Domestic violence has been shown to be associated with a range of mental health problems, including depression, post-traumatic stress disorder (PTSD), suicidal ideation, substance misuse, functional symptoms, and the exacerbation of psychotic symptoms (Golding, 1999; Campbell, 2002; Neria et al, 2005; Trevillion et al, 2012). In this chapter we review literature on the prevalence of domestic violence among men and women with mental disorders and present evidence that suggests a bi-directional causal relationship between domestic violence and mental disorders. We focus largely on intimate partner violence among women, but where data are available we present findings on domestic violence perpetrated by other family members and violence among men.

The prevalence of domestic violence in people with mental disorders

Community-based and non-psychiatric healthcare surveys

A recent review of the international literature found that there is a high prevalence of intimate partner violence among men and women across all diagnostic categories of mental disorder (Trevillion et al, 2012). The median prevalence of lifetime intimate partner violence among women was reported as 45.8% among those with depressive disorders, 27.6% among those with anxiety disorders and 61% among those with PTSD. In relation to men, two high-quality studies reported a prevalence of lifetime intimate partner violence among men with depressive disorders (5.3% and 31.3%) and men with anxiety disorders (7.4% and 27%). One high-quality study also reported a prevalence of 7.3% for lifetime intimate partner violence among men with PTSD. The review found that there is a higher likelihood of experiencing adult lifetime partner violence among women with depressive disorders (odds ratio (OR)=2.77), anxiety disorders (OR=4.08) and PTSD (OR=7.34), compared with women without mental
disorders. Although it was not possible to calculate pooled odds for other mental disorders and for domestic violence among men, the reviewers found that individual studies reported increased odds of domestic violence for men and women across all diagnostic categories, including psychosis, with a higher prevalence reported for women.

Smaller studies, conducted in healthcare settings or with community samples, also contribute to knowledge in this area. For example, a study of 126 consecutive admissions to a French emergency care service examined domestic violence by an intimate partner or family member and reported a lifetime prevalence of 42.9% among men and women with depression (Lejoyeux et al., 2002). The majority of research, however, has focused particularly on the prevalence of intimate partner violence among women with depressive, anxiety and post-traumatic stress disorders. The majority of such studies have been conducted in the USA (Cascardi et al., 1995; Tolman & Rosen, 2001; Tuten et al., 2004; Chang et al., 2009; Cerulli et al., 2011) and other high-income countries, but a small number report on the prevalence of intimate partner violence among women with mental disorder in low-income countries. This evidence base makes it clear that intimate partner violence is a significant global public health problem which is consistently associated with an increased risk of mental disorders. A community-based survey conducted in Ethiopia, for example, found a prevalence of 71.9% for physical violence and a prevalence of 62.5% for sexual violence among women with depression (Deyessa et al., 2009). In Pakistan, a study of female primary care users found that 89.2% of women with depression and 89.5% of women with PTSD reported physical and psychological violence (Ayub et al., 2009), and a study of women attending gynaecology clinics with vaginal discharge found verbal and physical abuse was significantly greater among women with common mental disorders than among women without disorders (Khan et al., 2012).

Less evidence is available on the prevalence of intimate partner violence among people with psychotic disorders: in three studies among women with schizophrenia and non-affective psychosis the prevalence ranged from 41.7 to 83.3% (Danielson et al., 1998; Wong & Phillips, 2009; Friedman et al., 2011). Each of these study samples, however, included fewer than 25 women.

Psychiatric surveys that examine the relationship between mental disorders and violence victimisation (i.e. encompassing physical, sexual and emotional abuse regardless of the relationship between victim and abuser) also indicate that people with mental disorders are up to 11 times more likely to experience recent violence than the general population (Walsh et al., 2003; Teplin et al., 2005; Choe et al., 2008). People with mental disorders are also more likely to report recent violence than people with other disabilities (i.e. non-specific impairments and intellectual disability) (Hughes et al., 2012). A recent meta-analysis (Hughes et al., 2012) reported an increased risk of violence among men and women with mental disorders
(OR 3.86) compared with controls, although substantial heterogeneity was observed between risk estimates across studies. Psychiatric victimisation studies, however, rarely provide information about specific types and contexts of abuse (Maniglio, 2009), even if this information has been collected.

As people with mental disorders are more likely to be victims of violence in general, it is likely that those at risk of domestic violence may be at increased risk of suffering other forms of non-domestic violence. However, the hidden nature of domestic violence and the intimate relationship between the abuser and victim means that the violence is often more frequent and severe than other forms of abuse (Kropp et al, 2005).

**Psychiatric healthcare surveys**

A systematic review on the prevalence of domestic violence across psychiatric settings worldwide identified a median prevalence of lifetime intimate partner violence as 31.7% among female in-patients, 33% among female out-patients and 31.6% among males across mixed psychiatric settings (Oram et al, 2013). Most of the studies were, however, conducted with small numbers of service users who were recruited through convenience sampling. None of the studies identified in the review included a direct comparison with a general population, with those facing similar levels of socioeconomic deprivation or other clinical groups, making it difficult to draw conclusions on the extent to which mental health service users are at greater risk of domestic violence.

