

Psychological Consequences and Daily Life Adjustment for Victims of Intimate Partner Violence

Roser Cirici Amell^{1, 2, 3}

Aloma Riera Soler⁴

Jesus Cobo^{3, 5, 6}

Joan Miquel Soldevilla Alberti²

¹Institut de Neuropsiquiatria I Addiccions (INAD), Parc de Salut Mar, Barcelona, Spain

²Department of Clinical Psychology and Psychobiology, University of Barcelona, Barcelona, Spain

³Research Workgroup on Women's Mental Health, Catalan Society of Psychiatry and Mental Health, Barcelona, Spain

⁴Consorci Sanitari Del Maresme, Mataró, Spain

⁵Mental Health Department, Consoreci Corporació Sanitària Parc Taulí – CIBERSAM - I3PT - Universitat Autònoma de Barcelona, Barcelona, Spain

⁶Department of Psychiatry and Forensic Medicine, Universitat Autònoma de Barcelona, Barcelona, Spain

1. INTRODUCTION

1.1. Background

Intimate partner violence (IPV) is a distressing reality for many women, with population studies showing that between 10% and 69% of women worldwide have reported being physically abused by a partner at some point in their lives. Similar rates have been found in European countries (18% and 58%) [1]. A study showed that 28.9% of 6,790 American women had experienced physical, sexual, or psychological IPV during their lifetimes. In this cohort, increasing psychological IPV scores were strongly associated with an increased risk of poor health and depressive symptoms [2]. These data indicate that IPV is a significant global public health problem.

IPV is not limited to physical acts of aggression. It also includes controlling behavior, restricted access to information, economic violence, isolation from family and friends, monitoring movements, rape and other forms of sexual coercion, and emotional abuse such as belittling, intimidation, gaslighting, contempt, and humiliation [3] [4] [5]. IPV significantly impacts the mental and physical wellbeing of women [6], and this extends beyond the period of trauma, with survivors typically experiencing long-term mental health disorders, substance abuse problems, interpersonal difficulties, and physical problems [7]. Literature consistently shows that victims compared with no victims, show more chronic health problems like fibromyalgia, gastrointestinal disorders like irritable bowel syndrome, and gynaecological signs including sexually transmitted diseases, as well as post-traumatic stress disorder, anxiety and depression among others [1]. In Bolivia, a demographic study found that 47% of women living with their partners had experienced some type of abuse by their husband in the past 12 months. Women who had experienced psychological abuse alone reported mental health symptoms that were nearly identical to those suffered by women who had also been physically abused. However, women subject to sexual abuse were at major risk for different mental health issues [8]. Other research also indicated that psychological IPV had the same detrimental effect as physical and psychological IPV combined, with sexual violence associated with a higher severity of depressive symptoms and with more suicide attempts [9].

In Spain, IPV appears to be a major social problem that affects a significant number of women. A cross-sectional survey of 10,322 women in primary care revealed that the prevalence of IPV was 24.8%; of these, 25.4% suffered control violence IPV, 21.9% psychological IPV, 10.8% economical IPV, 10.3% physical IPV and 8.1% sexual IPV. A comparison between women who had and had not suffered IPV revealed that those who had suffered IPV had a worse perception of their health, with more reports of anxiety, distress,

sadness, crying for no reason, and irritability. The risk of suffering from both physical and psychological violence increased as income and education levels decreased [10]. In an investigation conducted using a sample of Catalan IPV victims, all of them had suffered psychological violence throughout their lives and 89.7% had also suffered control violence; 82.1% economic violence; 74.4% physical violence; and 66.7% sexual abuse [11].

According to Menéndez Álvarez-Dardet et al. [12], IPV has serious implications in all spheres of daily life, including work performance, social life, and the use of free time. Moreover, it significantly affects physical health, leading to somatic symptoms, drug abuse, greater vulnerability to diseases, and insomnia. It also affects psychological health, leading to posttraumatic stress disorder (PTSD), depressive symptoms, anxiety, and low self-esteem.

