



FEATURE ARTICLE

# Psychological partner violence and women's vulnerability to depression, stress, and anxiety

Hanan Al-Modallal

Department of Community and Mental Health Nursing, Hashemite University College of Nursing, Zarqa, Jordan

**ABSTRACT:** Psychological partner violence is a considerable problem, despite its invisible outcomes on victims' physical health. Focusing on mental health, the present study looked at differences in mental illness, such as depression, stress, and anxiety, among victims and non-victims of psychological violence. A convenience sample of women ( $n = 267$ ) visiting health-care centres in refugee camps in Jordan provided data about their experiences of psychological violence and their mental health status. The results indicated that, compared to their non-victimized counterparts, women reporting psychological violence had significantly higher mean scores of depression ( $t = -4.92$ ), stress ( $t = -3.73$ ), and anxiety ( $t = -4.22$ ), with  $P < 0.0001$  for all results. It was suggested that factors that have significant roles in determining poor mental health status included victims' low self-esteem; poor socioeconomic profile, in terms of education level and income; and responsibilities associated with child and family requirements. The impacts of these factors on victims' mental health status are discussed.

**KEY WORDS:** mental health, partner, psychological violence, refugee, women.

## INTRODUCTION

Intimate partner violence has become a serious health concern for women. The physical health consequences of this have been documented, and include chronic illnesses (Coker *et al.* 2005), physical injuries (trauma) (Romans *et al.* 2007), and gynaecological problems (McFarlane *et al.* 2005; Salam *et al.* 2006). Health-related consequences of intimate partner violence negatively affect victims' mental health status in a variety of forms, such as depression, anxiety, and low self-esteem (Forte *et al.* 2005).

Psychological violence is a significant type of intimate partner violence, in spite of its lack of visible outcomes, such as physical injury and trauma, which are mainly associated with physical and/or sexual violence. Psychological partner violence has been found to be responsible for increasing the risk of mental illness

(i.e. depression) by more than threefold (adjusted odds ratio = 3.35, 95% confidence interval) = 1.42–7.91) (Coker *et al.* 2005), and also leads to increased rates of suicidal thoughts among victims (Pico-Alfonso *et al.* 2006). Furthermore, literature supports the relationship between suicide and depression experienced by victimized women (Houry *et al.* 2005). Generally speaking, information from related studies provides evidence about the seriousness of the impact of psychological violence in women's lives. Therefore, this topic should be appropriately researched from different perspectives.

Focusing on psychological partner violence, a high prevalence rate was documented among Jordanian constituents. For example, among 517 Jordanian women, 73.4% reported being victims of psychological violence (Clark *et al.* 2009). It also is important to add that the mental health impact of psychological violence is sometimes more serious than the physical health impact. This conclusion was supported in earlier studies. Hathaway *et al.* (2000) found that mental health outcomes (in terms of depression and anxiety) were more prevalent than poor physical health status among victims of partner violence (including fear of, or control by, the intimate partner).

**Correspondence:** Hanan Al-Modallal, Department of Community and Mental Health Nursing, Hashemite University College of Nursing, Zarqa 13115, Jordan. Email: hmodallal@hu.edu.jo  
Hanan Al-Modallal, RN, PhD.  
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### Palestinian refugees in Jordan

Jordan became a refuge for Palestinians as a result of Arab–Israeli wars in 1948 and 1967. An estimated two million refugees now live in Jordan, and 17% live in camps founded specifically for them. Each camp has either one or two health centres providing a variety of health-care services, including childcare, maternity care, treatment for chronic illnesses, laboratory services, and pharmaceutical services. However, due to a lack of funding, the insufficiency of services is likely (United Nations Relief and Works Agency for Palestine Refugees 2011).

Most refugees live in relatively small and congested brick houses, composing either nuclear or extended families; most share similar familial, social, and cultural beliefs as Jordanians. For instance, refugee communities honour the family unit, and having children is an expected outcome of marriage. In addition, the male is almost always the head of the household, and women's obedience to them is one of the principal rules in the relationship.