Few studies have examined the prevalence of domestic violence by non-intimate family members. A US study of 66 consecutive female admissions to a psychiatric in-patient service reported a lifetime prevalence (≥16 years of age) of 9.1% for physical violence by a father and 6.1% for physical violence by a brother (Bryer et al, 1987). A Swedish study conducted a comprehensive assessment of the prevalence of lifetime domestic violence among mixed psychiatric settings and attempted to survey, over the course of 1 week, all adult female users of psychiatric in-patient and out-patient services (Bengtsson-Tops et al, 2005). Self-administered questionnaires were completed by 1382 women, 25.6% of whom reported violence by a current partner, 23.1% by a previous partner and 11.1% by family members (experienced after 16 years of age).

In the UK, a study of female community mental health service users in south London found that 60% had experienced lifetime physical intimate partner violence and 40% of women reported injuries, with 15% reporting abuse in the previous year (Morgan et al, 2010). It is not yet clear to what extent there exist gender differences in the prevalence of domestic violence victimisation among people with severe mental illness but illnesses such as schizophrenia may increase the risk of becoming a victim for men as well as women.
The relationship between domestic violence and mental disorder

Multiple studies, conducted across a variety of countries and in a range of settings, suggest there is a high prevalence of intimate partner violence among women with mental disorder, and both men and women who are victims of intimate partner violence are at increased risk of experiencing mental disorders. This does not appear to be specific to certain disorders; studies (Golding, 1999; Campbell, 2007; Golinelli et al, 2009; Trevillion et al, 2012) have found associations with:

- depression
- anxiety disorders including post-traumatic stress disorder (PTSD)
- eating disorders
- bipolar disorders (I and II)
- psychotic disorders
- antenatal and postnatal mental disorders, and
- alcohol and substance misuse.

Research also suggests that there is a causal association between domestic violence and mental disorder. A systematic review found, for example, that the severity and duration of physical intimate partner violence is associated with the frequency and severity of depression, and rates of depression decrease as time since the cessation of violence increases (Golding, 1999). A review which examined PTSD among victims of domestic violence similarly reported that the extent, severity and type of abuse were associated with the intensity of post-traumatic stress symptoms (Jones et al, 2001). Although women’s experiences of physical, psychological and sexual abuse often overlap (Krug et al, 2002; Watts & Zimmerman, 2002), studies suggest that women who experience more than one form of abuse, or who are re-victimised, are at increased risk of mental disorder and comorbidity (McFarlane et al, 1998; Roberts et al, 1998; Jones et al, 2001; Romito et al, 2005; Tiwari et al, 2005; World Health Organization, 2013).

Mental disorder as a risk factor for domestic violence

The Dunedin Multidisciplinary Health and Development Study in New Zealand, a representative birth cohort study, found that psychiatric disorder can increase vulnerability to domestic violence (women who experienced abuse between the ages of 24 and 26 had reported significantly higher rates of major depression and substance misuse at age 18 than women in the same age group who had not been subjected to violence) and domestic violence was associated with an increased risk of psychiatric disorder among women at age 26 even after controlling for a history of
mental disorder (Ehrensaft et al., 2006). Data from the National Survey of Families and Households, a nationally representative US cohort, similarly suggest that women who experience domestic violence are more likely to report depressive symptoms after 5 years of follow-up (Zlotnick et al., 2006), whereas a pregnancy cohort study reported that antenatal violence was associated with postnatal depression (Ludermir et al., 2010).

There is also evidence that women with pre-existing mental disorders may experience an exacerbation of symptoms if they are victims of domestic violence (Neria et al., 2005). Mental disorder may increase vulnerability to domestic violence by increasing the likelihood of women being in unsafe relationships and environments (McHugo et al., 2005) and increase their vulnerability to violent victimisation (Briere & Jordan, 2004; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Indeed, research suggests that men and women with severe mental illness face 12 times the risk of violent victimisation (of all types) compared with the general population (Teplin et al., 2005).

Potential pathways linking intimate partner violence and psychiatric disorder include:

(a) the association of intimate partner violence with other factors linked with mental health difficulties (e.g. impairments in social functioning, use of medication and poor living conditions or co-occurring substance misuse);
(b) previous physical and sexual abuse (including witnessing domestic violence as a child and previous intimate partner violence);
(c) trauma-induced intrusive thoughts (leading to the modification of coping styles and subsequent maladaptive choices that bring about violence-related trauma).

