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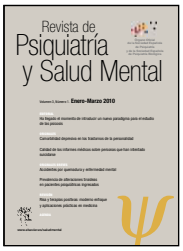

BRIEF REPORT

Violence Against Women in Mental Health Departments: is it Relevant for Mental Health Professionals?

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KEYWORDS
Mental health;
Public health;
Gender;
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Abstract
Introduction: Violence against women (VaW) directly influences their quality of life and mental health. Unfortunately, its influence may be ignored or underestimated by professionals attending these women.
Objectives: To describe a hospitalised sample of women suffering from emergent VaW who visited the mental health department for other reasons. To evaluate the degree of knowledge about VaW and interventions for VaW taken by health professionals.
Methods: We performed an observational, prospective study with systematic data collection on all cases of emergent and/or urgent VaW at the Corporació Sanitària Parc Taulí (Sabadell, Spain) from January-December 2004 and January-December 2006. The reference population consisted of 390,000 inhabitants, mostly urban and from the industrial and service sectors. A descriptive statistical analysis was performed.
Results: In the two study periods, 218 and 194 women, respectively, were attended for emergent and/or urgent VaW resulting in severe injures and/or medical and/or social assistance. Of these, up to 53 received or had received specialised mental health treatment. Most of these women (69.7%) withdrew from follow-up. We detected a high rate of comorbid abuse or dependence on alcohol (27.3%), benzodiazepines (33.3%) or other drugs, a high rate of suicide attempts (41.9%), and one successful suicide in these periods. VaW was explicitly registered in only 51.1% of the cases and a specific intervention for VaW was documented in only 15.2% of the cases.

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Conclusions: The prevalence of psychiatric and/or psychological disorders was very high in our sample, but the presence of VaW was not always specifically documented or treated.

PALABRAS CLAVE
Salud mental;
Salud pública;
Género;
Violencia de género

La violencia de género en la atención psiquiátrica y psicológica especializada: ¿es relevante la violencia de género para nuestros profesionales?

Resumen
Introducción: La violencia de género (VdG) influye directamente en la calidad de vida y la salud mental. Sin embargo, su influencia puede ser ignorada o desvalorada por los profesionales responsables.
Objetivos: Describir una muestra hospitalaria de mujeres que han padecido VdG emergente y se visitan por cualquier otro motivo en las consultas de salud mental. Determinar el grado de conocimiento o intervención de los profesionales.
Métodos: Diseño observacional. Realización: recogida prospectiva sistemática de casos de VdG emergente y/o urgente en la Corporació Sanitària Parc Taulí (Sabadell). Población de referencia: 390.000 habitantes, mayoritariamente urbanos y de predominio del sector industrial y de servicios. Periodos: enero-diciembre de 2004 y enero-diciembre de 2006. Estadística: descriptiva.
Resultados: Hasta 218 y 194 mujeres fueron atendidas durante estos periodos por episodios de VdG con resultado de lesiones y/o necesidad de atención médica y/o social emergente. De entre ellas, hasta 53 mujeres recibían o habían recibido en algún momento atención especialisada de salud mental. La gran mayoría (69,7%) abandonó el seguimiento. Se detectó una alta tasa de abuso o dependencia comórbido de alcohol (27,3%), benzodiacepinas (33,3%) y/u otras drogas y una alta tasa de antecedentes de intentos de suicidio (41,9%) y un suicidio consumado. Sólo en el 51,1% quedaba registrada explícitamente la VdG padecida. Sólo se documenta algún tipo de abordaje o intervención relacionado en un 15,2%.
Conclusiones: La prevalencia de enfermedad psiquiátrica y/o psicológica es muy alta en este grupo, pero la realidad de la VdG no siempre es documentada ni recibe un abordaje específico.

Introduction

Violence against Women (VaW) directly influences quality of life and mental health of the women who suffer it. It is, furthermore, well known, that persons with chronic mental disease suffer more violence than the population in general, among these, women with mental disease suffer more gender violence than those who do not have mental disease.[1] Moreover, chronic or specific situations of gender violence may trigger or worsen a previous disease or mental disorder.[2,3] This same prevalence or the influence of violence suffered by women in the course of mental disease may be ignored or devalued by mental health professionals who care for these women.[4-6] There is little data on these aspects in our state and there are many unknown facts related to this issue . Our question would be: Are professionals in our environment aware of this gender violence against women, and the consequences on the evolution and care of these women, who are usually treated when coming in to consultation for other reasons? Furthermore, does this situation affect the therapeutic approach used?