### Rationale for the study

Some investigators have focused on partner violence in Palestinian women (e.g. Haj Yahia 2000; 2002). In addition, a considerable number of investigators have emphasized this problem among Palestinian women residing in refugee camps in Jordan (Khawaja 2004; Khawaja & Barazi 2005; Khawaja *et al.* 2008). Although these studies unveiled the significance of partner violence in these women's lives, minimal studies have examined the mental health consequences of this.

Considering the significance of psychological partner violence and mental health in women's lives, and due to crowdedness and poverty factors affecting refugees in camps, we found it interesting to examine the prevalence rates of psychological violence and mental health in Palestinian women residing in refugee camps in Jordan. In addition, the present study was among the first aimed at identifying relationships between psychological partner violence and mental health, in terms of depression, stress, and anxiety, by examining differences in mental illnesses between victimized and non-victimized refugee women in Jordan.

## MATERIALS AND METHODS

### Design, setting, and sample

The study was a cross-sectional, descriptive design targeting women living in refugee camps in Jordan. A cross-sectional design was used because it allows us to examine participants at various stages, with regard to the indepen-

dent variables (Burns & Grove 1997). In the present study, the independent variable was psychological violence, defined as experiencing controlling behaviours, emotional violence, and both together. The setting of the study was health-care centres in refugee camps in three Jordanian cities (Amman, Irbid, and Zarqa). The inclusion criteria for the participants were women who: (i) were/had been married; (ii) could read and write, in order to complete the self-reported study questionnaire; (iii) were not accompanied by their intimate partners; and (iv) were not currently on prescribed medications for depression, stress, or anxiety. Women who were accompanied by their partners were excluded in order to limit the incidence of report bias. In addition, taking prescribed medications for depression, stress, or anxiety could confound the examined relationships between psychological partner violence and mental health. Therefore, participants taking such medications were excluded.

### Data collection

Data were collected by research assistants from women attending health-care centres in the refugee camps. A convenience sample of women seeking health assistance was required. Women were asked to participate in providing data for the study after being informed about the study objectives. Completing the questionnaires took place in the waiting rooms of the health-care centres. The final number of participants, based on the inclusion criteria, was 267.

### Ethical considerations

The study was approved by Hashemite University (7/2008/2009) and the Health Department and Ethical Committee Headquarter of the United Nations Relief and Works Agency for Palestine Refugees in Jordan. Women were provided a full description of the study. Those who agreed to participate and provided written consent were asked to complete the questionnaire. Women were reminded that their participation in the study was not obligatory, and that they could stop at any time throughout the data-collection procedure. Participants were reminded that the data obtained from their responses would not be disseminated to anyone other than the research team, and that the information they provided would be used for research purposes only. Data were collected anonymously from the participants.

### Measures

We used items from two studies to create two subscales of psychological partner violence: the controlling behaviours

of, and the emotional violence committed by, the male against the female partner.

Controlling behaviours of the intimate partner were measured using items from the World Health Organization (WHO) Multi-Country Study on Women's Health and Domestic Violence against Women (Garcia-Moreno *et al.* 2006). This WHO domestic violence questionnaire examines three types of partner violence: physical violence, sexual violence, and controlling behaviours by the intimate partner. In the present study, we focused on controlling behaviours as a type of psychological partner violence. There are six controlling behaviours provided in the WHO questionnaire. Examples of these items are: your intimate partner limits your contact with your family of birth, your intimate partner insists on knowing where you were, and your intimate partner gets angry if you speak to another man. Each item was coded as either '1' or '0', depending on the presence or absence of the controlling experience, respectively. These items were later tested for validity, and were found suitable in reflecting controlling behaviours of a partner (Clark *et al.* 2009). Cronbach's  $\alpha$  of the controlling behaviours in this study was 0.71.

Emotional abuse was measured by four items, as suggested in an earlier study (Forte *et al.* 2005). These items were whether the male partner had: (i) called the woman names she did not like; (ii) threatened to hurt somebody close to her; (iii) actually hurt somebody close to her; and (iv) destroyed something that belonged to her. Responses to each item were either 'yes' or 'no'. A 'yes' response was coded as '1', and '0' for the 'no' response.

