantly challenged by their partner' behavior, they find it increasingly difficult to trust their own perceptions of events (Jaquier & Sullivan, 2014). In the end, many fear they "are going crazy" (Pain, 2012). When professionals working with victims are not knowledgeable about the nature and consequences of IPV, they may not recognize the links between violence and psychological suffering (WHO, 2013a), which has serious consequences: women can be regarded as paranoid or poorly credible when disclosing the violence or as unreliable in caring for children (Hager, 2001; Jeffries, 2016; Zaccour, 2018).

Context of the study

According to the 2014 European survey, in Italy, 19% of women experienced physical or sexual IPV during their adult lives: 9% stalking and 38% multiple psychological abuse (European Agency for Fundamental Rights, 2014). Anti-violence centers (AVCs) are services dedicated to victims of violence and are based on the principle of women's autonomy and empowerment. They are operated by female advocates (UN Women, 2010) who work to support women in their journey out of violence. They offer counseling, legal advice, advocacy and shelter in lodgings with a secret address (D.i.Re, 2017). Women who seek the services of an AVC have

experienced high levels of both violence and psychological distress (Pallotta et al., 2014), a trend also found in other countries (Ferrari et al., 2014; Karakurt et al., 2014). These women represent a minority of those experiencing some form of partner violence (Istat, 2015), but we lack data for IPV victims according to whether they go to an AVC or not.

Researchers' aims

Our aims were to analyze the links between the types and intensity of partner violence and the prevalence of psychological health symptoms among victims of IPV attending an AVC in Italy.

Materials and methods

Procedure

We involved five AVCs in the north of Italy: all women coming to these AVCs between February and November 2015 were eligible for inclusion. At each center, the advocates asked the women if they wanted to participate in a study on women's health and explained that the questionnaire was anonymous and self-administered and that the women were free to refuse to take part. We asked women to give their written informed consent before presenting the questionnaire. Researchers trained the advocates in the procedure and met them regularly to discuss any problems and collect the questionnaires. The ethical committee of the first author's university approved the study.

Measures

We developed a questionnaire designed to investigate: socio-demographic information (age, number of children, nationality, level of education, employment, and living with the violent partner or not), partner violence, and women's psychological symptoms.

Intimate partner violence (IPV)

To assess violence during the last year, we used questions from the 2014 European survey (European Agency for Fundamental Rights, 2014). We added one item to the psychological violence scale ("threatened to kill himself") and one to the stalking scale ("made a scene at your workplace"). We asked women to report psychological violence (15 items), physical violence (nine items), sexual violence (five items) and two types of stalking (offensive or threatening communications [five items] and following, loitering or damage to property [four items]). Possible answers were "never,"

"once," "two to five times," and "more often." We developed one synthesis variable with three levels of violence experienced for psychological and physical abuse and a yes/no category for sexual abuse and stalking.

We created a global indicator of IPV, adding the score for all types of violence considered. We re-coded the continuous variable into three levels: 1, low; 2, intermediate; and 3, high.

Psychological health

We measured psychological health symptoms with four variables.

Nightmares and symptoms of panic attack

We used two indicators taken from the national survey on violence against women in France (Jaspard et al., 2003). We asked women whether during the last month they had nightmares or panic attacks defined as "occurrences of intense fear or discomfort, sometimes accompanied by palpitations, sense of suffocation, nausea, and fear of losing control or dying." Possible answers were "no," "1 or 2 times," or "more often" and were re-coded as no/yes.

Auditory hallucinations

To assess symptoms of psychotic experiences, we asked women to indicate whether during the last month they "had ever heard voices or sounds that no one else can hear." This question has demonstrated excellent predictive value for clinically verifiable psychotic symptoms (Kelleher et al., 2013). Possible answers were "no," "1 or 2 times," or "more often" and were re-coded as no/yes.

Depressive symptoms

We assessed depressive symptoms in the last month with the General Health Questionnaire (GHQ, Goldberg, 1972) in its 12-item version. Piccinelli and Simon (1997) internationally validated this scale. Other researchers used it in Italian studies on violence against women (Romito et al., 2005), and established that a score of ≥4 suggests potential psychological distress needing clinical attention (Vellante et al., 2012). To select more seriously distressed women, we choose a cutoff of >8 positive answers, and created a two-category variable: not depressed (score ≤ 8), depressed (>8).

Data analysis

We conducted analyses only for women who were victims of partner/ex-partner violence (IPV). We used descriptive analyses to determine the

frequency of IPV and women's psychological symptoms, and Chi-square test to investigate the association between the types of violence and symptoms. We conducted multivariate logistic regression analyses to estimate the magnitude of risk of each of four symptoms related to violence, taking into account potential confounders (women's age, having children, living or not with the perpetrator, education, employment, nationality, and the AVC), and estimated Odds ratios (ORs) and 95% confidence intervals (CIs). We defined statistical significance at $p < 0.05$. Because of missing data, the numbers shown in tables may vary slightly. We performed data analysis with SAS v9.4.