Objectives

On one hand, we describe a hospital sample of women who have suffered VaW, leading to an emergency hospital intervention, and who are attended by the specialised mental health services for any other reasons. On the other hand, we determine the degree of awareness on the part of the health professionals of this situation and the measures taken in consequence.

Material and Method

To achieve our objectives, we designed a simple study based on transverse and longitudinal observation methods. On one hand, we systematically reviewed all the cases of gender violence emerging and/or dealt with by the Emergency Service during two specific periods, between January and December 2004 and between January and December 2006, at the Corporació Sanitària Parc Taulí de Sabadell hospital within the Social-Medical Care Protocol for Gender Violence of our hospital. Then, we separated

the women who were directly by the psychiatric services at our hospital and we carried out an analysis of the evolution and diagnosis of these women in our mental health service during this period. We reviewed previous and subsequent data to emergency intervention due to gender violence and examined any document, reports or written referral related to the process.

Our reference is a population of 390,000, mostly urban and with a predominance of industry and service sectors. A growing number of immigrants were detected, with a wide cultural and social diversity. It must be kept in mind that the women attended do not represent all cases that took place during this period in our population, only those attended in our hospital Emergency Service and detected as such, since other cases could have been seen at primary care centres and another undetermined percentage of cases could have escaped detection by the emergency professionals for a variety of reasons. Data was anonymous to guarantee confidentiality at all times. Only descriptive statistical methods were used, means, standard deviations and percentages using the SPSS 14 program.

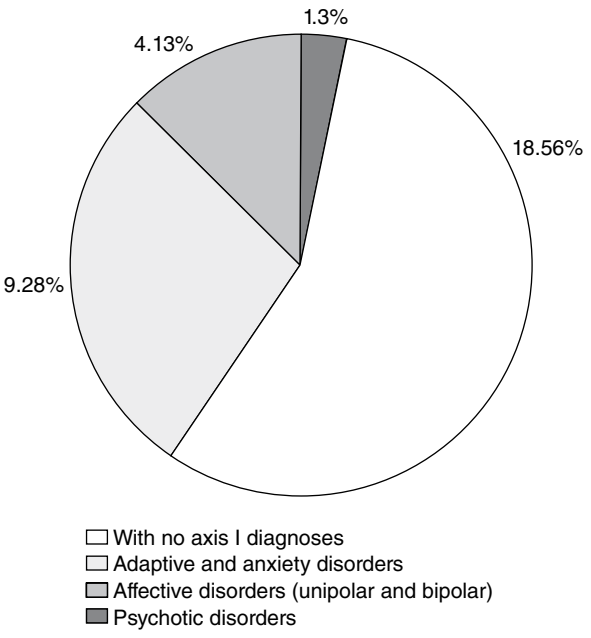

Figure 1 Axis I diagnoses.

Results

From January to December 2004 we attended, in our Hospital, 218 women due to VaW episodes and between January and December 2006, 194 women due to VaW. They presented injuries and/or required medical attention and/or social emergent and/or emergency care. In all cases there was severe physical damage, with resultant injuries of diverse degrees of severity. All of these cases were included in the Social-Medical Care Protocol for Gender Violence of our Hospital and subsequently received at least one social follow-up in our external consulting offices. Of all these, up to 53 women (24.3% or 26.8%, according to the period studied) were receiving or had received at some point in time specialised psychiatric or psychological attention in our consulting offices. It is possible that other women received psychological or psychiatric care through private professionals, primary care physicians or the Centre d'Atenció a la Dona del Ayuntamiento de Sabadell (Sabadell women's care centre), but in these cases it was not possible to access their histories.

Among all these women cared for, we were able to select 33 useful cases for analysis. Of the remaining cases, we were only able to obtain incomplete data or the women no longer came in for planned visits and we were not able to analyse their specific psychiatric disease (31 cases of the initial sample of 53 women, almost 60%).