Evidence that domestic violence is a causal factor in the development of mental disorder further underlines the importance of domestic violence as a public health issue. The calculation of population attributable fractions (PAFs) is one way of quantifying the public health implications of domestic violence. Population attributable fractions represent the proportion of mental disorders that can be attributed to exposure to domestic violence, based on an assumption of causality. The domestic violence-related PAF for postnatal depression, for example, was recently estimated to be 10% in a Brazilian population (Ludermir et al., 2010). An Australian study estimated domestic violence-related PAFs for women aged 18–44 years at 21% for major depression and 17% for anxiety (Vos et al., 2006). Similar estimates were also found among women in a South African population (Norman et al., 2010). Such estimates suggest that reducing the prevalence of domestic violence could contribute to a substantial reduction in the burden of mental disorder and lower health service costs; in England and Wales alone it is estimated that direct medical and mental healthcare costs for domestic violence exceed £1730 million per annum (Walby, 2009).
Impact of domestic violence on mental disorders

As highlighted earlier, people with mental disorders are at increased risk of violent victimisation, which is shown to be associated with the onset, duration and recurrence of mental disorders (Brown et al., 1994). However, chronic traumatisation among victims of domestic violence has been shown to result in greater levels of psychiatric symptomatology (Herman, 1992), as is outlined below.

Pico-Alfonso et al. (2006) compared three groups of women (non-abused, physically/psychologically abused and psychologically abused by their partners). They found that all the women who were subjected to physical violence also suffered from some form of psychological violence, with many also being sexually abused by their partners. The women exposed to physical/psychological and psychological abuse alone had a higher incidence and severity of depressive and anxiety symptoms, PTSD and thoughts of suicide than the control sample, with no differences between the two abused groups. Sexual violence was associated with a higher severity of depressive symptoms and a higher incidence of suicide attempts, whether the depressive symptoms were alone or comorbid with PTSD. State trait anxiety and thoughts of suicide were higher in abused women with depressive symptoms or comorbidity. Attempts at suicide were not, however, associated with specific symptomatology. This study, as do others (e.g. Jones et al., 2001; Coker et al., 2002; Romito et al., 2005), indicates that psychological violence can be as detrimental to mental health as physical violence. Perhaps surprisingly, exposure to psychological abuse can be more strongly and uniquely associated with PTSD symptoms than physical abuse (Taft et al., 2005).

The impact of domestic violence has been thought to have psychological parallels with the trauma of being taken hostage and subjected to torture (Dutton, 1992; Herman, 2001). Domestic abuse has been shown to have deleterious effects beyond other traumatic events. Research comparing Israeli women who had experienced domestic violence against women victimised by other traumatic events found that 52% of victims of domestic violence met the criteria for PTSD, and those reporting domestic violence experienced greater psychiatric symptomatology and suicide risk than those not reporting domestic violence (Sharhabani-Arzy et al., 2003).

Post-traumatic stress sequelae associated with domestic violence have undergone detailed examination in response to the complex presentation seen among victims exposed to extensive control and repeated assaults over a protracted period of time. Consequently, PTSD symptoms experienced by victims of domestic violence are seen to extend beyond the classic cluster of intrusive, avoidance and arousal symptoms to incorporate alterations in the victim’s relationship to self, distorted relations with others and loss of sustaining beliefs, which characterises complex traumatic stress syndrome (Herman, 2001). Additional key features of this presentation include pervasive personality disturbances, including borderline personality...
features (Pelcovitz et al, 1997). There is evidence to suggest that in some women alcohol and drug misuse is directly attributable to domestic abuse, as a manifestation of PTSD-avoidant dynamics (Campbell & Lewandowski, 1997; Campbell, 2007). Women who experience domestic violence are up to six times more likely to misuse or develop dependency on alcohol and drugs (Becker & Duffy, 2002; Golding, 1999).

Alongside managing psychiatric symptoms, victims of intimate partner violence are faced with multiple additional stressors associated with the violence, including (Jones et al, 2001; Rose et al, 2011):

- fear of further violence
- isolation and lack of social support
- mourning the loss of an intimate relationship
- concerns related to the welfare of their children
- concerns related to insecure immigration status
- fear of disruptions to family life/social networks/employment in the event of relocation
- fear of Social Services involvement and consequent child protection proceedings.

These factors also act as barriers to disclosure among victims of domestic violence when in contact with psychiatric services (Fig. 2.1, p. 25).

As will be outlined in Chapter 5, the chronic traumatisation experienced by victims of domestic violence highlights the need for trauma-based treatments, which are delivered in a context that addresses victims’ current needs and does not impede on their ability to utilise key sources of support and to establish physical safety (Johnson & Zlotnick, 2010).

**Conclusions**

There is a strong association between domestic violence and mental disorder, with evidence of bi-directional causality. Mental health services, in both primary and secondary care, should therefore ensure that domestic violence is identified to reduce risk of further violence, improve safety and potentially improve mental health.

The next two chapters discuss how to identify and respond to mental health service users who are victims of domestic violence.

**References**


Fig. 2.1 Service users’ barriers to disclosures of domestic violence (Source: Rose et al., 2011).


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