Results

Characteristics of the research participants

Overall, AVC advocates asked 179 women to participate, and 178 agreed. Because of a high proportion of missing values, authors decided to discard 13 questionnaires, one because the informed consent form was lacking. In total, 13 women reported violence from a perpetrator other than a partner/ex-partner and were excluded. Our analysis involved data from 151 questionnaires.

In Table 1, we present the characteristics of participants and the indicators of partner violence. Women's age ranged from 21 to 74 years, almost half being 40–49 years old; 84% were Italians; 34% had low educational level (66% had a high school diploma or a higher education); 70% were employed; 84% had children; and 38% were living with the violent partner.

All types of IPV in the last year were frequent: 73% of women reported physical violence and 43% sexual violence; all had experienced psychological abuse, of high intensity for 42%. More than 60% of women reported stalking. According to the global indicator of IPV, 27% of respondents experienced a relatively low level of violence (category 1); 48% had experienced category 2 violence and 24% category 3 violence, which indicates a high level of violence.

Psychological symptoms and association with types and intensity of partner violence

At the time of the survey, one quarter of women presented high levels of depressive symptoms. More than 60% of them reported nightmares and symptoms of panic attacks during the last month; 16% were "hearing voices" (Table 2).

Each type of violence and the global indicator were strongly associated with the prevalence of nightmares (Table 2). Except for verbal stalking, we found the same trend for hearing voices. In both cases, we observed a

Table 1. Sociodemographic characteristics of women and types of intimate partner violence (IPV) in the last 12 months (n = 151).

	N	%
Age *(years)*		
21–29	18	12.0
30–39	36	24.0
40–49	72	48.0
50–74	24	16.0
Nationality		
Italian	127	84.1
Non-Italian	24	15.9
Educational level		
High school or higher	100	66.2
Lower	51	33.8
Occupational status		
Employed	105	69.5
Not employed	46	30.5
Couple status: Lives with the perpetrator		
Yes	55	37.7
No	91	62.3
Children		
None	24	15.9
1	54	35.8
≥2	73	48.3
IPV in the last 12 months		
Physical violence		
None 0	40	26.8
Intermediate 1	71	47.6
High 2	38	25.5
Sexual violence		
No	83	57.2
Yes	62	42.8
Psychological violence		
Low 1	42	28.2
Intermediate 2	45	30.2
High 3	62	41.6
Stalking—communication		
No	45	30.2
Yes	104	69.8
Stalking—physical		
No	56	38.4
Yes	90	61.6
Global indicator of IPV		
Low 1	41	27.2
Intermediate 2	73	48.3
High 3	37	24.5

[a]Numbers may slightly vary due to missing values for some variables.

gradient: the more intense the violence, the more frequent the symptoms. When exposed to a high level of IPV (level 3), 68% of women reported nightmares in the last month and 30% hearing voices.

With increasing intensity of each type of violence, symptoms of panic attacks were more frequent, but the association was significant for only the global indicator of IPV, with 76% of women exposed to level 3 violence reporting panic symptoms. Depressive symptoms (GHQ-12 score >8) were not associated with the intensity of any type of violence.

In Table 3 we present the association of the indicators of psychological symptoms by the global indicator of partner violence adjusted for

Table 2. Prevalence of psychological symptoms by type of IPV in the last 12 months.

	Psychological symptoms			
	Nightmares[a]	Panic attacks[a]	Hearing voices[a]	Depression GHQ-12 score >8[b]
	(N) %	(N) %	(N) %	(N) %
Total	(150) 60.7	(151) 62.9	(151) 15.9	(151) 25.8
Physical violence				
None 0	(40) 40.0	(40) 55.0	(40) 10.0	(40) 17.5
Intermediate 1	(71) 70.4	(71) 63.4	(71) 9.9	(71) 26.8
High 2	(37) 64.9	(38) 73.7	(38) 34.2	(38) 31.6
P value	*0.01*	*0.23*	*0.01*	*0.34*
Sexual violence				
No	(83) 50.6	(83) 56.6	(83) 9.6	(83) 24.1
Yes	(61) 73.8	(62) 69.4	(62) 24.2	(62) 29.0
P value	*0.01*	*0.12*	*0.02*	*0.50*
Psychological violence				
Low 1	(42) 42.9	(42) 52.4	(42) 4.8	(42) 19.0
Intermediate 2	(45) 68.9	(45) 60.0	(45) 15.6	(45) 26.7
High 3	(61) 68.8	(62) 72.6	(62) 24.2	(62) 29.0
P value	*0.01*	*0.10*	*0.03*	*0.51*
Stalking—verbal				
No	(45) 33.3	(45) 53.3	(45) 13.3	(45) 22.2
Yes	(104) 72.1	(104) 66.4	(104) 17.3	(104) 26.0
P value	*<0.001*	*0.13*	*0.54*	*0.63*
Stalking—physical				
No	(56) 39.3	(56) 58.9	(56) 7.1	(56) 26.8
Yes	(90) 74.4	(90) 66.7	(90) 22.2	(90) 25.6
p	*<0.001*	*0.34*	*0.02*	*0.87*
Global indicator of IPV				
Low 1	(41) 31.7	(41) 48.8	(41) 7.3	(41) 24.4
Intermediate 2	(72) 73.6	(73) 64.4	(73) 13.7	(73) 26.0
High 3	(37) 67.6	(37) 75.7	(37) 29.7	(37) 27.0
P value	*<0.001*	*<0.05*	*0.02*	*0.96*