Mean ± standard deviation age of our sample was (n=33), at the time of aggression 36.6 ± 8.8 (interval, 17-60). Almost all the women (except one case) had psychiatric diagnoses of axis I, fundamentally between two large groups. Adaptation and anxiety disorders (18 cases, 56%) and affective disorders (unipolar or bipolar, 9 cases, 28%) and, less frequently, psychosis (4 cases, 13%) (fig. 1). The main axis I diagnoses, according to DSM-IV criteria, were heterogeneous and we have summarised them in table 1. It is striking that none of our patients was diagnosed with posttraumatic stress disorder, although it must be considered that, even among the women referred from the women's care centre, the reasons for requesting care were not apparently related to the consequences of ill-treatment. The difficulty in assigning standardised psychiatric diagnoses is also striking (in fact, the majority of cases were included in syndromes, non-specific or mixed diagnoses) due to the lack of typical clinical symptoms or

Table 1 Axis I DSM-IV Diagnoses of the Women Suffering Violence Attended at the Mental Health Centre

DSM-IV Diagnosis	n (%)
With no axis I diagnoses	1 (3)
Type II bipolar disorder	1 (3)
Bipolar type schizoaffective disorder	1 (3)
Non-specified bipolar disorder	1 (3)
Recurrent major depression	1 (3)
Major depression, single episode	1 (3)
Non-specified depressive disorder	4 (12.1)
Residual schizophrenia	1 (3)
Mixed adaptive disorder	9 (27.3)
Anxiety disorder (syndromic, non-specified)	4 (12.1)
Organic mental disorder (due to drugs)	1 (3)
Panic disorder	2 (6.1)
Non-specified psychotic disorder	1 (3)
Non-specified eating disorder	1 (3)
Non-specified dissociative disorder	2 (6.1)
Dysthimia	1 (3)
Disorganised schizophrenia	1 (3)
Total	33 (100)

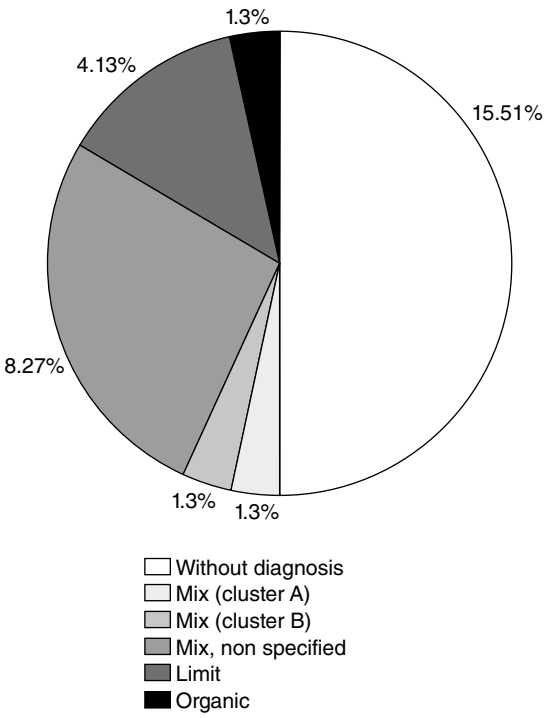

Figure 2 Diagnoses of personality disorders (axis II).

the complexity of the clinical symptoms, the variations in evolution and comorbid substance abuse and/or personality disorders. The most striking factor is the lack of typical symptoms.

Up to 27.3% of these women presented comorbid substance abuse or alcohol dependence, and 33.3% benzodiazepine dependence and/or other drug abuse (sometimes multiple drugs). More than half (58.1%) also had different diagnoses of axis II personality disorders (fig. 2). And 39.4% had other specific physical health problems in addition to their mental health disorders.

During this period, we detected that 31.9% of the total of women who suffered VaW and were cared for at our Hospital were immigrant. Among these, only 12.1% had visited our consulting offices, which may reflect specific difficulties encountered by immigrant women (and especially those suffering VaW) to access our mental health services. Although it is difficult to obtain precise data, due to the difficulties in obtaining reliable statistics, in any case, the proportion of immigrant women of diverse origin in the violence sample is much greater than the proportion of native population new to our area.

Up to 41.9% of the women attended in our mental health offices who had suffered VaW during this period had a history of attempted suicide, and some even some had repeated previous attempts. Between the period from December 2004 and June 2006, one of the women attended for VaW at our Hospital committed suicide. It is possible that other suicide attempts were carried out or achieved and not detected during this period, since the majority of women (69.7%) abandoned follow-up in mental health offices and did not come in for further consultations, and therefore we could not follow up these cases. Our analysis could not detect cases of homicide of these women during the period studied either. In some cases an attempt was made to continue follow-up of the women who abandoned it, but in most cases abandonment was not documented. It must be pointed out that in our reference sector there are other community or municipal services, or NGO concrete programs, that also follow-up these cases. However, the care of cases with significant psychiatric disease is mainly carried out by our hospital. Due to the study methods and the need for data confidentiality, it has been impossible to detect cases cared for by other means and/or agencies.