1.2. Violence against women, mental health symptoms, and social consequences

During the last two decades, researchers have found that experiencing IPV has severe consequences on a woman's physical, psychological, sexual, and reproductive health [3] [13]. Evidence suggests that women who are abused by their partners have higher levels of depression, anxiety, and phobias [9] [14] [15] [16] [17] [18]. The most frequent psychological symptoms among IPV survivors are anxiety, sadness, low self-esteem, lack of sexual drive, permanent fatigue, and insomnia [19]. Furthermore, these women are also twice as likely to experience depression and to have alcohol use disorders. IPV impacts not only a woman's health but also her work performance and ability to take care of herself and her family [7].

Regarding psychological disorders, some authors report that PTSD is the most frequent diagnosis for IPV survivors [1] [6] [9] [20], while others report that PTSD and depression have a similar prevalence [21]. In a meta-analysis of seven international studies on psychological indicators associated to IPV, Plazaola-Castaño and Ruiz-Pérez [1]

observed that the overall prevalence of PTSD ranged from 31% to 84.4%, that all studies concluded that there was a significant association between IPV and depressive symptoms, and that four also highlighted an association with anxiety symptoms and alcohol and drug abuse. Labrador et al. [22] later reported significant levels of PTSD among women abused by partners (37.2%), and they also found that PTSD co-occurred with depressive symptoms and decreased overall psychosocial performance. Moreover, in a national survey of pregnant women in Mexico, Lara et al. [23] noticed that the prevalence of any type of IPV was 5.4%, and that depressive symptoms were present in 16.2% of all pregnant women. It was also shown that 53.4% of pregnant women who reported IPV in the previous year also expressed having depressive symptoms, and that IPV predicted depressive symptoms during pregnancy (odds ratio = 6.23).

In regard to psychosocial adjustment the level of impairment appears to be higher when the episodes of maltreatment are more intense [24]. This seems to be because victims of IPV report constant fear for their lives, experience a greater sense of vulnerability, and suffer personal and financial dependency [25]. An international study by the WHO showed that emotional distress, thoughts of suicide, and attempted suicide were significantly higher among women who had experienced physical or sexual violence when compared with their peers who had no such experience [7].

Finally, in a study conducted by Echeburúa et al. [26], PTSD was present in 55% of the sample, with no significant differences between victims of psychological and physical abuse. Factors noted to intensify PTSD were: degree of maladjustment, lack of support, having experienced forced sexual intercourse, and not having reported the abuse. The rates of anxiety and depressive symptoms were 93% and 64%, respectively.

1.3. Psychological and physical IPV exposure and daily life adjustment

When women experience abuse or violence, they often feel excluded from normal social circles or are unable to connect with them [7]. Previous studies have analyzed the relationship between IPV and maladjustment. Using the Maladjustment Scale (MS), a study from Spain indicated that maltreatment had a significant effect on various aspects of women's social health [27]. Among these were their ability to engage in an intimate relationship, to believe they could have a new relationship, and to have leisure time or a social life [28]. Amar and Ocampo [24] confirmed that IPV was clearly associated with PTSD (84.3%) and poor adaptation (93.3%), supporting the notion that violence will result in difficulties with daily life activities. Nonetheless, despite its relevance, this notion has received little attention in the literature.

1.4. Aims

The purpose of this study is to provide further knowledge about the mental health of IPV victims referred by primary care doctors to clarify the psychological consequences and daily life maladjustments that result from their experiences. We plan to analyze a specific cohort of IPV victims in Catalonia to add more data on how this issue affects women in our region and to compare our results with existing literature. Therefore, the main aims of the study are as follows: a) to examine the prevalence of PTSD, depressive symptoms, and anxiety symptoms in women treated for IPV at a public mental health care institution; b) to analyze the relationship between the level of IPV exposure (psychological and physical) and the psychological consequences; and c) to consider the relationship between the level of IPV exposure (psychological and physical) and daily life adjustment.

2. METHOD

2.1. Design and participants

The study was carried out at the Adult Mental Health Center of Sant Cugat del Vallès, Mútua Terrassa University Hospital (Barcelona), after receiving approval by the relevant Review Board and Ethics Committee. Data confidentiality was guaranteed. All participants were recruited by their primary care doctors, who encouraged them to participate in a care program for IPV victims. All women participated voluntarily and signed an informed consent form.