The 20-item Center for Epidemiologic Studies – Depression (CES-D) scale (Radloff 1977) was used to measure depression. Each item was rated on a four-point scale. Four items had their scores reversed, as they are positively stated. Scores from 0 to 60 represent the final CES-D score, where higher scores indicate more experience of depressive symptoms. The validity and reliability of the CES-D were supported among women (Spijker *et al.* 2004; Zauszniewski & Graham 2009). Cronbach's  $\alpha$  for the CES-D in 3030 individuals was 0.89 (Onelov *et al.* 2007). The CES-D was used in this study because it showed good psychometric properties in terms of validity and reliability among Jordanian women (Al-Modallal 2010).

Stress and anxiety were measured using two subscales: the stress subscale and the anxiety subscale of the Depression Anxiety Stress Scales (Lovibond & Lovibond 1995). Each subscale is composed of seven items rated on a four-point scale. The total score for each subscale was obtained by summing ratings for all items within each

subscale. The total stress and anxiety scores ranged between 0 and 42, as scores were doubled (Lovibond & Lovibond 2004). Higher stress and anxiety scores were indicative of higher stress and anxiety levels, respectively. The stress and anxiety subscales showed evidence of acceptable psychometric qualities. Cronbach's  $\alpha$  for the stress and anxiety subscales were 0.95 and 0.92, respectively (Antony *et al.* 1998).

### Analytic strategy

Data was analyzed using SPSS statistical analysis software (SPSS, Chicago, IL, USA). Frequencies and percentages reflected women's personal and familial demographic characteristics as well as their experiences of psychological partner violence. Descriptive statistics were implemented to represent participants' mental health status in terms of depression, stress, and anxiety. Independent samples *t*-test was used to test for the presence of significant differences in depression, stress, and anxiety between victims and non-victims of psychological violence. Dependent variables in the analysis were depression, stress, and anxiety in their continuous forms, and the independent variable was victimization status. Differences in the means of depression, stress, and anxiety between victims and non-victims were calculated, and *t*-test values presented significance of the differences. The significance level for the analysis was determined at 0.05.

## RESULTS

Data from 267 refugee women were used in this analysis. The women's ages ranged between 16 and 62 years (mean = 31, standard deviation = 8.7). The demographic characteristics of the women showed that the majority were currently married, had children, and went to school at some point in their lives. Nearly 86% ( $n = 228$ ) of the women were housewives, with no specified job outside the home. Only one-fifth reported being pregnant during the time of data collection, and 'good' general health status was reported by nearly one-third of the participants (Table 1).

Nearly half of the women were victims of both types of psychological violence ( $n = 122$ , 47.7%). When broken down by type of violence, the controlling behaviours of the partner were reported by 201 (77%) women, and emotional violence was reported by 138 (52.7%) women. For women's reports of mental illness, depression was the most prevalent, reported by nearly 64% of the women, followed by anxiety and stress (Table 2).

**TABLE 1:** Participant characteristics (n = 267)†

Demographic characteristic	n	%
Marital status		
Married	244	91.4
Was married	23	8.6
Have children		
Yes	243	91
No	24	9
Level of education		
Less than 6th grade	21	7.9
7–12th grade	198	74.4
College degree or higher	47	17.7
Income		
Low	126	47.2
Medium	138	51.7
High	3	1.1
Pregnant		
Yes	55	20.8
No	210	79.2
Housewife		
Yes	228	86
No	37	13.9
Health status		
Poor/fair	72	27.3
Good	83	31.4
Very good/excellent	109	41.3

†No. participants in some demographic categories do not add up to total sample size due to missing data.