The patients were cared for by different health professionals with different backgrounds, age and orientation: at least 7 psychiatrists (3 men and 4 women) and/or 3 psychologists. Most patients were cared for only by 1 psychiatrist (69.7%) and did not receive support or therapy from psychology professionals. Patients, independent of their evolution and visits to the Emergency Service, were basically referred from primary care physicians (57.6%) and were not normally related to the VaW, but to the consequences of the patients' psychopathological process. Only 2 cases were referred from a women's care centre due to their psychiatric diseases.

Even keeping in mind objective severity, only 51.5% of these women had violence documented in their clinical history. In a remaining 6.1% of cases it is possible that the health professional knew of this violence, but in any event it was not documented or reported as such. Only in 14 cases (35.8%) is there exact information entered by the health professional on the VaW episode or episodes. In the remaining clinical histories VaW is not documented or considered. No significant difference were detected between different types of health professionals (psychologists or psychiatrists) with reference to sex (male or female) of the health professional in charge of the case at the time of aggression. Therefore, female health professionals did not detect aggression more frequently than their male counterparts, although in a larger sample, it may be possible to detect a positive difference in their favour.

In those cases in which, according to the clinical history, this situation related to violence is documented, only some type of approach or intervention related to this is documented in 15.2% of cases. In the remaining cases no specific action is documented.

In some cases, references to the violence in psychological or psychiatric medical histories were documented in the form of 'euphemisms'. Set phrases or generic expressions were used, maybe those used by the women themselves or translated in "inverted commas" by the health professionals who attended them. In some cases, the health professional, without any differences due to age or sex, used specific repeated euphemisms to describe the situation of a couple in conflict that, at that time, had already been the cause of severe physical violence against the woman ("ambivalence", "in the process of separation", "in the process of divorce", etc.)

Discussion

In spite of the mediocre results of VaW detection among the health professionals of our sample, it must be remembered that, according to different studies, the ill-treatment detection capacity of different health care professionals in the literature is very scarce: between 10, 28 or a very meritorious 40%[7-9] of cases seen by primary care doctors, 17% of those seen by gynaecologists,[7] or 6% of those seen by internal medicine specialists.[7] Therefore, comparatively, our mental health professionals are capable of detecting violence more effectively than primary care doctors, gynaecologists, or internal medicine specialists in the studies mentioned; but, is a detection rate of 51.5% optimum in this specific case?

Obviously, appropriate professional training and experience are significant when facing this health problem. But the influence of the environment and many other social and organisation factors can also help to achieve a better capacity of detection of this problem. Therefore, in several previous studies, several factors have been detected that may significantly influence an improvement in this detection rate. In the Zink et al[5] sample, aggressions were also detected in only 50% of cases, but it was also seen that older women were more reticent when it came to relating aggressions suffered, and therefore, it is necessary to be more alert with this population. In our sample, due to its heterogeneity and small size, we were not able to detect a generation factor, but culture may have influenced case detection.

In the excellent review and meta-analysis performed by Feder et al,[4] women who had suffered abuse or aggression by their partners described how they had perceived the reactions of the health professionals when they reported these aggressions and what sort of care they would like (or would have liked). In this review it was clear that women suffering aggression required certain basic conditions in a health professional:

- A non-directive attitude
- Non-prejudiced behaviour to their attitude
- Individualised, personal care
- Understanding of the complexity of the situation

These women also required repeated investigation of the situation of abuse during subsequent contacts with the health professionals, making it necessary for the health professionals not to assume that the abuse or aggression initially detected was a specific episode.[4] These characteristics required by the women in different studies may be factors worth analysing when quantifying how satisfactory interventions can be in these women that have suffered such severe aggressions, frequently in a continuous manner.

The study performed by Chang et al[6] also analyses certain aspects of the care that women who have undergone aggression would like to receive as part of their health care. These are things that they feel as part of effective care by health professionals who know of their aggression or at least markedly suspect that it has occurred:

- When there is suspicion of aggression, health professionals must explain why they are carrying out an exam and explain this suspicion to the woman.
- They must create an atmosphere of safety and support.
- They must provide information, support and access to resources even if the woman is not willing to recognise or report said aggression.