GHQ-12: General Health Questionnaire 12-item.
Numbers may slightly vary due to missing values.
[a]Last month.
[b]At the time of the survey.
P value = comparison of percentages by Pearson's chi-square test.

confounders: women's age, having children, couple situation (living or not with the perpetrator), education, employment, nationality, and the AVC. After adjustment, three indicators of poor psychological health were associated with the global indicator of violence: when exposed to a high level of IPV (level 3), women were more likely to have nightmares (OR 4.41, 95% CI 1.46–13.36), symptoms of panic attacks (OR 3.72, 95% CI 1.14–12.06), and auditory hallucinations (OR 4.86, 95% CI 1.05–22.48) as compared with women at level 1. Feelings of depression were not associated with the global indicator of IPV.

Discussion

The women in this study who experienced IPV presented a high level of suffering and a high frequency of psychological symptoms. A true comparison with the prevalence of these symptoms in the general

Table 3. Multivariate logistic regression analysis of the association of psychological symptoms with global indicator of IPV in the last 12 months.

	Psychological symptoms			
	Nightmares[a]	Panic attacks[a]	Hearing voices[a]	Depression GHQ-12 score >8[b]
	aOR[c] [95% CI]	aOR[c] [95% CI]	aOR[c] [95% CI]	aOR[c] [95% CI]
	N = 144	N = 145	N = 145	N = 145
Global indicator of IPV				
Low 1 (reference)	1	1	1	1
Intermediate 2	6.54 [2.44–17.49]	2.55 [0.96–6.74]	1.34 [0.31–5.81]	1.08 [0.37–3.14]
Higher 3	4.41 [1.46–13.36]	3.72 [1.14–12.06]	4.86 [1.05–22.48]	1.17 [0.34–3.99]
P value	p < 0.001	p = 0.07	p = 0.04	p = 0.97

[a]OR [95% CI]: adjusted odds ratio [95% CI]; GHQ-12: General Health Questionnaire 12-item.
N indicates the number of women included in each multivariate logistic regression model.
[a]Last month.
[b]At the moment of the survey.
[c]Adjustment for age as continuous variable; women's education, employment, couple situation as a 2-class variables; number of children as a 3-class variable, nationality, and center as a 5-class variable by logistic regression models.
P-value from Wald's chi-square test calculated by multivariate logistic regression model.

population is not possible given the differences in methods and instruments. However, data from an Italian study of a non-clinical sample of young adults (Vellante et al., 2012) can help in understanding the seriousness of psychological distress in this sample of women accessing an AVC. As we did, Vellante et al. (2012) used the GHQ-12 (Goldberg, 1972) and found that 33% of women gave ≥4/12 "depressive" answers; in our sample, 26% of women gave ≥8/12 "depressive" answers. In the Vellante et al. study, less than 5% of respondents (sex not specified) reported auditory or visual hallucinatory experiences; in our sample, 16% of women reported "hearing voices." Other researchers confirm these trends: in a sample of women seeking help from domestic violence support services in the United Kingdom, the mean psychological distress score was almost four times higher than in women in the general population (Ferrari et al., 2014).

Our data show that each type of IPV and the global IPV index were associated with nightmares, panic attacks, and auditory hallucinations, with a clear gradient: with an increase in IPV, the rate of symptoms increased. In the group of women with a high score (level 3) on the global indicator of violence, representing one quarter of the sample, 68% had nightmares, 75% had panic attacks, and 30% were hearing voices. We found these associations after controlling for several socio-demographic factors. Hearing voices, in particular, was more frequent among women with a high score (level 3) on the global IPV indicator than women with the lowest score.