**TABLE 2:** Women's experiences of psychological partner violence and mental illness

Variable	n	%
Controlling behaviours	201	77
Emotional	138	52.7
Both (emotional and controlling behaviours)	122	47.7
Depression	156	63.9
Stress	73	27.8
Anxiety	116	41.6

The *t*-test results indicated that, compared to their non-victimized counterparts, women who experienced control by their partners, emotional violence, or both types of psychological partner violence, had on average higher scores on all mental health measures in terms of depression, stress, and anxiety. Significant differences (all  $P < 0.05$ ) in the mean scores of depression, stress, and anxiety were noted between victims of controlling behaviours, emotional violence, and both types of psychological violence, compared to non-victims. For example, women who were victims of both types of psychological violence had higher depression scores ( $t = -4.92, P < 0.0001$ ), higher stress scores ( $t = -3.73, P < 0.0001$ ), and higher anxiety scores ( $t = -4.22, P < 0.0001$ ), compared to those

**TABLE 3:** Relationship between psychological partner violence and mental health of the participants (n = 267)

Mental health outcome	No. within violence strata	Mean	Standard deviation	Mean difference	<i>t</i> -test value
Controlling behaviours					
Depression					
	Yes	164	21.9	12.4	-5.18
	No	48	16.7	11.6	-2.59*
Stress					
	Yes	180	14.3	10.1	-4.56
	No	53	9.8	9.3	-2.94**
Anxiety					
	Yes	189	11.2	11.4	-4.48
	No	56	6.8	8.3	-3.24**
Emotional violence					
Depression					
	Yes	110	24.7	13.5	-8.12
	No	104	16.6	9.2	-5.15***
Stress					
	Yes	119	15.7	10.6	-5.2
	No	113	10.5	8.9	-4.06***
Anxiety					
	Yes	127	13.1	12.3	-6.02
	No	118	7.1	8.1	-4.55***
Both					
Depression					
	Yes	99	24.9	13.7	-8.12
	No	111	16.8	9.6	-4.92***
Stress					
	Yes	107	15.9	10.7	-4.93
	No	122	10.9	9.1	-3.73***
Anxiety					
	Yes	113	13.2	12.5	-5.88
	No	127	7.3	8.4	-4.22***

\* $P < 0.05$ , \*\* $P < 0.005$ , \*\*\* $P < 0.0001$ .

who were not victims of psychological violence. Similar results were revealed between victims and non-victims of controlling behaviours, and between victims and non-victims of emotional violence (Table 3).

## DISCUSSION

One of the main findings of the present study was women's experiences of psychological partner violence. This finding was congruent with previous international investigations, in terms of presence of this phenomenon (Straight *et al.* 2003; Zink *et al.* 2005). In terms of prevalence rates, a group of investigators revealed that the prevalence of emotional abuse among women was 19.3% (Romans *et al.* 2007). Targeting the Jordanian population, the reported prevalence rates of control by the partner and psychological violence were 97.2% and 73.4%,

respectively (Clark *et al.* 2009). The results of the current investigation were closer to those of Clark *et al.* (2009), which indicate that Jordanian women, and women in refugee camps specifically, could be more vulnerable to psychological partner violence compared to women from other cultures. This assumption is supported by the lower prevalence rates of emotional violence reported by women from US (Coker *et al.* 2002a) and Australian communities (Hegarty *et al.* 2004), compared to the results of the present investigation.

Women's vulnerability to psychological violence has been previously examined. Robertson and Murachver (2007) indicated that greater dominance attitudes were associated with victims' suffering of psychological violence ( $r = 0.403$ ,  $P < 0.05$ ) (Robertson & Murachver 2007). Male dominance was clarified by Douki *et al.* (2003, p. 167): 'The husband's role is thus authoritarian, and he assumes responsibility for maintaining the family structure in whatever means he feels are justified, including violence'. Male dominance could have a significant impact on women, such as our participants. The women in the present study were members of low-to-medium-income families. Most women were housewives; that is, they were financially dependent on their husbands. Financial dependence on the male spouse justifies his dominant role and strengthens its effect. This dominance is expressed in women's liability of being subject to, but not perpetrators of, psychological violence.

Communication problems were a factor correlated with victims' suffering of psychological violence (Robertson & Murachver 2007). In the Arab culture, the husband is the head of the household, and has the right to control and dominate the family. Women in the present study, however, were characterized by a low educational level, economic hardship, and financial dependence on the male spouse due to unemployment. A combination of these factors contributes to women's feelings of inferiority, and superiority of the male partner. This combination makes it hard for some women to communicate (argue/converse) with the male on issues of daily life or issues that are important for the family. The inability of women to argue/converse with their partners means that abusive partners may use violence, such as psychological violence, anytime or in any situation, as they believe that it is their right to do so as the head of the household.