In our samples, the association between aggressions and attempted suicide or, unfortunately, successful suicide, as well as (in other samples) homicides or greater morbidity and mortality due to diverse causes, is a fact. However, the comorbidity with alcohol abuse, and, in other cases, abuse of hypnotic or sedative drugs or abuse of other prescribed or illegal drugs, is of interest, as it is less well known.[10] According to a Northamerican study, up to 55.5% of women suffering aggression, have comorbid alcohol abuse.[10] In our sample, the frequency is lower, but should not be underrated, since emergent alcohol abuse, especially in women without a clear history of this problem, frequently may mask long term abuse or aggression.

It is crucial that we address the problem of VaW in our patients. The consequences of different types of aggression suffered by women are devastating. In an excellent study in our environment, María Picó et al[11] demonstrated that both physical and psychological violence, or so-called only "mental" violence, accompanied or not by sexual aggression, deteriorate victims' mental health and endanger their lives and their health in many ways, including suicide. The prevalence of posttraumatic stress disorder is very high, and it is associated in most cases with depressive symptoms, but also anxiety and suicide ideation.[11] The study also shows that the so-called "mental violence", which does not include in principle any contact or physical damage to the victim, has an evident effect on their mental health. The age of the women suffering aggression may modulate the consequences of this violence, as was shown in the study performed by Sarasúa et al.[12]

Meanwhile, in our environment, we have sufficient resources to assess and investigate this issue,[13] and considerable advances are being made in the identification and typification of male aggressors, especially in the characterisation of risk factors,[14-20] as also in the treatment of women with mental disease secondary to aggression.[21]

However, beyond social characteristics, the organisation characteristics of the health services and the existence or not of legal measures to fight against this violence, the attitude and sensitivity of health professionals must be modified. University education is not a "vaccine" against VaW, as has been shown in our state by the study of attitudes and beliefs carried out by Ferrer et al.[22] The barriers and significant difficulties for the identification of violence by health professionals, of different origin, have already been discussed in several previous studies and will not be specified in this one.[23-26]

We also believe that more training and greater sensitivity are necessary in mental health care professionals so as to detect and treat the consequences of VaW and especially that type of severe physical violence with consequences in the short and medium term, which are well known and defined in social and scientific circles. It is also necessary to stimulate

and increase the role of nursing and, especially, psychiatric nursing, in the detection of and approach to these cases, as also close working relationships between teams (municipal, social, basic areas and mental health) that care for these severe cases. Up to 90% of women who have suffered abuse or aggression think that systematic screening by health professionals is useful and 71% wished that it had been carried out at the time when they suffered daily aggression.[10]

The evident limitations of the study, which we wish to highlight, is the small size of the sample, the fact that it only came from one health area and specific health care professionals, the high rate of consultation abandonment (and therefore loss of follow-up and evolution), and the method itself. It only made it possible to determine detected evidence effectively recorded by health professionals in writing (so-called "documented violence" compared to "iceberg violence"). However, we believe that it is an excellent way of drawing attention to the problem.

Conclusions

A significant percentage of the women attended due to VaW episodes with resulting injuries and/or the need for medical care and/or social emergent and/or emergency care in our hospital received or had been receiving at some time psychiatric or psychological specialised care in our consulting offices for other reasons. A high percentage of immigrant women was detected in relation to the total number of women who were suffering VaW, but their follow-up rates in our consulting offices were relatively low. There was low adherence to follow-up and treatment, since the great majority of women abandoned follow-up in mental health consulting offices. Among the different diagnoses, we were struck by the number of addictions, with a high rate of comorbid substance abuse or alcohol, benzodiazepine and/or other drug dependence, as also the high rate of histories of attempted suicide.

Although the prevalence of psychiatric or psychological disease is very high in this group of women who have suffered severe gender violence, this reality in many cases is not known to the health professional who is caring for the patient nor is it documented, nor apparently, is it the object of specific treatment. This information has practical implications when treating these women. The high rates of follow-up abandonment provide a brief overview of the difficulties in dealing with these cases within the mental health framework in our environment.

Conflict of Interest

The authors affirm that they have no conflicts of interest.

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