Other researchers have found links between violence and PTSD (including nightmares and panic attacks) (Coker et al., 2002; Mechanic et al., 2008), with a dose–response effect (Basile et al., 2004; Chandra et al.,

2009; Ferrari et al., 2014), but only a few researchers considered psychotic symptoms. Boyda et al. (2014) and Shevlin et al. (2013) found strong associations between some types of IPV and auditory hallucinations. We believe that from a clinical perspective, having data on distinct symptoms is useful to help women recognize the effect of the context of life on their psychological wellbeing. Auditory hallucinations can be alarming for those who experience them. Out-reach messages from authoritative sources such as the British National Health Service present hallucinations as a sign of mental illness, without mentioning the possible association with aggression, threats, manipulation, or constant fear occurring in real life (NHS, 2019). For these reasons, we think that the links between this symptom and the intensity of partner violence should be discussed with women victims of IPV and with the professionals who work with them.

In this study, one in four women reported a high percentage of depressive symptoms, yet we found no association with the specific types of violence and these problems or with the levels of the global IPV indicator. Several researchers established links between IPV and women's depression (Beydoun et al., 2012; Chandra et al., 2009; Dillon et al., 2013). In a national sample of French women, Jaspard et al. (2003) found a dose–response effect: with increasing exposure to partner physical violence, the rates of depressive symptoms increased.

Depression among battered women has been found to be chronic, with symptoms continuing to exist over time (Mechanic et al., 2008). In our sample of severely victimized women, depressive symptoms may have been less influenced by recent than older violence. In Italy, Bastiani et al. (2018) showed that, before attending an AVC, most women had already and actively sought help from various sources. We also drew our sample from a population of women attending an AVC: these women were in a process of actively seeking help to be free from violence, a behavior that could indicate that hopelessness and depressive feelings were kept, at least at the time, at bay. In a sample of American Latino women from primary care services, Fedovskiy et al. (2008) found no significant association between a history of IPV and depression. These authors postulated that the high baseline levels of depressive disorder among the women interviewed could be a potential confounder that masked any significant effects of IPV. In their review of the literature on the associations between IPV and women's health, Dillon et al. (2013) cautioned that there is a bias toward publication of papers showing significant results rather than those that support the null hypothesis. We think that it is important to show our results on the lack of significant association between type and intensity of IPV and women's depression.

The psychological suffering of women victims of violence is a sensitive issue: on the one hand, despite all the research on the subject, survivors of IPV experience significant barriers in receiving the necessary healthcare

support they often require, one of the barriers being the identification of IPV in women attending health services (Chandan et al., 2020; WHO, 2013b). On the other hand, there are indications that some magistrates have a model of the IPV victim, passive and distressed, which may not correspond to women who seem to not have major depressive features (Creazzo, 2013). In these cases, the links between IPV and psychological distress may be unseen or misunderstood, and women are in danger of being deprived of the health care they need and the justice they deserve.

Limitations and strengths

We think that the main limitation of this study is the inability to generalize the results to women who are victims of IPV but do not have access to AVCs, a limitation shared with other similar studies (Estefan et al., 2016; Ferrari et al., 2014; Pomicino et al., 2019). The size of the sample was relatively small; however, quantitatively investigating this population of severely victimized women is difficult, and we think that we achieved this goal satisfactorily. One of the strengths is that the study was multicenter, and the sample included a great diversity of individual and contextual situations. The response rate was good, and women completed the questionnaires carefully: only one woman in 179 refused to participate and researchers discard only 13 questionnaires because they were incomplete. We assessed IPV with detailed questions, including about verbal and physical stalking, taken from an international survey (European Agency for Fundamental Rights, 2014). We collected women' social characteristics, which allowed for adjusting our estimates for these factors, and evaluating ORs free from the effects of potential confounding factors. Among the psychological symptoms, we included auditory hallucinations: we think that it was important to show the gradient-like associations between intensity of IPV and this frightening, psychotic-like symptom. It was also important to discuss the counter-intuitive finding on the lack of associations between IPV and depressive symptoms and its implications. In addition, this is one of the few studies of the links between IPV and women's psychological health carried out in a southern European country.

Conclusions

Our results provide further support for the dose–response association between IPV and several women's psychological symptoms, including auditory hallucinations. At the same time, they allowed us to draw attention to the absence of associations between violence intensity and depression in this sample of severely victimized women. When professionals working with victims of

violence are not aware of the nature of IPV and its consequences, they may miss or misunderstand the links between psychological symptoms, women's behaviors, and the intensity of violence. Understanding the impact of IPV on women's mental health is necessary to support their path to liberation, improve their psychological health and prevent more chronic and serious suffering.

Acknowledgements

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Compliance with ethical standards

Written informed consent was obtained from all participants before presenting the questionnaires. The study was conducted with the approval of the ethical committee of the University of Trieste (24/3/2015).

Disclosure statement

There are no conflicting interests.

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