The main results of the present study indicate that psychological partner violence, defined as experiences of control by the partner, or experiences of emotional violence, had a highly significant relationship with victims' reports of mental illness. Participants who were victims of psychological partner violence reported higher

depression, stress, and anxiety scores compared to their non-victimized counterparts. Differences in the mean depression, stress, and anxiety scores between victims and non-victims were significant ( $P < 0.05$ ).

There is evidence of the positive relationship between psychological partner violence and women's mental health status in the published literature (Coker *et al.* 2002b; Houry *et al.* 2006; Pico-Alfonso *et al.* 2006; Ramos & Carlson 2004). Furthermore, a positive dose-response association between psychological partner violence and mental health, in terms of depressive symptoms, was supported in women (Coker *et al.* 2002b). The role of victims' self-esteem can help clarify this relationship. It is known that partner violence is a predictor for low self-esteem in victims (Bullock *et al.* 2006; Clements *et al.* 2005). Low self-esteem, in turn, is responsible for poor mental health status, in terms of severe depression, anxiety, and other psychological symptoms (Matud 2005). Although self-esteem was not measured in this study, its role in explaining the relationship between psychological partner violence and women's mental health status is worth emphasizing. Future studies explaining this role are needed in this area.

The rates of mental illness were obviously high in the present study. Women in this study mainly lived in crowded camps because of impoverishment; impoverished women are targets for psychological distress (Wenzel *et al.* 2004). Psychological distress, in turn, would explain the poor mental health status of these women. Earlier research revealed that psychological violence significantly predicted victims' complaints of depressive symptoms (Nurius *et al.* 2003) and anxiety (Ramos & Carlson 2004). It was also found that socioeconomic factors, including employment, income, and education, significantly predicted the depression level of victims beyond the effect of partner violence, including psychological partner violence ( $F = 57.69$ ,  $P < 0.001$ ) (Nurius *et al.* 2003). Although mental health variables did not regress on socioeconomic factors in this study, it can be speculated that women's socioeconomic factors are significant predictors for their poor mental health status, based on the results of Nurius *et al.* (2003). This speculation emerges from the poor socioeconomic profile of the participants in this study. Detailed information about the effect of socioeconomic factors on mental health needs to be considered in future studies.

It is important to bear in mind that refugee women share similar beliefs about family and home, including what is expected of them, as Jordanian women. As well as this, and as stated earlier, women in refugee camps live in relatively uncomfortable conditions (e.g. crowdedness

and poverty). Family demands, household chores, and poor living conditions are reasonable predictors for women's poor mental health status. Al-Modallal *et al.* (2010) noted the effects of these factors on Jordanian women's depressive symptoms. As such, it is assumed that these factors are highly significant in refugee women's lives in terms of mental illness.

## IMPLICATIONS FOR MENTAL HEALTH NURSING

Mental health nurses are in a unique position to help women experiencing psychological abuse by providing primary intervention. This can be done by identifying women who are prone to partner violence, such as our participants. Such women become targets for intervention for the purpose of preventing the occurrence of mental illness. Educational programmes focusing on understanding the impact of psychological abuse can be directed at women. The establishment of counselling clinics that provide services, such as crisis management, group therapy, and marriage counselling, are examples of services that can best be provided by mental health nurses to women at health-care centres. Furthermore, early identification of victimized women can be successfully accomplished via fostering regular home visits to women in the community. In other situations, mental health nurses can identify early mental illness in women, and can start intervening before the illness becomes chronic. The chronicity of mental illness might have unpredictable consequences on victims, yet such consequences could be eliminated by proper nursing interventions.

Finally, negative impacts of psychological partner violence on women's general health should not be undermined. Therefore, the mental health status of women who experience psychological abuse should be a crucial focus of all health professionals who deal with women on a regular basis.

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