2.2. Procedure

Data was collected between 2010 and 2016. Patients were evaluated at their Primary Care center by completing a self-administered series of tests under the supervision of a clinical psychologist. It took approximately one hour for patients to complete all tests. In cases of illiteracy or visual motor coordination difficulties, tests were administered by the psychologist. Correct understanding of the tests was checked and all answers were reviewed. Patients with severe mental health issues (Bipolar Disorder and Schizophrenia) were excluded using their clinical history records and an initial clinical examination because of the difficulties entailed in isolating the IPV sequelae from the symptoms of the comorbid disorder.

2.3. Instruments

We used five tests that assessed IPV severity, psychological symptoms, and social adjustment, as is our routine practice in the initial evaluation of IPV victims. These are the Spanish versions of the Index of Spouse Abuse (ISA), the Beck Depression Inventory (BDI-II), the State-Trait Anxiety Inventory (STAI), the Severity Symptom Scale for Posttraumatic Stress Disorder (EGS), and the Maladjustment Scale (MS) (Table 1). A structured

psychological interview was also conducted to collect socio-demographic data and to explore the history of victimization.

The ISA [29] was used to evaluate the intensity and type of violence. This instrument divides violent behavior into physical violence (including sexual violence) and non-physical violence. Psychological symptoms were assessed with standard widely used instruments (BDI-II, STAI, and EGS). Severity of depression was assessed with the BDI-II [30]. Anxiety was evaluated with the STAI [31], including the state anxiety scale for current anxiety and the trait anxiety scale for relatively stable “anxiety proneness”. The prevalence and severity of current PTSD symptoms were assessed using the EGS [32]. This consists of a 17-item questionnaire based on the DSM-IV’s criteria; it includes three subscales that measure specific PTSD categories (re-experiencing the traumatic event, avoidance, and hyperarousal). The level of social adjustment was assessed with the MS [27]. This scale consists of six items that evaluate the degree to which abuse affects different areas of daily life: work, social life, leisure time, possibility of a new intimate relationship, family relationship, and the degree of global maladjustment to everyday life.

Finally, statistical analysis was performed using IBM SPSS version 19.0 (IBM Corp., Armonk, NY, USA). We analyzed the descriptive statistics, using numbers, percentages, and means and standard deviations (mean $\pm$ SD), as appropriate. Finally, we used Pearson’s correlation to assess bivariate correlations.

3.RESULTS

3.1. Incidence of referral to the IPV treatment program

The total population in the study region was 90,664 inhabitants (46,558 women). Between 2010 and 2016, primary care practitioners referred 164 women to the AMHC for

IPV treatment. Therefore, we had 5.8 new case referrals per 10,000 women per year.

The final sample was comprised by 102 women (62.2% of those referred) who had been victims of IPV and agreed to participate in the study after being referred.

3.2. Sociodemographic data

Sociodemographic data for the cohort are summarized in Table 2. The mean age was 44.98 (range, 19–71 years). The women's relationships with their partners started at an average age of 25.55 years (range, 12–46 years) and they lasted an average of 18.29 years (range, 3 months to 54 years) with a mean of 1.8 children per couple (range, 0–6). Most husbands or partners were described as having predominantly moderate incomes (52%), but many also had high incomes (26%) or low incomes (22%). About three-quarters (74%) of the women were employed and one-quarter (26%) exclusively performed unpaid domestic work.

3.3. Descriptive analysis of the IPV, psychological, and life adjustment data

Table 3 shows a summary of the test results. Concerning the ISA, 73% of the sample scored above the cut-off point (50th percentile) for physical IPV, and all women scored above the threshold for non-physical IPV.

As reflected in the BDI-II scores, many of the women had depressive symptoms, with no fewer than 73% of the sample scoring above the cut-off point of 20 (mean score, 25.74; standard deviation, 11.38). The STAI scores also revealed high levels of both state and trait anxiety: for trait anxiety, 77% scored above the 50th percentile (mean 69.39 ± 30.57); and for state anxiety, 87% scored above the 50th, with 70% of these scoring above the 75th percentile (mean 78.19 ± 23.04). PTSD was also prevalent, with 87% of the sample scoring above the 25-point cut-off in the EGS scale (mean 28.57 ± 12.28). Regarding the subscales, 80%

scored a mean of 8.58 ± 4.55 for re-experiencing symptoms, 84% scored 11.44 ± 5.72 for avoidance symptoms, and 87% scored 8.49 ± 4.20 for arousal symptoms.

Concerning the consequences for the victims' daily lives, the MS scores indicated that suffering IPV profoundly interfered with all aspects of daily life, with 92% of the cohort scoring above the 12-point cut-off (mean 21.05 ± 6.41). Significant percentages showed that being maltreated affected their studies/work (87%; mean score 3.38 ± 1.59), their social lives (87%; 3.31 ± 1.44), their leisure time (89%; 3.40 ± 1.47), their belief in the possibility of a new intimate relationship (92%; 3.96 ± 1.47), and their family lives (85%; 3.28 ± 1.58). Finally, 98% stated that IPV had affected their overall daily lives (mean score 3.95 ± 1.07).

3.5. Correlations

Table 4 shows the correlations between exposure, psychological variables, and global maladjustment. There was a significant correlation between the degree of IPV suffered and the severity of depressive symptoms. For both physical abuse ($r = 0.21$; $p < 0.05$) and psychological abuse ($r = 0.27$; $p < 0.1$), the higher the level of IPV exposure, the more severe were the depressive symptoms.

Concerning anxiety-state symptoms, there was also an association between psychological IPV and suffering anxiety ($r = 0.21$; $p < 0.05$). Additionally, higher levels of both physical IPV ($r = 0.27$; $p < 0.01$) and psychological IPV ($r = 0.51$; $p < 0.001$) were associated with greater PTSD severity. Finally, our results showed that the level of psychological IPV exposure predicted the subsequent degree of interference with daily life functioning ($r = 0.37$; $p < 0.001$).

4. DISCUSSION

The first aim of our study was to investigate the prevalence of depressive, anxiety, and PTSD symptoms in women suffering from IPV. Our findings confirm that suffering IPV is associated with a higher risk of mental health problems and negative social outcomes [2] [6] [8] [9] [10] [28] [33]. We found significantly increased percentages of women with symptoms of depression (73%), anxiety (trait, 77%; state, 87%), and PTSD (87%) in our sample. Overall, these results are consistent with those reported by Echeburúa et al. [26] and by Amar and Ocampo [24].

The second aim was to analyze the relationship between the levels of physical and psychological IPV exposure and the subsequent psychological consequences. Notably, the severity of depressive symptoms increased with the levels of both types of exposure, and anxiety symptoms increased with the level of psychological IPV. Concerning PTSD, both IPV types were associated with a more severe PTSD symptomatology. Together, these results support those of Echeburúa et al. [26], Coker et al. [2], and Labrador et al. [22]. Pico-Alfonso [6] also reported that psychological IPV was the strongest predictor of PTSD. Therefore, we stress the importance of not underestimating the effect of psychological violence. Our results confirm what other authors have already revealed: that the consequences of emotional abuse are of the same magnitude compared to those derived from physical violence [1] [2] [3] [8] [9].

The third aim was to analyze the relationship between the level of physical and psychological IPV exposure and the degree of daily life adjustment. Most of our sample (92%) scored above the MS cut-off point, similar to that reported by Amar and Ocampo [24] (93.3%). Thus, IPV appears to be strongly associated with poor social adjustment, and we recommend that health care practitioners actively seek to detect maladjustment. Once identified, appropriate referral can help reconstruct the victim's social network, including their work activities, social activities, family relationships and leisure time.

5. LIMITATIONS AND IMPLICATIONS FOR PRACTICE

Some of the limitations of our study are that all participants were recruited from one primary care unit and that they were not compared with a control group. The small sample size and the European Mediterranean population could also be limitations. However, we did include many women suffering from IPV with good economic and work situations, which previous studies have often lacked in representation. Finally, although we collected information about physical and psychological IPV, we did not consider emotional, sexual, economical, and control IPV separately.

We conclude that it is appropriate to advocate routine screening for female IPV victims [2] [7] [33], consistent with evidence that such screening can increase the identification of cases in healthcare settings [34]. Questions about impoverishment in their social life or about abandoning daily life activities should be included regularly in clinical consultations. Offering social assistance and psychological support can help women suffering from IPV [20] [35].

Routine screening should also consider the detrimental effect of all types of abuses (including the psychological), not only physical abuse. Asking questions related to maladjustment may be a useful way to alert healthcare providers to the need for follow-ups and more in depth evaluations.

6. CONCLUSIONS

Our study showed that women that were found to be suffering from IPV in their Primary Care center experienced many mental health symptoms and a high level of interference in all aspects of their daily lives, nearly all of the participants expressed that

IPV had affected their overall daily lives. In addition, the results indicate that consequences of psychological abuse and those of physical violence were of similar scope. These results could help to understand the many struggles that victims of IPV face in their daily lives, which include their academic results, work performance, social and family life, leisure time and their confidence in creating new intimate relationships.

REFERENCES

- [1] Plazaola-Castaño J and Ruiz-Pérez I. (2004). [Intimate partner violence against women and physical and mental health consequences][Article in Spanish]. *Med Clin (Barc)* 2004;122: 461-467.
- [2] Coker AL, Davis KE, Arias I, et al. Physical and mental health effects of intimate partner violence for men and women. *Am J Prev Med* 2002; 23: 260-268.
- [3] Blanco P, Ruiz-Jarabo C, García de Vinuesa L, et al. [Partner violence and women's health][Article in Spanish]. *Gac Sanit* 2004; 18: 182-188.
- [4] Cirici R, Querol N and Ripoll A. [The health consultation: a privileged space for the detection and treatment of gender violence?][Article in Spanish]. *FMC Form Medica Contin en Atencion Primaria* 2010; 17: 550-559.
- [5] Lorente M. [Gender violence: facing the future][Chapter in Spanish]. In: López E (coord.). *Violencia contra las mujeres: descripción e intervención biopsicosocial*. Jaén (Spain): Universidad de Jaén, 2010, pp. 9-14.
- [6] Pico-Alfonso MA. Psychological intimate partner violence: the major predictor of posttraumatic stress disorder in abused women. *Neurosci Biobehav Rev* 2005; 29: 181-193.
- [7] World Health Organization. *Understanding and addressing violence against women: Intimate partner violence*. WHO, 2012. <https://apps.who.int/iris/handle/10665/77432>

- [8] Meekers D, Pallin SC and Hutchinson P. Intimate partner violence and mental health in Bolivia. *BMC Womens Health* 2013; 13: 28.
- [9] Pico-Alfonso MA, Garcia-Linares MI, Celda-Navarro N, et al. The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *J Womens Health (Larchmt)* 2006; 15: 599-611.
- [10] Ruiz-Pérez I, Escribà-Agüir V, Montero-Piñar I, et al. Prevalence of intimate partner violence in Spain: A national cross-sectional survey in primary care. *Aten Primaria* 2017; 49: 93-101.
- [11] Ayats M, Cirici R and Soldevilla JM. [Therapy groups for women victims of gender violence][Article in Spanish]. *Psiquiatr Biol* 2006; 15: 29-34.
- [12] Menéndez Alvarez-Dardet S, Pérez Padilla J and Lorence Lara B. Partner violence against women in Spain: quantification and characterization of the problem, victims, aggressors, and the social and professional context. *Interv Psicosoc* 2013; 22: 41-53.
- [13] Villavicencio P and Sebastián J. [*Domestic violence: its impact on the physical and mental health of women*][Book in Spanish]. Madrid: Instituto de la Mujer, 2001.
- [14] Cascardi M, O'Leary KD, Lawrence EE, et al. Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict. *J Consult Clin Psychol* 1995; 63: 616-623.
- [15] Dienemann J, Boyle E, Baker D, et al. Intimate partner abuse among women diagnosed with depression. *Issues Ment Health Nurs* 2000; 21: 499-513.
- [16] Petersen R, Gazmararian J and Andersen Clark K. Partner violence: implications for health and community settings. *Womens Health Issues* 2001; 11: 116-125.
- [17] Ludermir AB, Schraiber LB, D'Oliveira AF, et al. Violence against women by their intimate partner and common mental disorders. *Soc Sci Med* 2008; 66: 1008-1018.

- [18] Follingstad DR. The impact of psychological aggression on women's mental health and behavior: the status of the field. *Trauma Violence Abuse* 2009; 10: 271-289.
- [19] Pérez JM and Montalvo A. [*Gender Violence: Prevention, detection and intervention*][Book in Spanish]. Madrid: Editorial Grupo 5, 2011.
- [20] Echeburúa E, Sarasua B and Zubizarreta I. Individual Versus Individual and Group Therapy Regarding a Cognitive-Behavioral Treatment for Battered Women in a Community Setting. *J Interpers Violence* 2014; 29: 1783-1801.
- [21] Bosch E and Ferrer VA. [*The voice of the invisible. The victims of a bad love that kills*][Book in Spanish]. Madrid: Ediciones Cátedra, 2002.
- [22] Labrador F, Fernández-Velasco MR and Rincón P. [Psychopathological characteristics of female victims of intimate partner violence][Article in Spanish]. *Psicothema* 2010; 22: 99-105.
- [23] Lara MA, Natera-Rey G, Berenzon S, et al. Intimate partner violence and depressive symptoms in pregnant Mexican women: national survey results. *Rev Invest Clin* 2014; 66: 431-438.
- [24] Amar JJ and Ocampo LE. Posttraumatic Stress Disorder and Adaptative Capacity in Victims of Intimate Partner Violence. *Psicol Caribe* 2012; 29: 257-275.
- [25] Echeburúa E, Fernández-Montalvo J and Corral P. Are there differences between serious violence and less serious violence against the couple?: a comparative analysis. *Int. J. Clin. Health Psychol* 2008; 8: 355-382.
- [26] Echeburúa E, De Corral P, Amor PJ, et al. [Psychopathological repercussions of domestic violence on women: a descriptive study][Article in Spanish]. *Rev de Psicopatol Psicol Clin* 1997; 2: 7-19.
- [27] Echeburúa E, De Corral P and Fernández-Montalvo J. [Maladjustment Scale (EI): Psychometric properties in clinical contexts][Article in Spanish]. *Anál Modif Conduct*

- 2000; 26: 326-340.
- [28] Domínguez JM, García P and Cuberos I. [Violence against women in the domestic sphere: consequences on psychosocial health][Article in Spanish]. *An de Psicol* 2008; 24: 115-120.
- [29] Plazaola-Castaño J, Ruiz-Pérez I, Escribà-Agüir V et al. [Spanish adaptation of a diagnostic instrument and another of screening to detect violence against women in the couple from the health field] [Document in Spanish]. Madrid: Observatorio de Salud de la Mujer, 2006.
- http://www.mscbs.gob.es/organizacion/sns/planCalidadSNS/e02_t03_Instrumentos.htm
- [30] Sanz J, Vázquez C and Perdigón AL. [Spanish adaptation of the Beck-II Depression Inventory (BDI-II): 2. Psychometric properties in the general population][Article in Spanish]. *Clin Salud* 2003; 14: 249-280.
- [31] Seisdedos N. *STAI: State-Trait Anxiety Inventory*. Madrid: TEA, 1982.
- [32] Echeburúa E, De Corral P, Amor PJ et al. [Scale of symptoms of Posttraumatic Stress Disorder: psychometric properties][Article in Spanish]. *Anál Modif Conduct* 1997; 23: 503-526.
- [33] Kumar A, Nizamie SH and Srivastava N. Violence against Women and Mental Health. *Ment Health Prev* 2013; 1: 4-10.
- [34] O 'Doherty L, Hegarty K, Ramsay J, et al. Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev* 2015; 7: CD007007.
- [35] Stewart DE. The International Consensus Statement on Women's Mental Health and the WPA Consensus Statement on Interpersonal Violence against Women. *World Psychiatry* 2006; 5: 61-64.

Table 1. Psychological battery used for evaluation.

Test	Measured concept	Characteristics
Beck Depression Inventory II (BDI-II). Spanish version [30]	Depression	21 items, 4 response options. Rank: 0-63 Cut-off-point to detect clinically significant symptoms for depression: 20 Internal consistency Cronbach's alpha coefficient: around 0.9
State-Trait Anxiety Inventory (STAI). Spanish version [31]	Anxiety as a personality trait (STAI-T) and as a transitory state (STAI-S)	40 items, 4 response options (Likert scale) Rank: 0-100 Cut-off-point: percentile 50 Range of scores for each subtest is 20–80 Higher score indicating greater anxiety. Internal consistency alpha coefficients were high ranging from 0.86 to 0.95.
Severity of Symptom Scale of Posttraumatic Stress Disorder (EGS). Spanish version [32]	Posttraumatic Stress Disorder (PTSD)	17 items, 3 response options (Likert scale) Ranges: - Re-experiencing symptoms: 0-15 - Avoidance symptoms: 0-21 - Arousal symptoms: 0-15 Total Range: 0-51 Cut-off point: 5, 6 and 4 in the subscales and 15 in the total score. High internal consistency: Cronbach's alpha of 0.92
Index of Spouse Abuse (ISA). Spanish version [29]	Degree of psychological and physical IPV	30 items, 5 response options (Likert scale) Range: 30-150 Higher scores indicate more severe violence Cut-off point: percentile 50 Good internal consistency: Cronbach's alpha was 0.85 for the physical violence subscale and 0.94 for the non-physical violence subscale.
Maladjustment Scale (MS). Spanish version [27]	Interference of the abuse in different aspects of daily life	6 items, 5 response options (Likert scale) Range: 0-30 Cut-off point: 12 in the total score, 2 in each subscale Cronbach's alpha of 0.82.

Table 2. Demographic data of the sample.

Variable	n	%	Mean (Standard Deviation)
Age at the evaluation	-	-	44.98 (10.63)
Age at beginning of the relationship	-	-	25.55 (7.43)
Duration of the relationship (years)	-	-	18.29 (14.05)
Number of children	-	-	1.8 (1.21)
Current civil state			
married/with couple	38	37	-
separated/divorcee	59	58	
single	5	5	
Economic status			
low	22	22	-
medium	53	52	
high	27	26	
Employment status			
paid	75	74	-
unpaid (domestic)	27	26	

Table 3. Descriptive variables.

Variable	%	M (SD)
ISA		
Physical	73%	30.29 (22.27)
Psychological	100%	67.01 (21.78)
BDI-II	73%	25.74 (11.38)
STAI		
STAI-T	77%	69.39 (30.57)
STAI-S	87%	78.19 (23.04)
EGS	80%	8.58 (4.55)
Re-experiencing	84%	11.44 (5.72)
Avoidance arousal	87%	8.49 (4.20)
<i>Total score</i>	87%	28.57 (12.28)
MS		
Work/studies	87%	3.38 (1.59)
Social life	87%	3.31 (1.44)
Free time	89%	3.40 (1.47)
Couple relationship	92%	3.96 (1.47)
Family life	85%	3.28 (1.58)
Overall scale	98%	3.95 (1.07)
<i>Total score</i>	92%	21.05 (6.41)

ISA: Index of Spouse Abuse [29]; BDI-II: Beck Depression Inventory II [30]; STAI: State-Trait Anxiety Inventory [31]; EGS: Scale of Severity of Symptoms of Posttraumatic Stress Disorder [32]; MS: Maladjustment Scale [27].

Table 4. Correlations between level of IPV exposure (ISA) and both the psychological variables (BDI-II, STAI-E, EGS) and the overall level of maladjustment (MS).

	BDI-II		STAI-S		EGS		MS	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
ISA physical	0.21*	0.03	-0.01	0.94	0.27**	<0.01	0.18	0.07
ISA psychological	0.27**	<0.01	0.21*	0.03	0.51**	<0.001	0.37**	<0.001

ISA: Index of Spouse Abuse [29]; BDI-II: Beck Depression Inventory II [30]; STAI-S: State-Trait Anxiety Inventory, trait [31]; EGS: Scale of Severity of Symptoms of Posttraumatic Stress Disorder [32]; MS: Maladjustment Scale [27]; Signification: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$